Approved: March 21, 2005
Date

MINUTES OF THE HOUSE HEALTH AND HUMAN SERVICES COMMITTEE

The meeting was called to order by Chairman Jim Morrison at 1:35 P.M. on March 15, 2005, in Room 526-S of the Capitol.

Committee members absent:
Representative Brenda Landwehr- excused

Committee staff present:
Melissa Calderwood, Kansas Legislative Research Department
Mary Galligan, Kansas Legislative Research Department
Renae Jefferies, Revisor of Statutes' Office
Gary Deeter, Committee Secretary

Conferees appearing before the committee:
Representative Peggy Mast
Detective Bill Howard, Kansas City, Kansas, Police Department
Mike Farmer, Kansas Catholic Conference
Jeanne Gawdun, Lobbyist, Kansans for Life
Kathy Ostrowski, Legislative Research Director, Kansans for Life
LaVeta Adams, Board Secretary, Women's Resource Center, Arkansas City
Mark Pederson, Aid for Women, Kansas City
Julie Burkhart, ProKanDo
Sarah London, Public Affairs Director and Lobbyist, Planned Parenthood of Kansas and Mid-Missouri
Irene Bettinger, MD, practicing in the Kansas City area
Jana Mackey, Lobbyist, National Organization of Women

Others attending:
See attached list.

The Chair opened the hearing on **HB 2503.**

Detective Bill Howard, Kansas City, Kansas, Police Department, told of being called to the Affordable Medicine Clinic, the abortion clinic of Dr. Krishna Rajanna, to investigate a theft. (Attachment 1) He then described his shock in seeing a clinic where Dr. Rajanna was unkempt, the clinic rooms, including the procedure room, were grossly unsanitary, Dr. Rajanna's record-keeping was spotty, abortion remains were stored in a freezer, and the employees were dispirited. He said he reported the conditions to the District Attorney, Nick Tomasic, and was informed that no law had been violated.

Representative Peggy Mast spoke in favor of the bill. (Attachment 2) She said an identical bill passed the legislature last year and was vetoed by the Governor; she noted that for three years attempts have been made to obtain enforceable standards to ensure a sanitary environment for abortion clinics.

Mike Farmer, Kansas Catholic Conference, spoke as a proponent. (Attachment 3) Commenting that accurate information has been difficult to obtain, he said that 75-80% of women who undergo an abortion do not return for a follow-up exam and over half do not live in Kansas. He stated that abortion clinics are unregulated and even the one abortion clinic that is licensed, Planned Parenthood in Overland Park, when cited for deficiencies, was not penalized. He commented that there have been at least four known, litigated deaths following abortions from Kansas-licensed practitioners. He said that the regulatory standards of the bill reflect standards and protocols promulgated by national abortion organizations.

Jeanne Gawdun, Lobbyist, Kansans for Life, testified in support of the bill, saying that the bill, known as the Women's Health Protection Act, would assure safety regulations for abortion clinics. (Attachment 4) She said presently the Kansas Board of Healing Arts is the only agency with regulatory oversight; the Board regulates only the doctors, not the abortion premises, and appears to be lax in enforcing standards for doctors who perform abortions. In noting that the bill applies only to abortion clinics, not clinics in general, she cited similar selective licensing legislation in other states which has been upheld by courts.

Kathy Ostrowski, Legislative Research Director, Kansans for Life, spoke as a proponent. (Attachment 5) She deplored the Board of Healing Arts' dilatory response to complaints regarding the Rajanna clinic and noted that Kansas does not license by speciality, allowing doctors other than those trained in obstetrics and gynecology to do abortions, leading her to conclude that in regard to abortions the Board does not protect women.

LaVeta Adams, Board Secretary, Women's Resource Center, Arkansas City, spoke in favor of the bill, saying that because of a rape that resulted in pregnancy, she had an abortion by a physician using unsterile instruments, an action which produced a sexually transmitted disease that left her infertile. (Attachment 6)

Marsha Strahm, Legislative Liaison, Concerned Women for America of Kansas, provided written testimony as a proponent. (Attachment 7)

Mark Pederson, manager of Aid for Women, an abortion clinic in Kansas City, spoke as an opponent to the bill. (Attachment 8) He said that stories about abortions being unsafe were unfounded, that supporters of the bill resorted to emotionally-charged words, and that the assertion that the bill reflects national standards was untrue. He said that comparing abortion clinics to veterinarian clinics was misleading, and that if all the provisions of the bill were implemented, it would force his clinic out of business.

Julie Burkhart, Lobbyist for ProKanDo, spoke in opposition to the bill. (Attachment 9) She said that although similar bills have been passed in other states, the original law in Arizona is being challenged in court. Commenting on complaints about physicians, she stated that complaints dealing with abortion physicians represent only 0.76%, and in Kansas, of the malpractice payout from 2000-2005 (reported by the Health Care Stabilization Fund), only 1.35% were related to abortion. She said an abortion procedure is safer than a tonsillectomy, an appendectomy, or childbirth. She then suggested that abortions could be reduced if contraceptive information and medications were more widely distributed.

Sarah London, Public Affairs Director and Lobbyist, Planned Parenthood of Kansas and Mid-Missouri, spoke as an opponent. (Attachment 10) After commenting on the valuable services provided by Planned Parenthood, she noted that the bill singles out abortion for regulation without credible justification, observing that the Board of Healing Arts governs all doctors, including abortion physicians, and that the Board recently adopted Kansas Medical Society guidelines for out-patient surgery, which apply equally to all procedures, leading her to conclude that the bill is prejudicial and unfair. She stated that the bill, modeled after 1999 Arizona legislation, is outdated when compared to Planned Parenthood standards, and that standards should be developed by medical personnel, not legislators. She ended by encouraging legislators to pursue an alternative–more effective dissemination of contraceptive information and services.

Irene Bettinger, MD, a neurologist practicing in Kansas City, spoke in opposition to the bill. (Attachment 11) She said medicine, not politics, should determine patient care, and that abortion is a part of mainstream medical care, commenting that the National Abortion Federation and the Planned Parenthood guidelines are superior to the standards of the bill.

Jana Mackey, Lobbyist, National Organization of Women, testified as an opponent. (Attachment 12) She said that although the organization usually supports measures that provide safety for women, she stated that the bill, by regulating only abortion clinics, is unfair and leaves the impression that abortion is more dangerous than other surgical procedures, a belief which she dispelled by comparing complications from abortions with those from other procedures. Further, she noted that meeting the regulations of the bill will add to the cost of operating clinics, perhaps causing some to close, and thereby making abortion less accessible. She concluded by listing contraceptive measures which would be a better use of the committee's attention.

The proponents for the bill provided documentation in support of the bill. (Attachment 13) Likewise, opponents provided documentation for their assertions. (Attachment 14)

Members asked conferees numerous questions, queries such as qualifications for abortion clinic staff, emergency procedures, what specifics in the bill that opponents objected to, and whether the bill reflected the National Abortion Federation's or Planned Parenthood's published standards. Mr. Pederson said abortion fees started at $380. Ms. Ostrowski said that if the bill was outdated and was inferior to NAF guidelines, it at least represented a minimum standard to which opponents should not object. She noted that federal courts have declared that, since the Casey decision, abortion is unique and can be regulated separately from other medical procedures. Mr. Pederson said that in his clinic the person who monitors patients under anesthesia has had 30 years' experience, but is not educationally trained or certified. He said in his 12 years of experience with the clinic, an authentic emergency which necessitated calling an ambulance occurred only once. He answered that the physician in his clinic did not have hospital privileges and any patients needing hospitalization were sent to the emergency room. He replied that he had no medical credentials, rather a Bachelor's degree in physics; he commented that as clinic manager his best preparation would have been accounting. Ms. Burkhart said there was nothing specific in the bill to which she objected, since the entire bill was prejudicial, unprecedented in Kansas, and unfair to abortion clinics. Ms. London replied that about 11,000 abortions were performed in Kansas last year, a number that represented 0.9% of the total abortions performed in the United

States. Detective Howard replied that he saw the clinic before business hours, and had he been there when the clinic was open for business, he might have called the county health department.

The meeting was adjourned at 3:11 p.m. The next meeting is scheduled for Wednesday, March 16, 2005.

HOUSE HEALTH AND HUMAN SERVICES COMMITTEE
GUEST LIST

DATE: MARCH 15 2005

NAME	REPRESENTING
HERBERT HODES, MD	SELF (M.D.)
John D Currie	KFL
Claire Foushee	KFL
Jeanne Gawdun	KFL
Mike Farmer	Kansas Catholic Conference
Karen Myers	Youth for Life
Eileen Myers & Becky	True Majority
Joyce Blanchard	Choices Medical Clinic
Mary Ann Phillips RN, IBCLC	self
Robyn Johnson	KFL
Jon Josserand	University of Kansas
Sharon Patnode	KDHE
Zach Cobb	Rep. Steward for
Kristina Hillwalt	Rep. Watkins
Jenny Davis	Conkle Consulting
Rebecca Bailey	KMS
DEBORAH STERN	KS. HOSP. ASSOC.
Jess Cafferata	Kansas Assoc.

Proponent, House Bill 2503 March 15,2005
House Committee on Health and Human Services
Dear Chairman Morrison and committee members,

My name is Detective William Howard. I joined the Kansas City Kansas Police Department in 1982. I am here today to testify truthfully about events that I witnessed at an abortion clinic while performing my lawful duties as an officer. I am only here to relay the facts of my official investigation and do not represent either side of the issue of abortion by virtue of my role in the community.

On September 18th, 2003 my partner and I went to investigate a theft reported by **Dr. Krishna Rajanna, at the Affordable Medicine Clinic at 1030 Central Ave,** in **KCK.** Dr. Rajanna took us to the rear area, which could be described as a break room, to discuss employees he held responsible for money missing from his business. During this interview phase, my partner and I made these observations.

First, the doctor had an unkempt appearance. Dr. Rajanna lacked personal hygiene. His hair was messy, hands dirty, and his clothing was wrinkled and stained. He put on old, used foot booties while we were there.

The clinic was dirty inside. As we proceeded through the facility I noted the back area was very dark and dingy looking with poor lighting and smelling musty. We entered the "break room" to interview Rajanna. There were dirty dishes in the sink and on the tabletop, trash everywhere, and roaches crawling across the countertops, with a smell of a stench in the room. Frankly, I was reluctant to sit down. I noted there weren't containers for medical waste with universally recognized hazardous waste labels on them. On the way out my partner observed that the "procedure room" was filthy. He told me that he saw dried blood on the floor and the room looked "nasty" to him.

The clinic was disorganized. Papers and other miscellaneous documents were strewn about causing there to be "clutter" everywhere. Dr. Rajanna apparently kept very poor records. He could not recall when these alleged thefts had occurred nor was he organized enough to locate any documents to support his allegations. I also noticed that the assistants seemed to be running everything though they were barely out of their teens. There were no credentials on the wall. One spoke only Spanish. I looked at the patient sign-in sheet as part of the investigation and it consisted merely of notebook paper.

This general lack of a professional and sanitary environment starkly contrasted with all my experiences inside other doctor offices.

It was determined that Dr. Rajanna' theft charges could not be substantiated. Bank employees told us Dr. Rajanna has such loose record keeping practices concerning payroll checks that fraud could never be verified. Apparently the employees are allowed to write out their own payroll checks because Dr. Rajanna's printing is difficult to read. I was also given several checks to verify this for comparison and his signature is indeed a scribble mark.

I received full co-operation from the Employees accused of the theft. They were initially treated as suspects, given their Miranda rights and provided us with full statements. In a statement to me one witness/suspect related how Dr. Rajanna was a filthy man who did not properly sterilize his equipment. The medical equipment was cleaned with Clorox and water then put in a "dishwasher". The aborted fetuses were placed inside Styrofoam cups and put in the refrigerator freezer next to TV dinners. The female witness went on to describe of how she and other girls actually witnessed Rajanna microwave one of the aborted fetuses and stir it into his lunch. I have heard that some Middle

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Easterners eat the placenta from birth and that they believe that this adds longevity to life. I thought "Maybe" this could be what she was referring to. This witness claimed other employees who had seen him do the very same thing.

The initial witness related that she felt that she had been terminated because she was pregnant. She was repeatedly encouraged to terminate the pregnancy and told that she would not serve as a good representative of this clinic by carrying the pregnancy to term. According to this witness, she was starting to feel compassion for the females who were being summarily ushered in and out without adequate recovery time.

I became so disturbed by the condition of this medical clinic that I contacted District Attorney Nick Tomasic and requested a meeting to discuss these issues. Bare in mind, I am an experienced police officer who has worked in every aspect in law enforcement and had spent my last five years in the homicide unit where I worked countless community deaths. I thought I had heard and seen every vile, disgusting crime scene but was in for a new shock when I started this investigation. Nick Tomasic permitted me an appointment so I brought the witness directly to him where she gave him a first person statement of her account. I repeatedly warned her not to lie or exaggerate. The witness was also told that she could be prosecuted for any false statements made from this moment forward, but that the prior statements would not be prosecutable. She told the exact same story to DA Tomasic as she had told us.

I was informed that no laws had been violated. After this Meeting, Mr. Tomasic told me that he would have his staff research the information for any law violations. Later, Mr.Tomasic provided me a list of 3 numbers and agencies that I could contact to complain to about this clinic. I personally contacted the numbers on the list. One of the people I talked with was a female from Board of Healing Arts. I no longer have her name or any of the numbers I called regarding this investigation, but I believe I contacted Board of Healing Arts and someone from hazardous waste disposal center. I do not recall the third agency. The person at the Board, whose name I don't know, related that numerous complaints had been made about the clinic but no laws have been violated. Finally, I gave this list of phone numbers to the witness and advised her that she could contact these numbers to describe the environment she had worked in and this was my very last contact with anyone involved with this investigation.

In March of 2004, I learned that an official investigation was underway and was requested to give a statement. My partner has testified as to these same events April 30, 2004, before a group of Senators here at the Capitol at the request of Sen. Kerr. Thank you for your time, I stand for questions.

TESTIMONY ON HB 2503

Representative Peggy Mast

Tuesday, March 15, 2005

I want to thank the committee for their indulgence once again on a bill that is not a pleasant one to deal with. I regret that this bill had to come before this committee again this year after being heard for the past three years, but the need for this legislation has not changed. As a matter of fact, recent developments have exposed that this issue is one that must be addressed and we must pass this legislation to help prevent future injury to more women and to ensure they have decent health care.

For three years I have proposed that another female be in the room when a woman is examined for pregnancy and when the abortion takes place. For three years, we have heard opposition on this issue even though women have told me of sexual abuse when the examination was performed.

For three years we have tried to obtain enforceable standards for abortion clinics in order to ensure a sanitary environment, and proper health standards were in place. We were finally able to get an inspection on a clinic that had been exposed months before and our greatest fears were confirmed. The condition inside the clinic was outrageous! The staff was untrained, medicine was not properly labeled or stored. Medications that had been expired were found, and perhaps the most disconcerting finding to me was the fact that frozen human tissue was stored next to food items in the freezer. I don't think that Kansans are ready to accept this, yet the Board of Healing Arts made only a token attempt of addressing the problem. I also received recent pictures of the practitioner taking out the medical waste and transporting it to someone else's dumpster on his way home.

I won't belabor this issue. We all know that it needs to be addressed. With that, I stand for questions.

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March 15, 2005

House Health and Human
Services Committee

6301 ANTIOCH • MERRIAM, KANSAS 66202 • PHONE/FAX 913-722-6633 • WWW.KSCATHCONF.ORG

Testimony In Support Of HB2503

Chairman Morrison and members of the committee:

Thank you for the opportunity to testify in support of House Bill 2503, which would implement minimum health and safety standards for abortion clinics that operate in Kansas. My name is Mike Farmer and I am the Executive Director of the Kansas Catholic Conference, the public policy office of the Catholic Church in Kansas.

Abortion is an invasive, surgical procedure that can lead to numerous and serious medical complications. Because there are no uniform state collection requirements for data on abortion complications, the actual risk of medical complications are impossible to accurately quantify.

Numerous ex-clinic employees agree that 75-80% of women ordinarily do not return to the abortionist for a follow-up exam. Add to that the fact that roughly half of the women undergoing abortion in Kansas don't even live here. Therefore it is even more important that abortion clinics meet minimum health and safety requirements.

Abortion clinics in Kansas are unregulated. There are five known abortion businesses operating out of seven locations in Kansas. Six of the seven locations are not inspected nor require any licensing from the state because they are considered "doctor offices" under the authority of the Kansas Board of Healing Arts. The seventh, the Planned Parenthood facility in Overland Park, has a license under the Kansas Department of Health & Environment to operate as an Ambulatory Surgical Center. The ASC license is voluntary and seems to carry no penalties for violations; for example, KDHE did not levy any fine or close Planned Parenthood doors in 2002 when it was cited for numerous deficiencies. (see attachment)

The state Healing Arts Board is charged with granting or denying licenses to practitioners, not facilities. But even in that charge, the Board is lenient. The Board has not removed the license of Kansas City abortionist Krishna Rajanna even when they showed Rajanna to be severely out of compliance with the Board's Guidelines for Office-Based Surgery. The Board spent one year arriving at a finding of fact that was plainly evident in photos of the clinic made public last April by the Attorney General's office.

At that presentation, it was pleaded that all legislators ignore politics and enact clinic licensing. Unfortunately, that didn't happen and now an abortionist without certification in addressing cardiac events and resuscitation emergencies is permitted to stay open for business. That was the situation Missouri found (see attachment) after a Planned Parenthood abortion patient died when under the care of an abortionist without this same certification

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There are six current abortionists who reside in Kansas and of those six, three (Zaremski, Rajanna and Tiller) have disciplinary files with the Board, and two others (Hodes and Crist) have amassed at least 40 malpractice suits. There have been at least 4 known, litigated, deaths following abortions from Kansas-licensed practitioners: 1988 in Kansas City, 1991 in Houston, and 1981 and 1997 in St. Louis. Now we await confirmation as to the cause of death of a 19-year-old Texas woman who died on or about Jan. 13, 2005, having been rushed by ambulance to Wesley hospital from George Tiller's abortion clinic.

The regulatory standards embodied in HB 2503 are derived from standards and protocols promulgated by abortion providers and abortion advocacy groups, specifically the Planned Parenthood Federation of America and the National Abortion Federation. The language of HB 2503 bill has been upheld repeatedly in circuit courts and district courts. For more information on court decisions and answers to commonly raised objections, I encourage the committee to review the testimony of Denise M. Burke, a senior litigation counsel with Americans United for Life, with extensive experience in constitutional law and abortion jurisprudence.

The Kansas Catholic Conference unreservedly supports passage of HB 2503 and would urge you to recommend this bill favorable for passage.

Planned Parenthood of Mid-Missouri Eastern Kansas

Sample excerpts of how Planned Parenthood failed inspection in Kansas:

5-24-02 KDHE Inspection

"based on record reviews and staff interview, the facility failed to establish a policy that would allow patients the right to access the information in their medical record." 28-34-521 (a) (4)

"facility failed to provide education to facility staff related to reporting of reportable incidents. 28-34-55a (e)

"Staff...would not necessarily report medication or treatment errors" 28-34-55a (e)

"failed to assure that only authorized personnel had access to medical records" 28-34-57(b)

"boxes of medical records stored in an unlocked open room" 28-34-57(b)

"facility failed to initiate and maintain an ongoing infection control program" 28-34-58a (a)

"facility failed to require medical examinations upon employment and subsequent medical exams or health assessments thereafter" 28-34-58a (b)

"employee files ...failed to have immunization histories" 28-34-58a (b)

"outdated drugs dispersed among other drugs on the shelves in Pharmacy" 28-34-59a (h)

"bulk narcotics...nurses have access to these narcotics they are not counted by nursing" 28-34-59a (h)

Sample excerpts of how Planned Parenthood failed inspection in Missouri:

6-24-97-inspection by Missouri Department of Health following death of abortion patient; the physician is abortionist Robert Crist at Planned Parenthood in St. Louis

"facility failed to see that all licensed personnel are CPR certified. The physician involved in the medical emergency failed to have CPR certification" 19 CSR 30-30.060(1) (B) 11.D

"Facility failed to have the necessary emergency equipment immediately available to the procedure room as required by 19CSR 30-30.060(3)(L)"

"the facility failed to have the necessary equipment needed in a respiratory and cardiac arrest situation" 19CSR 30-30.060(3)(L)

"the patient was in cardiac arrest...no CPR was attempted by the provider" 19CSR 30-30.060(3)(L)

"facility failed to have the necessary emergency endotrachial equipment available" 19CSR 30-30.060(3)(L)

"An abortion was performed on patient whose hemoglobin was 8.0. the facility policy indicates that anyone in the first trimester that has a hemoglobin of 8 should be ineligible for the procedure" 19CSR 30-30.060(3)(L)

"On 4-30-97 ...22 year old patient who had an abortion, began seizing, lost consciousness and ceased to breathe....patient was transferred to an acute care hospital via ambulance where she later died." 19CSR 30-30.060(3)(L)

Testimony in support of HB 2503
House Health and Human Services Committee
Tuesday, March 15, 2005

Chairman Morrison and Members of the Committee:

Good afternoon, I am Jeanne Gawdun, lobbyist for Kansans for Life. I am here to testify in support of HB 2503, now known as the Women's Health Protection Act. This bill would enact safety regulations for abortion clinics that must be met for the business to operate. This is a bill where licensing follows KDHE inspection, in contrast to the state Board of Healing Arts, which licenses physicians and allows them to stay in business even when deficient.

The main problem addressed by clinic licensing is the INADEQUACY of the Board to protect women. The entire state system of safety, particularly in abortion clinics, relies on low-wage earners being smart enough to know what's wrong, and then having the inner resolve to find the proper authorities and pursue it.

Since the Board is structured without the ordinary ability to inspect doctors' offices and clinics, they rely on patients or clinic staffers to blow the whistle on problems. Restated, the safety of women depends upon patients who want to forget about their abortion or staffers who don't want to jeopardize their jobs. No wonder whistle-blowers are rare.

As reported in the New York Times, abortionists employ cheaply paid-rapid turnover staff with little medical training. Non-medically trained workers really aren't aware of oversight boards. (This was the case for the girl who eventually took these clinic photos; she has common sense but no high school diploma.) In contrast to those employed in mainstream physician offices, high numbers of staffers in abortion clinics aren't always trained in the duty to report problems and in conveying patient rights—as noted by KDHE. In 2002, they found the Overland Park Planned Parenthood had failed Ambulatory Surgical Center regulations to inform patients of grievance policies and to have a policy for reporting abuse, neglect or exploitation of patients. (They also cited Planned Parenthood deficient in over a dozen ways, including outdated drugs and violations of privacy for patient files.)

The provisions of this Women's Health Protection Act are based on the published standards of the abortion industry. Thus opponents raise a ridiculous claim that adopting licensing standards-- that the abortionists are already supposed to be following --will drive them out of business! Furthermore, opponents argue that implementing their own industry standards is an unacceptable burden! In the 2003 hearings for this bill, Planned Parenthood admitted that they "nearly met" their own standards. Amazingly, abortion has enjoyed mainstream acceptance without providing mainstream standards.

In 2004, Planned Parenthood's director said, "If a licensing bill is solely directed at abortion clinics, it's totally unacceptable." But the Courts repeatedly say otherwise when allowing similar licensing bills in Louisiana, Texas, Tennessee, South Carolina and

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Arizona. Those Courts reflect the 1992 Casey decision, in which the Supreme Court declared that the State has every right to protect women' health by regulating abortion clinics; "abortion is a unique act… fraught with consequences for others."

Abortion is NOT like other medical procedures. Regulating abortion alone is NOT unfair. The state regularly legislates piecemeal—it's not all-or-nothing in other areas.

The politics are amazing for a bill to license seven clinics with regulations that are already basically written. The second year this bill was worked in the House, the fiscal note nearly doubled to $291,000 though no provision had changed. Then an amazing fiscal note was published of $160, 000 for the alternative bill which would attempt to regulate EVERY doctor office in the state. Why is the estimate for thousands of offices less than that of seven? It isn't--the actual estimated cost of regulating all offices was "incalculable" according to KDHE's Joe Kroll.

The desire to avoid oversight is understandable when we see evidence of assembly line clinics. The shortcuts made by abortionists were consistently observed by whistleblowers (see documents submitted by KFL). A lack of equipment for monitoring and sterilizing was accompanied by staffing and sanitation shortcuts. What other service has kept the same price for over 30 years—the price of an early abortion remains $250-$300! The need for cutting corners opposes the requirements for safety.

For Rajanna, the abortionist whose clinic is pictured, the Board of Healing Arts found pre-drawn syringes, declared he was not in compliance with medical standards and ordered him to keep his patients in a recovery area for an hour. These are some of the same complaints they found against Rajanna's former co-abortionist, Kristin Neuhaus. In both cases, they cited abortionists as substandard but then allow them to stay in business. In fact, after the Board declared Neuhaus an "imminent danger to the public", the Board never closed her. They even bragged they never forced her to close.

It is obvious that the Board is failing to protect women at abortion clinics. What the Women's Health Protection Act does is make the abortion industry accountable to their own stated standards-- without relying on reports from abortion staffers and videotapes of ambulance runs to the hospital. Kansans for Life urges you to pass HB 2503 favorably out of committee. Thank you, I stand for questions.

Testimony in Support of HB 2503
House Health and Human Services Committee
Tuesday, March 15, 2005

Chairman Morrison and Members of the Committee:

Good afternoon, I am Kathy Ostrowski, State Legislative Research Director for Kansans for Life. I am here to support the Women's Health Protection Act, on its own merits, but more specifically today to underscore the need for HB2503 based on the actions of the state Board of Healing Arts.

Jeannie's testimony (and out submitted documentation) points out that abortion clinics are in deplorable condition, and untrained staffers can't be relied upon to report to the Board. Those are structural problems. What I want to highlight is that even when the Board receives whistleblowers' reports and notice of severe restrictions from the federal Drug Enforcement Agency, they stubbornly refuse to address problems in an aggressive, woman-protective way. When it comes to abortion, the Board

1) protects abortionists and keeps their doors open after proclaiming them substandard and

2).allows them to "slide" into compliance, micromanaging their practice at tax-payer expense.

Last year KFL presented the testimony of a former employee (we call her Ruby). She described a filthy, substandard abortion clinic and took pictures to back up her claims Everything she alleged was reflected in the Board of Healing Arts' Feb.12, 2005 disciplinary order against Krishna Rajanna.. Unfortunately, it took the Board a year to

1) affirm the filthy conditions,

2) issue a small fine (the price of 3 early abortions) and

3) proclaim that Rajanna must obey the Board's Guidelines for office-based Surgery.

And without Kansans for Life, they never would have reviewed his business! The Board had been contacted in September 2003 by law officers and the District Attorney, but basically blew them off. In fact, when photos were brought February 18, 2004 to the Board with an official form, they didn't even have the courtesy to sit down with the complainant or call him for 3 months! By this time the AG had released the whistleblower photos to the media and legislators. And the legislative session was over—how convenient.

They hadn't even visited the Rajanna clinic for 5 weeks, even when legislators repeatedly called for information. SO, basically the Board had all the time they wanted to show their true colors –and they have only strengthened the case for the Women's Health protection Act.

I attended the June 2004 meeting where the Board discussed and decided it did not want to inspect abortion clinics, and they had not the staff, expertise nor budget to attempt more than they presently do. I agree—they have several hundred open cases. Surely a

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licensing law with abortion-specific protocols to insure safety, and one that governs facilities, not doctors, is something the Board should support.

At that meeting, one Board member was disturbed to learn that Kansas does not license by specialty. Thus a Kansas medical license allows the practitioner to do business in ANY branch of medicine, regardless of training. This explains how Kansas ended up with these abortionists:

1)A 76-year old pulmonary (lung) physician began aborting when his substance-abusing, felon, KCK abortionist partner lost his Kansas license.

2)A 72 year old Lawrence abortionist did not report the rape of a child (a case that was eventually successfully prosecuted) but was not disciplined by the Board.

3)A washout surgeon with paternity and alimony financial troubles, and who was identified in a lawsuit as selling drug scrips for his livelihood, began aborting in KCK at age 63.

4)A 76 year old family practitioner in KCK was aborting quietly without advertisement, and more dangerously, without using sonograms, according to his staffer. All 4 of these abortionists have had disciplinary actions against them from the Board, and that's not all that do. During the last 10 years, 13 private abortionists resided in Kansas, of whom 8 have disciplinary files with the Board. Yet there is no deterrence from these Board actions. The whistleblower in 2003 cited the same criticisms about Rajanna that were voiced in the 1992 whistleblower testimony about Rajanna's former co-abortionist Malcolm Knarr. The cost-cutting cited in Neuhaus was practiced by Rajanna

The Board of Healing Arts protection to women is inconsistent or nonexistent:

1) They order Rajanna to obtain certification but do not stop him from doing business without it. Either it's necessary to practice safely or it's not; there's no middle ground. If they say it's necessary to be certified, how can they allow him to do business without it?
2) They order certain facility improvements but allow him one year to pass inspection.
   Again, either he is unsafe without sufficient equipment and protocols or he isn't unsafe.

When it comes to abortion, the Board isn't protecting women, and isn't deterring bad practitioners. But it is checking into the death of a 19 year-old woman with Downs Syndrome, who was rushed to the hospital from the Wichita clinic of general practitioner George Tiller. The Governor wants to know if her veto of this bill in 2003 can be faulted in the death. Will it take the Board one year to answer?
In the meantime, please pass HB2503. Thank you, I stand for questions.

March 14, 2005

Dear Concerned Legislators:

My name is LaVeta Adams and I am the Board Secretary of an adoption agency and women's resource center on Arkansas City, Kansas. We provide prenatal information, free pregnancy testing, guidance regarding abortion, and adoption guidance. I have been with this agency as a volunteer since 1997 and as a board member since 1999.

The testimony I would like to present today is in regards to House Bill 2503. In 1987 I had an abortion. It was by far my most horrible experience. I was raped by my first cousin. Several medical professionals told me that there was no chance for my baby to live a normal life and that it would have mental and or physical birth defects. I went through with the abortion in a abortion hospital. The doctor used instruments which had not been steralized properly which resulted in infections. I physically contracted a sexually transmitted disease from that procedure. I contracted trechinosis from the abortion procedure. Other complications included various infections such as mastritus, and I am facing the reality of being sterile from the procedure. The infections I had were so severe I faced having surgury. I was fortunate that my OB doctor was able to give me the right medications to keep me from having those surgeries.My husband and I have been married for eleven years and have never
concieved. I have to live daily knowing that my decision may have caused me to never be able to have a child again. It has also affected my mental health as I will never forget the medical trauma I went through. The abortion and the complications resulting from the abortion were much worse for me than experiencing the rape. Unregualted abortion and abortion procedures do hurt women. I was one of those women who have been hurt from abortion. Please support House Bill 2503 and regulate abortion so other women don't have to go through the events I went through.

Thank you,
LaVeta Adams

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March 15, 2005

Members of the Health and Human Services Committee:
Abortion: safe but rare. This statement reflects wishful thinking on the part of policy-makers and abortion proponents who often use this slogan as a shield to obscure the real facts. The facts are that women continue to die and suffer complications from abortions. Abortion is a surgical procedure that carries risks of perforating the uterus, infection, hemorrhage and other complications. The opportunity lies before you to do something about half of the slogan…to make abortion safer…to require the abortion industry to give credence to their motto by submitting to the same regulations as all other surgical care centers. In light of the flurry of ambulance calls to the Tiller clinic in the past 12 months, including at least one death, it is imperative that an invasive surgical procedure such as an abortion be carefully monitored and regulated by an entity that can actually ensure the safety of women.

The legitimate function of government is to protect the health and safety of its citizens and that duty is being thwarted by a mentality that says *any regulation* of the abortion industry is tantamount to harassment; that abortion clinics are accurately self-reporting statistics about injuries and complications in the abortion procedures performed; and that the performance of abortions is sacrosanct and above regulation. The abortion industry made its case thirty-some years ago by claiming that "women were dying in back-alley abortions." Women are still dying, being rendered sterile and suffering complications from abortions **now**. Because of a deficiency of reporting requirements, abortion deaths and complications are often not reported as such. In addition to the industry's "immunity" from proper reporting, abortion complications are often under-reported because of lack of follow-up care sometimes precipitated by shame or anxiety on the part of the woman. Millions of dollars flow through abortion clinics across this country; yet states are reluctant to regulate clinics because they are uniquely insulated by the abortion industry's claim to the so-called Constitutional "right to choose." Yet the Supreme Court has never put abortion clinics or providers outside of the State's "legitimate interests from the outset of the pregnancy in protecting the health of the woman and the life of the fetus that may become a child." *[Planned Parenthood v Casey, 505 U.S. 833, 852 (1992) at 846]* Another Court opinion, *Greenville Women's Clinic v. Bryant* illustrates that the Constitution does permit health and safety regulation of abortion clinics and services. [*Greenville Women's Clinic*, 222 F.3d 157 (4th Cir. 08/15/000), *cert. den'd Feb 26, 2001]* The regulations in question were to promote proper sanitation, housekeeping, maintenance, staff qualifications, emergency equipment and procedures to provide emergency care, medical records and reports, laboratory, procedure and recovery rooms, quality assurance, infection control and information on and access to patient follow-up care necessary to keep women safer. To the ordinary person, these requirements seem like a no-brainer in light of the intense scrutiny given veterinarian clinics, beauty parlors, barbers and nail technicians. In light of the recent serious violations by a clinic in KCK invoking a "slap on the wrist" by the Board of Healing Arts *one year later*, and with the clinic operating for that time, it seems that the urgency for action has accelerated considerably. That is, it is urgent if we are sincere about protecting women. Most reasonable people see that a medical procedure such as abortion should be regulated and under scrutiny by the state to protect the health and safety of women, rather than trusting the industry to regulate itself or entrusting that regulation to a board that is appointed and appears to lack a sense of urgency in violations.

As a women's organization, we ask you to protect those women who choose abortion by requiring and enforcing that abortion clinics follow safe medical practices; accurate and complete reporting; and proper protocol for ensuring emergency care should a serious complication arise and that regulation be under the scrutiny of an agency that can actually do something should infractions occur.

Women deserve better than the words of a cleverly devised slogan. Women deserve to be protected.

Judy Smith, State Director, Concerned Women for America of Kansas
Marsha Strahm, Legislative Liaison

Attachment 7
HHS 3-15-05

HB2503 Opponent, Mark Pederson, Manager, and Zaremski, MD, Medical Director
Capitol Bldg., Rm 526-S, 15March2005, 1:30pm, Human & Health Services Cmte.

Aid For Women, abortion clinic, 720 Central Avenue, Kansas City, KS 66101, 913.321.3350
National Abortion Federation (NAF) member

This is at least the fourth attempt to get abortion health restrictions in place [1] which presumes abortions are unsafe, and for the fourth time, "Where are those facts about abortion risks? I will agree that 2nd trimester abortions are slightly riskier than 1st trimester, but those mortalities are still better than childbirth[2,3], and yet birthing can still be done at home. Driving to the clinic is riskier than either of these. [4] Last year's HB2751 proponents and the Attorney General media-splashed low-cost abortion provider (Rajanna) as the stereotype, yet this bill will not affect him.

Proponents will not be appeased until abortion is eliminated. This bill is not about women's health care otherwise they would not have forbid abortions at ambulatory KU Medical Center in 1998.[5] Don't believe these proponents who claim to want to make abortion safer, **unless safer means none** . Are there plans to regulate births which are ten times more dangerous? Nope, even though there have been 37 birth-related deaths since 1990.

What regulations would prevent abortion clinic deaths, specifically please? Which causes of deaths have there been and how will these regulations prevent them? In my opinion it won't prevent any deaths. Proponents will use the loaded word 'botched,' the real word being 'incomplete' which isn't life-threatening and preferable over 'perforation,' and still has more to do with doctor skill (curettaging too lightly or heavily) and patient's circumstances (lying about medical history). This bill doesn't fix doctor skill or patient mistakes. That's why we go to annual NAF meetings for continuing medical education. ProLifer's also bandy the phrase 'vulnerable women' who won't talk when wronged, but our patients are not vulnerable if they have crossed through the proLife gauntlet picket line.

Why have proponents not enabled the Board of Healing Arts with more power? Proponents claim that BOHA is 'toothless,' 'impotent,' and 'reactive, not pro-active' to fix poor abortion clinics.[6] We've had our problems, and BOHA has dealt us Corrections. BOHA doesn't seem so toothless, but I am open to broadly based increases in BOHA's power. By the way, if this bill is supposedly pro-active, pro-active implies before problems have happened. Is that an accidental admission?

Proponents have claimed abortion deaths are being hidden by coroners out of respect, collusion by the CDC et cetera, and therefore proponents couldn't get needed proof of risks. We've been told that ambulances have arrived at our clinic silently, proof of city collusion to hide problems.[7] Conspiracies abound. A coroner told me that they have no problem declaring embarrassing Cause-of-Death statements such as AIDS, accidental auto-erotic hangings, drug overdoses, and suicides. In Wyandotte county a death outside of a hospital is required to be sent to the coroner. Part of proponent's mis-impression comes from the fact that there must be a direct or indirect causal relationship to abortion to be listed as an "abortion death" [8]. An anesthesia-related death during an otherwise uneventful abortion shouldn't be an abortion death. Also, deaths in another state attributable to a Kansas abortion provider don't count unless the state's other numbers are included. Keep it simple.

The 1997 CDC mortality rate for legal abortions is 0.6 per 100K abortions[9], and abortion is done exclusively in outpatient clinics. The mortality for birthing ranges from 6.0 per 100K births for white women and up to 24.9 for black women, the national average being 8.9.[10] Most deliveries are in hospitals. Car accidents kill 16 people/100K people annually, while suicide consumes 11 people per 100K people annually. Remove the mote from thine own eye first.

Ambulatory rules under SB155 require local hospital privileges or transfer agreements with a local hospital[11] and rules under HB2503 require hospital privileges in state[12]. Will there be legal remedy provided for the abortion provider when the hospital discriminates by refusing

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to make transfer agreements by use of the Conscience Clause that same proponents have pushed for? Providence Medical Center would never make a tacit transfer agreement with any abortion clinic. KU Medical Center cannot make a transfer agreement for fear of losing their State funding. Those are MY local hospitals. To get ONE abortion done at any other secular ambulatory surgery center requires a committee meeting, much less ten thousand KS abortions annually. HB2503 requires an RN or LPN, but our 3 female CPR-trained CMA's will not suffice. An LPN would be an over-qualification for dressing patients, making bottle labels, taking Histories, Vitals, and discussing birth control. Our female surgery nurse of 35 years experience doesn't qualify to provide post-operative monitoring under these rules. Under SB155, ambulatory regulations require 5' wide hallways. [13] I have a 43" wide corridor. Ambulatory regulations require a 360 sqft surgery room minimum[14] and I have a 9'9" x 11' surgery room. Regulations require an X-ray illuminator in each surgery room.[14] I have one hallway X-ray illuminator and have never used it for abortions. I worry about what the regulations under HB 2503 would become.

Proponents claim that these are minimum requirements BASED ON national standards, implying national acceptance. The phrase "based on" is a lie as HB2503 goes beyond NAF standards, and therefore is not a minimum. Where in the minimum NAF Clinical Policy Guidelines will one find the hospital privileges requirement, or the requirement for LPN's or RN's that exclude CMA's? You will find the current online 2005 NAF Clinical Policy Guidelines at http://www.guidelines.gov/summary/summary.aspx?doc_id=6518&nbr=4087. NAF members annually sign a promise to follow these standards. We follow them because we want to be better than the proLifer's think.

Proponents claim that veterinary clinics are more regulated than abortion clinics, that a woman would be better off at a veterinarian clinic than an abortion clinic. That is misleading. Veterinary standards at the statute-level are general. At the regulation-level directed by the Board of Veterinary Examiners, they are quite proscriptive. But then again, veterinarians aren't required to have malpractice insurance, something all physicians must have, and veterinarians are unlikely to get sued and have no death reporting requirement. Specific proscriptive laws are usually implemented by regulation not statute.[15]

Anti-abortion proponent Mark Crutcher of Life Dynamics, Inc. urges that abortion can be made unavailable by regulating it out of business. His goal, he wrote, is to create an America where abortion may indeed be perfectly legal but no one can get one."[16] Until KU Medical Center starts performing abortions again, the State helps finance important public health renovations at abortion clinics, and make annual licensing fees the same as ambulatory facilities (free), proponent's safety motives shouldn't be believed.

KDHE KIC statistics[17]

Mortalities 1990-2003:		**Hospital diagnoses (not deaths) 1995-2002:**	
11,351	Pneumonia	25,173	Complications of surgical procedures or medical care
6,825	Motor vehicle accidents		
4,442	Suicides	21,367	Scepticemia
3,034	Septicemia	9,658	Aspiration pneumonitis, food/vomitus
2,078	Homocides		
1,799	Pneumonitis (throwing up during anesthesia)	1,815	Ectopic pregnancies
		1,083	Miscarriages-spontaneous abortion
348	Complications of medical & surgical care	154	Post-abortion complications (abortion, ectopic, and molar)
302	Influenza		
37	Pregnancy complications	123	Induced abortion
0	Legal abortion		

FOOTNOTES

[1] Senate Bill 155 (2005) full ambulatory restrictions, House Bill 2751 (2004 3rd incarnation) partial ambulatory with $49,000 per clinic annual registration fee (6 clinics), House Bill 2176 (2003 2nd incarnation) partial ambulatory with $32,000 per clinic annual regisration fee, and HB2819 (2002 1st incarnation) partial ambulatory and claims to follow our own national standards.

[2] "The risk of death associated with abortion increases with the length of pregnancy, from 1 death for every 500,000 abortions at 8 or fewer weeks to 1 per 27,000 at 16-20 weeks and 1 per 8,000 at 21 or more weeks." New York: Allan Guttmacher Institute, http://www.agi-usa.org/pubs/fb_induced_abortion.html and made reference to previously published report titled "AGI, Abortion and Women's Health: A Turning Point for America?" New York: AGI, 1990, p. 30.

[3] Pearlman et al, *Obstetric & Gynecologic Emergencies: Diagnosis and Management*, (ISBN 0-07-145740-2), Chapter 6, Stubblefield P & Borgatta L, Complications of Induced Abortion, McGraw-Hill Companies, Inc., p. 65, c. 2004.

[4] http://www.cdc.gov/nchs/data/hus/hus04.pdf, Annual deaths from Vehicular Accidents, p. 190, 15.7 per 100K people; annual Suicides, p. 197, 11.0 per 100K people, 2002, all ages crude rate.

[5] KSA 76-3308(i)

[6] Kline news conference last April 28, 2004 regarding poor cleanliness of Dr. Rajanna's clinic. Mason: Was this discussed with BOHA? Rep Long: Larry Buenig [BOHA] was notified 4 weeks ago, and is finally up for review. Mason: They are powerless without new laws. But HB 2741 would enable BOHA to do something. Kline: No clear jurisdiction. Det. Howard to Tomasic: Inability to do anything. A restuarant health inspector has more power. Kline: BOHA is broken. During House Federal & State Affairs, HB 2751 2004 Proponent Mary Kay Kulp of Kansas Right To Life: Complaints [to BOHA] don't do anything. No standard of care. BOHA reacts but doesn't prevent.

[7] Mary Kay Kulp complained that they had seen ambulances at KCK clinic but ambulance was quiet, that there was collusion with the city to hide problems. We had an 8-month pregnant woman wearing over-alls, dropped off at our clinic without appointment by boyfriend who screeched his tires while leaving, and she demanded that we get this pregnancy out of her NOW because she was going to get arrested if she went to the hospital... [assumed drug use]. Her water broke while talking with us, and she went into labor with contractions about 5-minutes apart. We called 911, explained the situation, they arrived quietly, and they gurneyed her out the back door. Ignorant anti-abortion Eugene Frye from across the street was taking pictures like crazy, assuming we had just butchered an abortion patient. Why bother to tell him? Another time it was a minor who had a seizure and we sent her to the hospital via ambulance also. Later we were told at the hospital that she had faked the seizure to scare her mother who had pushed her into having the abortion! This is the kind of insanity we deal with every year, including this bill.

[8] http://www.cdc.gov/mmwr/PDF/ss/ss5309.pdf, Morbidity and Mortality Weekly Report, November 26, 2004, Vol. 53, No. SS-9, US Department of Health and Human Services, Centers for Disease Control and Prevention, Abortion Surveillance - United States, 2001, p. 3, "An abortion death was defined as a death resulting from 1) a direct complication of an abortion, 2) an indirect complication caused by the chain of events initiated by an abortion, or 3) aggravation of a pre-existing condition by the physiologic or psychologic effects of an abortion (1,2)"

[9] Ibid., p. 32, Table 19, Number of deaths and case-fatality rate for abortion-related deaths reported to CDC, by type of abortion - United States, 1972 - 2000.

[10] http://www.cdc.gov/nchs/data/hus/hus04.pdf, p. 189. Crude rates were used. Maternal mortality of complications of pregnancy, childbirth, and the puerperium, according to race, Hispanic origin, and age: United States, selected years 1950-2002. Typically these results are

for deaths up to 42 days after childbirth. Other reputable studies include all deaths up to 1 yea. after childbirth.

[11] K.A.R. 28-34-52b. Assessment and care of patients **(g) The ambulatory surgical center shall have a written transfer agreement with the local hospital for the immediate transfer of any patient** requiring medical care beyond the capability of the ambulatory surgical center, **or each physician** performing surgery at the ambulatory surgical center **shall have admitting privileges with a local hospital**.

[12] HB2503(d) "The Secretary shall adopt rules and regulations relating to abortion clinic personnel. At a minimum these rules shall require that: (3) A physician with admitting privileges at an accredited hospital in this state is available."

[13] KAR 28-34-62a Construction Standards. (a) General provisions. All ambulatory surgical center construction, including new buildings and additions or alterations to existing buildings, shall be in accordance with standards set forth in sections 1,2,3,4,5,6, **and subsections** 9.1, **9.2,** 9.5, 9.9, 9.10, and 9.32 in the American Institute of Architects Academy of Architecture for Health, publication number ISBN 1-55835-151-5, entitled **"1996-1997 Guidelines for Design and Construction of Hospital and Health Care Facilities,"** copyrighted in 1996, and hereby adopted by reference.

> **9.2)** Common Elements of Outpatient Facilities, **H1.** Details shall comply with the following standards: **(a) "Minimum public corridor width shall be 5 feet (1.52 meters)."**

[14] Ibid., Section **9.2)** Common Elements of Outpatient Facilities, **B3.** Treatment rooms(s). **Rooms for minor surgical** and cast procedures (if provided) **shall have a minimum floor area of 120 square feet** (11.15 square meters), excluding vestibule, toilet, and closets. Or more strictly, under Section **9.5)** Outpatient Surgical Facility, **F2. Each operating room shall have a minimum clear area of 360 square feet** (33.48 square meters), exclusive of cabinets and shelves,... **There shall be at least one X-ray film illuminator in each room.**

[15] Kansas Board of Veterinary Examiners, http://www.accesskansas.org/veterinary/policies.html
Kansas Board of Healing Arts, http://www.ksbha.org/regs.html
Specific proscriptions fall under rules and regs. See Physician Assistants, Short Term Treatment of Obesity, or Light-based Medical Treatment' [usually plastic surgery using laser knife or Lasix eye surgery];
State Board of Examiners in Optometry, http://www.kssbeo.com/Statutes.htm
Specific proscriptions fall under rules and regs. See Minimum Standards For Ophthalmic Services;
Kansas Dental Board, http://www.accesskansas.org/kdb/legislation.html
Specific proscriptions fall under rules and regs. See Sedative and General Anaesthesia;

[16] Targeted Regulations of Abortion Providers (TRAP), The Center for Reproductive Law and Policy, New York, NY, May 1999 handout.

[17] http://kic.kdhe.state.ks.us/kic/, Kansas Department of Health and Environment, Kansas Information for Communities (KIC).

Addendum 15 March2005:

Previously I said :

Part of proponent's mis-impression comes from the fact that there must be a direct or indirect causal relationship to abortion to be listed as an "abortion death." An anesthesia-related death during an otherwise uneventful abortion shouldn't be an abortion death.

My correction:

An anesthesia-related death during abortion **shouldn't** be listed as an abortion death, but it **would be** listed as such since all abortions are done at clinics without hospitals. The coroner replied to my question of how would typical abortion complications be coded, the approximate reply was:

- Hemorrhage during an abortion.
- Amniotic fluid embolism during an abortion.
- Anesthesia oxygen insufficiency, strictly anesthesia-related if at a hospital but would include another cause like abortion if outside hospital setting.
- Sepsis from perforation during an abortion.

Mark Pederson
Manager

Phone: 913.321.334
Facsimile: 913.321.3348

Sherman C. Zaremski, MD, PA
720 Central Avenue
Kansas City, KS 66101-3546

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Mark Pederson
Manager

15 March 2005

Chairman Jim Morrison
House Health and Human Services Committee
300 SW 10th Ave. Room 171W
Topeka, Kansas 66612-1504

Dear Chairman Morrison and Committee Members:

My name is Julie Burkhart and I am the executive director of ProKanDo, which is a pro-woman, reproductive rights organization. Thank you for affording me to opportunity to address the committee regarding HB 2503.

This bill, "Targeted Regulations Against Abortion Providers," has appeared, in a variety of forms around the United States for the past several years. This is the third year in which I have testified against this particular bill and the fourth year it has appeared before the legislature. HB 2503 originated in Arizona and was subsequently passed in 1999; however, it was enjoined shortly thereafter and as a result, has never been enacted. In the State of Kansas, we are facing the same scenario that Arizonians have faced: the potential to spend thousands of dollars on litigation in defense of a prejudicial bill.

For those who are unsure about the origin and intent of this bill, please make no mistake, the sole purpose of this bill is to further limit the number of abortion providers, thus restricting health care services to women, with punitive, detrimental measures that increase costs and restrict the surgical healthcare options. Simply, the facts do not substantiate the necessity for this bill.

For example, the Health Care Stabilization Fund reports that payout between fiscal years 2000-2004 for medical malpractice, specifically relating to abortion, was 1.35%. The total malpractice payout for other medical procedures during those years was $91,550,800.22. Turning to the State Board of Healing Arts, between 1999-2004, 925 complaints were filed against M.D.'s and D.O.'s. Out of those complaints, abortion physicians represent 0.76% of all complaints. Additionally, if the public health and welfare are threatened because abortion clinics are not operating under these proposed prejudicial guidelines, why then is there not an outcry about the public health and welfare for those who receive other office-based surgical procedures such as breast augmentation and reduction, liposuction, hernia repairs and knee arthroscopies – just to name a few? In fact, the American Society of Anesthesiologists states that, "By the year 2005, an estimated 10 million procedures will be performed annually in doctors' offices…"

The fact about abortion is that it entails half the risk of death involved in a tonsillectomy, one-hundredth the risk of death involved in an appendectomy and one-tenth the risk of death associated with childbirth. Of women who have first trimester abortions, 97% report no complications, 2.5% have minor complications and less than 0.5% require additional surgical procedure or hospitalization.

I would like to clear up a misperception that some might have regarding abortion clinics and current regulations because there's been a lot of talk about clinics going unsupervised and operating out of arms length of any regulatory authority. Presently, clinics adhere to the federal rules and regulations set up by the Health Insurance Portability and Accountability Act (HIPAA),

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Occupational Safety & Health Administration (OSHA) and Clinical Laboratory Improvement Amendments (CLIA). All clinics operate with a licensed physician or physicians in the State of Kansas who are subject to disciplinary actions if and when warranted. Physicians also carry malpractice insurance.

If we're really concerned as a society about reducing the number of abortions, then the legislature should seriously consider a bill that would allow marketing Emergency Contraception (EC) as an over the counter drug and to provide educational materials so that the broader population has knowledge of EC. For those of you who are unfamiliar with medication, if it is within 72 hours of unprotected sex, an unintended pregnancy can be avoided, thus, lowering the need for abortion services. Additionally, we can also work to provide contraceptive equity so that women will not have to bear the brunt of the cost for contraception. We can also work to make sure that girls and women receive comprehensive sex education so they will be able to make the best decisions for themselves, which will be line with their moral convictions. These are just a few things that the legislature could do if the intent is to reduce the number of abortions performed each year.

The American College of Obstetricians and Gynecologists has publicly stated that, "Abortion is a confidential, medical matter that should be protected between the physician and their patient. The intervention of legislative bodies into medical decision-making is inappropriate, ill advised, and dangerous. Women who wish to obtain an abortion should be unencumbered by obstacles such as: …stricter facility regulations for abortion than for other surgical procedures of similar risk."

In conclusion, this bill is bad for women and is bad for the "smaller" abortion providers. Quite clearly, this legislative measure is intended to restrict abortion even further by eliminating several small practitioners who safely do abortion procedures in their office-based practices. I urge you to oppose this bill, as it is purely political, misogynistic and does not respect the intellect of women in this state to decide what is best for themselves and their families.

Sincerely,

Julie Burkhart

My name is Sarah London. I am the Kansas Public Affairs Director and Lobbyist for Planned Parenthood of Kansas & Mid-Missouri. Thank you, Chairman Morrison and members of this committee, for giving me the opportunity to discuss HB 2503 and my opposition to it.

Planned Parenthood operates three health centers in Kansas, in Wichita, Hays, and Lawrence. We also operate eight centers in Missouri. We are affiliated with Comprehensive Health of Planned Parenthood of Kansas & Mid-Missouri in Overland Park, an ambulatory surgical center licensed by the Kansas Department of Health and Environment (KDHE). Comprehensive Health provides comprehensive reproductive health services, including abortion care. In 2004, Planned Parenthood provided family planning and related care to over 30,000 women and men; comprehensive health provided abortion care to 4,000 women.

Today I would like to clear up some possible misconceptions about healthcare regulations, in order to demonstrate how unfair and unprecedented HB 2503 truly is. I would also like to draw some distinction between Planned Parenthood's medical guidelines and the restrictions presented in HB 2503. Finally, I would like to suggest better ways to protect women's health through preventing unwanted pregnancies, rather than making abortion services more expensive and less accessible.

This bill singles out abortion for extra regulation without credible justification.
Let's put this into context. The Kansas Department of Health and Environment governs hospitals and ambulatory surgical centers. KDHE issues licenses to both types of facilities and conducts periodic inspections to ensure compliance. No doctors are required to license their facilities to perform outpatient surgery. According to KDHE, the most common reason for obtaining a state license is to qualify for third–party reimbursement. Furthermore, there are no medical procedures, including outpatient surgeries that must be governed by KDHE.

The Board of Healing Arts governs all doctors. They have the authority to revoke or suspend licenses, as well as impose limitations when professional standards of conduct are not met. BHA governs gynecologists, podiatrists, general practitioners and many other specialties. BHA recently adopted the KMS guidelines for outpatient surgery, which apply equally to all procedures.

Clinics currently adhere to the federal rules and regulations set up by the Health Insurance Portability and Accountability Act (HIPAA), Occupational Safety & Health Administration (OSHA), and Clinical Laboratory Improvement Amendments (CLIA). Clinics follow state and local health department rules, as well as the rule of national accrediting agencies, including the National Abortion Federation (NAF) and the American College of Obstetricians and Gynecologists (ACOG).

A few very important points to consider:

1. No medical procedures in Kansas have regulations similar to 2503. These rules are prejudicial, unfair and unjustified.
2. Doctors choose to obtain a state license, usually for third-party reimbursement. There is no requirement for any type of outpatient procedure to be performed in a state-licensed facility. HB 2503 sets a new precedent of state micromanagement for one procedure.
3. Doctors adhere to professional standards of care, national and state guidelines, and federal regulations. Any more regulation should encompass all outpatient surgeries equally.

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If proponents of HB 2503 are interested in protecting women's health, why aren't we regulating office-based surgery to protect Kansans getting face lifts?

Planned Parenthood guidelines vs. HB 2503

I want to dispel the fiction that HB 2503 simply reflects Planned Parenthood's standards. We have compared HB 2503 with our *Manual of Medical Standards and Guidelines*. While some of the standards are similar, there are many substantial differences. HB 2503 is modeled after legislation passed in Arizona in 1999. Our manual is revised at least annually and usually more often. The current version was updated in August 2003. The "standards" in HB 2503 are thus already five years out of date. HB 2503 is currently seven pages long; the abortion care section of our manual is 34 pages, with many additional attachments.

Most importantly, however, a statute regulating the practice of medicine is vastly different than medical standards and guidelines in three other ways.

First, medical standards are established by medical experts. HB 2503, in contrast, was developed by medical laypeople for purely political reasons. Planned Parenthood's national medical committee, comprised of forty distinguished physicians, nurses and other leading health professionals establishes Planned Parenthood's standards. The committee includes experts in all areas of reproductive health, including obstetrician/gynecologists, endocrinologists, gynecologic oncologists, surgeons, pharmacists, anesthesiologists, pathologists and others.

How many of you or your colleagues – or lobbyists for Kansans for Life – have similar credentials?

Second, medical standards are revised constantly because medical practice and technology change constantly. Planned Parenthood's medical committee meets throughout the year to evaluate the latest advances in medical technology and practice. They review the professional literature. They review the latest findings of the FDA, AMA, ACOG, NIH, CDC and other professional advisory groups. All this is considered when updating the *Manual of Medical Standards and Guidelines*. The Kansas Legislature, in contrast, meets annually for about 90 calendar days, followed by a three to eleven day wrap up session.

If HB 2503 is enacted, will the Kansas Legislature meet throughout the year to update it? The Arizona Legislature apparently has not. As only one example, HB 2503 – again, modeled on Arizona's law – requires "ultrasound equipment in those facilities that provide abortions after 12 weeks' gestation". Planned Parenthood's standards now require ultrasound in first trimester procedures in several circumstances. At Comprehensive Health, ultrasound evaluations are performed before every abortion.

The standard of care has and will continue to change. How quickly will the Kansas Legislature convene to change HB 2503 when magnetic resonance or computerized tomography techniques evolve to replace gynecologic sonography? Will you even know when that change is needed?

Third, medical standards advise practicing physicians on the latest advancements in medicine and advise them on standards of practice. But they always respect the responsibility of the treating physician to assess each patient in each situation and to apply his or her professional judgment. This bill does neither. Instead, it mandates standards, which may quickly become out of date and does not provide the physician to use his or her professional judgment that the patient requires something different. The American College of Obstetricians and Gynecologists has written *Guidelines for Women's Health Care*. Within the manual it states, "The information in *Guidelines for Women's Health Care* should not be viewed as a body of rigid rules. The guidelines are general and intended to be adapted to many different situations…

Variations and innovations that improve the quality of patient care are to be encouraged rather than restricted…"

Rather than single out abortion care, we should focus on making all surgery safer. The Kansas Medical Society recently published its *Guidelines for Office-Based Surgery and Special Procedures*. A twenty-one-member task force, representing twelve medical specialties, developed the guidelines after reviewing guidelines and materials from other states and national medical specialty organizations. The Kansas Board of Healing Arts subsequently adopted those *Guidelines* in October of 2002. They are far superior to HB 2503 because they apply to all medical specialties; they were written by physicians, who know best how to practice medicine; and they are professional standards and guidelines.

Prevent unwanted pregnancies to protect women's health.
In addition to abortion care, Planned Parenthood is committed to help men and women with family planning. Through community and peer educators, we strive to give teens and parents information about reproductive health and sexuality and to help them make informed and decisions about relationships and sexual behavior. Our experts keep up to date on the best strategies to prevent unwanted pregnancies—the best way to protect women's health.

All outpatient surgical procedures carry risk. Ideally, women would not have to seek abortions in the first place. As Senator Hillary Clinton recently said, it is a sad and tragic choice for many women. If this committee would like truly reduce the number of abortions in Kansas, we have several suggestions:

First, we could provide more information about and access to emergency birth control, or EC. If taken up to 72 hours after unprotected sex, EC can prevent an unwanted pregnancy.

Second, we could enforce our state law that requires comprehensive sex education so that our young people will have facts about protecting themselves.

Third, we could enact "contraceptive equity," which would require insurance companies to cover birth control if they cover other prescription drugs.

All three of these measures could prevent unwanted pregnancies in Kansas and reduce the number of abortions in our state. All of these measures would do more to protect women's health than HB 2503. I would be happy to work with the committee to move forward on these critical health issues.

You heard testimony from advocates with a single agenda—to close clinics providing abortion in Kansas. Where is the objective indication of any problem or the proof that abortion, above all other medical procedures must be regulated by the Kansas Department of Health and Environment? All independent data from KDHE, CDC and the Healthcare stabilization fund point to the safety of abortion care in Kansas—above all other surgical care.

No one advocates more strongly for women's health than Planned Parenthood. No one is more committed to protecting women's health than Planned Parenthood. No one provides women's health care more safely than Planned Parenthood.

Let's be honest. Protecting women's health is not the true intention of HB 2503. It is part of the effort by opponents of abortion to make abortion more expensive and less available.

HB 2503 is deceptive and opportunistic. It is bad public policy and does not deserve your support.

Testimony submitted by Dr. Irene Bettinger, M.D. in OPPOSITION to HB 2503

The following is a summary of the main points:

Medicine, not politics, should determine appropriate settings for patient care. The state currently does not require any specific medical procedures to be performed at a licensed specialty clinic. HB2503 singles out surgical abortion, as the **only** office-based surgical procedure that would have to be performed at a special clinic with a special license. **There are risks associated with all office-based surgical procedures.** There is no credible medical justification for singling out surgical abortion for extra regulation-just politics.

Medical professionals must adhere to a standard of care or face malpractice suits and/or lose their license. Since 1996, there have been over 350 disciplinary actions taken, including 49 revocations. Every year, Kansas physicians face more than $100 million in malpractice claims. We already have a system in place for protecting patients. Over the past five years, the Healthcare Stabilization Fund reported that only 1.35% of malpractice awards were as a result of abortion care.

Abortion is part of mainstream medical care. Despite political efforts to move abortion procedures to the margins of medicine, first-trimester abortion continues to be one of the most common and safest surgical procedures. Abortion may be safely performed in an outpatient clinic. In fact, many more risky procedures are performed in doctor's offices. Clinics in this state are meeting women's needs safely, efficiently and effectively.

NAF and Planned Parenthood guidelines are superior to the standards in HB2503. These guidelines include the latest technology and most up-to-date standards of practice. HB 2503 is outdated. PP's guidelines respect the responsibility of the treating physician to assess each patient in each situation and to apply his or her professional judgement. This bill micromanages medicine and restricts variation and innovation that are critical to good health care.

Attachment 11
HHS 3-15-05

P.O. Box 1061
Lawrence, KS 66044

National Organization for Women
Jana Mackey - Lobbyist

785.840.5717
lobbyist@kansasnow.org

Oppose HB 2503. It will hurt women, not help them.

The National Organization for Women's purpose is to take action to bring women into full participation in the mainstream of American society now, exercising all privileges and responsibilities thereof in truly equal partnership with men. Kansas NOW has 760 active members, distributed throughout the state. Those members have agreed upon an agenda that includes increased access to comprehensive healthcare and feel that the passage of HB 2503 would interfere with that goal.

It may seem contradictory for NOW to oppose legislation that claims to make a medical procedure safer for women. After all, we as an organization are very concerned about the quality of care available to women in Kansas. This apparent inconsistency, however, is resolved when one takes a closer look at the intent of HB 2503 and the consequences it would have for women.

In the first place, it must be noted that no other medical procedure is regulated in the way that HB 2503 proposes. The special treatment of abortion may lead us to believe that abortion is a very dangerous type of surgery. Supporters of this type of legislation often refer to the idea that abortion is a unique procedure and therefore requires unique oversight. I would argue that childbirth is also a very distinctive process. Interestingly, women are ten times more likely to die as a result of carrying a pregnancy to term than they are to die as a result of complications associated with abortion, according to the Center for Disease Control. Other routine procedures have fatality rates that even further outweigh the risk of death associated with abortion – it entails half the risk of death involved in a tonsillectomy and one-hundredth the risk of death involved in an appendectomy.

In light of these facts, we must question the urgency of regulating abortion clinics alone. A possible argument would be that abortions are more dangerous in Kansas than in the rest of the country, but the facts do not support this assertion, either. According to the KDHE, there were 152 deaths due to "medical misadventure" between 1990 and 2003. Not one of these deaths were related to abortion services.

Considering that the fatality rate related to abortion procedures has seen an overall decline since abortion was legalized in 1973, and considering that abortions performed in Kansas are no exception to this trend, the goal of HB 2503 is very clear: to place an unnecessary and, in many cases, detrimental burden on abortion clinics. If these restrictions are signed into law, the cost of compliance will be very high for the clinics. In order to cover these costs, they will have to increase the prices of their services, placing them out of reach of many women, arguably the women who most desperately need them. If this is not sufficient, clinics will be forced to close down, leaving women with fewer options.

Increasing the cost of abortions and closing down the clinics that perform them would not protect women's health. In fact, by interfering with women's ability to access and afford reproductive healthcare, HB 2503 would place them in more danger. The most important thing a woman can do to avoid abortion complications is to have the procedure as soon as possible – the earlier the abortion, the safer it is.

This bill, if passed, would work in a number of ways to delay women's abortions and consequentially make them more dangerous. By forcing unnecessary responsibilities and restrictions upon doctors, it would interfere with their ability to work efficiently and provide timely care to patients. By adding to the cost of abortions, it would add to the time it takes many

Attachment 12
HHS 3-15-05

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National Organization for Women
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women to procure the resources necessary to afford this already-expensive procedure. Also, by forcing some clinics out of business, it would make it more difficult and time-consuming to locate and travel to a provider.

All in all, HB 2503 is nothing more than an effort to place abortion out of women's reach. One needs only look, however, to the number of abortions performed before Roe v. Wade (that is, more than at any time since) to realize that women will do whatever they need to do to stay in control over their bodies. Quite simply, women will find ways to have abortions no matter how difficult any legislature may try to make it. For this legislature to callously disregard the health and well-being of these women by delaying their abortions and making them more dangerous would be an insult and a threat to Kansans.

NOW shares the goal of reducing the number of abortions that women must undergo. We, however, believe that there are more effective and less harmful ways to set about this goal. The fact is that the only way to prevent abortions is to prevent unwanted pregnancies. There are a number of proven ways to achieve this goal that, interestingly are not being discussed by the Health and Human Service Committee nor elsewhere in the Kansas Legislature.

- 80% of teen pregnancies are unplanned. Comprehensive sexuality education, unlike abstinence education, has been proven effective in reducing unwanted pregnancy. It would be in the state's best interest to find ways to encourage the implantation of such a curriculum in all of its schools.
- Emergency Contraception, often confused wrongly with medical abortion, is a safe and effective way to reduce the risk of pregnancy for up to five days after intercourse during which protection was either not used or failed. The state should invest in efforts to promote EC and guarantee women's access to it.
- According to the Allan Guttmacher Institute, 308,670 Kansas women are in need of contraceptive services and supplies, and 157,410 need public support to get them. The state should work to see that these women have what they need to prevent pregnancies. A good starting point would be requiring insurance companies that cover other prescriptions to cover prescription contraceptives. (Currently, even state employees are not covered for contraception.)

These are just a few of the many ways in which the goal of reducing abortions could be reached while helping – not hurting – women. As for the supposed goal of this legislation, there are a surely ways that all surgical procedures could be made more safe for Kansas women. Targeting abortion clinics alone is not the way to go about making surgery safer.

NOW opposes HB 2503 and any legislation that is prejudicial toward women.

Testimony of Laura Kenny, M.D.
House Federal and State Affairs Committee
House Bill 2751 – Abortion Clinic Licensing
February 16, 2004

Mr. Chairman and Members of the Committee, Thank you for this opportunity to address you regarding HB 2751.

I'm Dr. Laura Kenny. I'm a Board Certified Obstetrician/Gynecologist with 14 years of private practice experience in Overland Park. For the past three years I have held an administrative position with a managed care company. A significant part of my current role involves quality improvement and quality oversight of the providers of health care.

I'm submitting this testimony today because I am concerned about the quality of care that women are receiving when they undergo abortions and the lack of quality oversight surrounding this procedure.

Abortion is one of the most frequently performed surgical procedures in this state, yet it is one of the least regulated. All other surgical procedures that I know of that require the same degree of skill and carry the same amount of risk as abortion, are performed in licensed facilities or hospitals, where they are required to meet certain quality standards and are subjected to peer review. The techniques that are used to perform abortions, specifically D&Cs or D&Es, are the same techniques that obstetrician/gynecologists use to empty the uterus when a woman's baby dies or when the woman has an incomplete miscarriage.

Reputable Ob/Gyns doing these procedures would thoroughly examine the patient prior to the procedure, use well-maintained equipment, work with properly trained staff, and have a protocol for managing unexpected complications. When these procedures are performed on women who have lost their pregnancies, they are virtually always done in outpatient surgical facilities or hospitals because there is risk associated with them. They are done in facilities which are regulated by the KDHE, which are subjected to inspections and are held to specific quality standards. Emptying the uterus of a pregnant woman, whether the fetus is alive or dead, is not a simple low risk procedure.

Abortions, for a number of reasons that don't have anything to do with the difficulty of the procedure or the risk associated with the procedure, are usually performed in physician offices or clinics. These abortions carry the same risk of injury or death as the surgical procedures which are being performed in outpatient surgery centers or hospitals, yet there is currently no mechanism to monitor or regulate what is happening in physician offices or clinics from a quality stand point.

Attachment 13
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Women believe that legal abortion equals safe abortion. They believe that the quality standards that apply to other surgical procedures also apply to abortion.
In reality while we have made abortion legal, we have not made it any safer than it was when it was not legal. Legal abortion does not equal safe abortion.

Only adherence to sound quality medical standards and guidelines will reduce the risk inherent in the surgical procedures themselves that are used for abortion.
Currently, abortion procedures remain free from the type of review, regulation, and accountability that is an integral part of the rest of the medical profession. Abortion services for the most part remain out of the medical mainstream and as such are not subjected to the same scrutiny as virtually all other surgical procedures. Unfortunately, this lack of accountability has allowed some providers to place women seeking abortions in very dangerous positions.

HB 2751 would establish regulation and accountability for clinics and offices where abortions are being performed. This bill outlines the minimal standards required to provide quality care to women and gives the KDHE the ability to enforce these standards. The standards set forth in this bill are the same standards set forth by Planned Parenthood, the National Abortion Federation, and the American College of Obstetricians and Gynecologists. Any reasonable physician providing quality care to women should be meeting these standards already.

These are not standards that are difficult to attain. They are basic quality requirements that can be accomplished by physicians providing abortions in their offices or clinics.

For example, the bill requires the clinic to have personnel trained in CPR. It requires the physician to have admitting privileges at a hospital and be able to admit a patient if a complication occurs. It requires the staff to check the patient's blood count prior to the surgical procedure. It mandates proper sterilization of equipment and proper medical supervision of patients in the post-operative recovery period. It requires a through and complete exam prior to the procedure. It requires follow-up of the patient after the procedure. It mandates proper maintenance, use and calibration of equipment. This bill will also give KDHE the power to enforce compliance with these standards.

HB 2751 is good legislation. It will allow those who provide abortion services to document to the people of Kansas that they are meeting the minimum standards promulgated by the abortion industry itself. This is the expectation of the women who are seeking abortion services. I believe that it is our obligation to assure these women that they are receiving care that at minimum meets these standards.

I strongly encourage you to support this legislation and welcome any questions you might have.

February 16, 2004
Testimony to the Kansas House of Representatives
House Federal and State Affairs Committee

Thank you for this opportunity to address you regarding HB 2751, clinic licensing and regulation.

I am Dr. Brendan Mitchell, a Board Certified Obstetrician/Gynecologist in practice ten years in the Johnson County area. I am part of a large single specialty group practice that performs a wide variety of surgical procedures in different settings. My patient population is diverse, covering a wide range of ages, educational levels and socioeconomic status. My colleagues and I are subject to quality assurance at every hospital and ambulatory surgery center where we practice, and rightly so.

It is the role of the state to protect the consumers of health care, and to insure that a mechanism is in place to monitor the quality of health care delivered. From my conversations with patients, I am gravely concerned about the quality of health care that women are receiving when they undergo abortion procedures, and the lack of quality oversight surrounding these practitioners and this procedure.

With over 12,000 abortions occurring annually in the state of Kansas, it is surprising to me that the abortion facilities are unregulated. Because of my experience treating women with miscarriage in the first and second trimesters, I understand that abortion is a procedure that is fraught with potential hazards, even in the most experienced hands. Women treated for miscarriage in the first and second trimester, and fetal death in the third trimester, are treated at hospitals and licensed ambulatory care facilities. These facilities are modern, clean, and secure, but most importantly, they are subject to independent quality assurance entities as a requirement for their operation.

Reasonably well-trained Ob-Gyns performing these surgical procedures for miscarriage would be expected to examine the patient prior to the procedure. They would perform basic laboratory analysis for anemia and Rh typing. They would be working with well-maintained equipment, and well trained and qualified staff. They would monitor the patient's condition during anesthesia, and in the postoperative period. Procedures to empty the uterus, after a pregnancy has been lost, are performed in a hospital or a licensed ambulatory care center. These facilities are regulated by the KDHE, and are subject to inspections to ensure minimum quality standards. Most physicians, myself included, would not want to perform these procedures, with their inherent risk of complications, in a substandard facility.

I have had personal experience with unexpected complications arising from this procedure. I was performing a D&C for first trimester miscarriage and encountered heavy unexpected hemorrhage. Despite the administration of numerous drugs to cause the uterus to contract, the patient continued to bleed and her condition deteriorated to the point of shock. It was necessary to perform an emergency hysterectomy to control the bleeding, and the patient required several units of blood and blood products. Because of the expert care delivered by a team that included an anesthesiologist and well-trained nurses, the patient survived. The hysterectomy specimen was sent to pathology as required, and an explanation was derived from examination of the specimen. The case was then reviewed by my peers. Had this D&C been performed in an area abortion clinic, the patient would not have survived.

For a variety of reasons, abortion is generally not performed in a regulated and licensed facility, and these reasons have nothing to do with the safety, complication rate or difficulty of the procedure. Abortions are generally performed in an office or clinic setting, and they are not substantially different in risk from similar procedures performed in a hospital. There is currently no mechanism to regulate the quality of surgical and anesthesia care administered in an office or clinic performing abortions.

Abortion in this country has become less restricted since Roe vs. Wade. However, this does not abdicate lawmakers' responsibility to ensure the safety of patients undergoing surgical procedures in the state of Kansas. The public perceives that legal abortion is safe abortion. Indeed many of the proponents of abortion rights cite safe abortion as the main justification against laws restricting abortion. The public believes that the same standards that apply to other surgical procedures, apply to legal abortion. However, this is not the case. In the absence of quality standards, there is no evidence that abortion is safer now than before 1973.

Obviously, there is a social stigma associated with abortion for many patients. Because of this, patients undergoing abortion are at great risk for substandard care or even abuse. Most abortion providers operate on a cash basis with no insurance coverage involved, eliminating quality assurance or facility standards that an insurance company would place on its participating providers. Many patients having abortions are given anesthetic agents producing amnesia for the experience, and are reluctant to report any perception of substandard care. They are not in a position to protect themselves.

I have had many patients with a history of abortion complain that they were given poor consent, that the ultrasound and other medical equipment appeared to be antiquated, and that the facility appeared unsanitary.

I have recently delivered a patient that was a former employee of an abortion clinic and reported poor training and appalling conditions. In my own practice it has become obvious to me that many patients undergoing the abortion procedure are not given adequate means to follow up in case of a complication. HB 2751 would establish a minimum set of standards of quality for offices and clinics where surgical abortion is taking place. It establishes regulations and standards that any reasonable consumer of health care would expect in a facility administering anesthesia and performing surgical procedures that carry a risk of infection or life threatening bleeding, and gives the ability to enforce these standards.

The standards proposed in this bill are the same standards set forth by the American College of Obstetrics and Gynecology, Planned Parenthood and the National Abortion Federation. These standards are basic and not restrictive, and are attainable by facilities practicing abortion.

The role of laws regulating the practice of the healing arts is to protect the public. Providers of health care are already subject to these laws. Unfortunately, however, the abortion industry has remained unfettered by the regulation designed to ensure safety and quality of care, and, because of the politically divisive nature of the abortion debate, it has managed to stay unregulated. This is bad for the consumer of abortion services. HB 2751 is good legislation. It will ensure that those who provide abortion in our state document to the people of Kansas that they are meeting the minimum standards promulgated by the abortion industry itself.

This is what the public expects of its elected officials and of its government.

I encourage you to support this legislation and welcome any questions you may have.

Testimony of Abortion Clinic Staff Whistleblower
House Federal and State Affairs Committee February 16, 2004

Mr. Chairman and Members of the Committee:

Kansans for Life has recently been in contact with a former employee of Kansas City, Kansas abortionist Krishna Rajanna, age 66. Even though Rajanna advertises in the yellow pages as "Abortions Affordable," his office at 1030 Central has never had his name on the door.

The information in this testimony comes from a young woman whom we shall call "Ruby," in order to protect her identity. "Ruby" became pregnant in high school and never graduated. At the time of her interview with KFL, she had been employed for over a year at Rajanna's office, without incident, and continued there for several more weeks.

"Ruby" was distressed at the practices of Rajanna and the deplorable, filthy conditions inside his offices. She said other employees were also disgusted with the way Rajanna did business.

Another former employee, "Kay," told "Ruby" that she had at one time sent information on the conditions in Rajanna's office to the "authorities." "Ruby" did not know what kind of "authority" regulated doctors and their offices. Out of desperation, "Ruby" spoke to someone at a crisis pregnancy center and was encouraged to contact Kansans for Life. KFL Legislative Director Kathy Ostrowski interviewed "Ruby" and urged her to make a report to the Kansas State Board of Healing Arts. "Ruby's" testimony below is unsolicited, uncompensated and self-motivated. Neither "Ruby" nor her family has any connection to Kansans for Life.

"Ruby" revealed the following irregular JOB PRACTICES:
Rajanna employs 4 staffers, and for part of "Ruby's" employment time Rajanna employed a Certified Nurse Aide. Other than the CNA, no one with any formal medical training was employed during her tenure. No published medical training materials were ever given to "Ruby". She claims that references were not checked on anyone who applied for a job nor was the truth of their alleged job experience confirmed.When "Ruby" was interviewed, she was not asked to produce a record of immunizations, nor was she told to obtain any missing immunization shots. She believes that was also the case for other employees.

"Ruby" had applied for a position as receptionist /physician helper. She was surprised when, soon after being hired, she was called inside the procedure room to assist with abortions. "Ruby" was uncomfortable in the role of surgical assistant.

Rajanna's employees, including "Ruby", picked up his drug orders from neighborhood pharmacies. Drugs were stored in a locked closet on site to which all employees had key access. At the time she was hired, "Ruby" can recall no questions asking if she had a criminal record.

"Ruby" revealed the following disturbing practices PRIOR TO SURGICAL ABORTIONS:
"Ruby" was shown how to take a patient's blood sample for the Rh test. She was not made aware of several procedural variances that can affect the accuracy of the test. When completed, the bloody slides, gloves and other contaminated products are tossed into regular plastic trash bags. There are no Bio-Hazardous waste containers anywhere onsite.

Minors who come for abortions are counseled over the phone. Prior to the issuance of the attorney general's opinion in June, "Ruby" knew some minors had been aborted as young as 13. After the opinion, staff was told not to take appointments for minors under 16.

"Ruby" revealed the following disturbing practices DURING SURGICAL ABORTIONS:
There are no changing rooms for patients and only one bathroom onsite for use by the public, patients and staff. A woman being aborted is brought to the procedure room clothed and put up on a bare table. An employee helps her lower her slacks and places a drape under her bottom. On her own initiative, between patients, "Ruby" said she wiped the table with alcohol.

"Ruby" was told how to insert an IV (intravenous line). No patient vital signs are taken during the abortion. "Ruby" has no training in CPR and believes the other employees also do not possess such training. She recalls being frightened at witnessing one abortion in spring 2003 where a minor went into shock from an allergic reaction to abortion medications. Rajanna lifted up the patient and literally carried her into his car, taking her to hospital.

"Ruby" revealed the following disturbing practices AFTER SURGICAL ABORTIONS:
After the abortion, an employee removes the IV, immediately puts sanitary pads inside the patient's underwear and pulls up the patient's lower garments. The patient, though unsteady, is then walked to a couch with staff assistance but without use of a wheelchair. This "recovery" area is barely a semi-private space. The patient's friend, not an employee, attends the patient on the couch. No post-procedure vital signs are taken.

The patient is dismissed approximately 20 minutes later. No blood flow has been checked and no exam or discussion with doctor takes place before leaving the clinic. The patient is given antibiotic pills to take at home and has been given papers saying she can call the clinic, even after office hours. Patient has been requested to return within 21 days, although it was "Ruby's" observation that 25% or less of the women actually returned for follow-up.

"Ruby" revealed the following disturbing STERILIZATION & DISPOSAL PROBLEMS:
Rajanna and staff wear gloves, but Rajanna's medical jacket is infrequently washed, exhibiting dried blood-stains, food and dirt. Sometimes, clinic instruments were rinsed in bleach, but not sterilized. Two dishwashers adjoining a toilet are the "sterilizers."

Unexamined fetal remains are strained through a sock into a jar and then put inside plastic bags, plastic convenience store cups and milk cartons. The cups and cartons are stored in the office refrigerators and freezers, adjoining unsealed and open food.

Nearly every area in the clinic is dirty and disheveled. There is no medical waste pickup service. At the end of the business day, all clinic trash, including bio-hazardous materials, is put into large trash bags that Rajanna loads into his car. Rajanna then drives with these bags to his Missouri home where they have been seen set outside for regular residential trash pickup.

KANSAS BOARD OF HEALING ARTS

LAWRENCE T. BUENING, JR.
EXECUTIVE DIRECTOR

KATHLEEN SEBELIUS, GOVERNOR

MEMO

TO: Interested Persons

FROM: Lawrence T. Buening, Jr.
Executive Director

DATE: February 14, 2005

RE: **Krishna Rajanna, M.D.**

You have previously indicated an interest in receiving notification if the Kansas State Board of Healing Arts took a disciplinary action against the above-captioned physician based upon a complaint filed in February 2005. Enclosed is a copy of a Consent Order filed in the Board office this date and which was approved by the Board as a whole at its meeting Saturday, February 12.

I have not attached three documents that are attached to the original Consent Order that was filed in the Board office. These are as follows:

a. 36-page document entitled "Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists";
b. 6-page document entitled "Guidelines for Office-Based Surgery and Special Procedures" approved by KMS House of Delegates May 5, 2002; and
c. One-page document entitled "Appendix B" providing a list of accrediting organizations for office-based surgery.

The "Guidelines for Office-Based Surgery and Special Procedures" can be accessed from our website at www.ksbha.org. Please advise if you would like copies of the other two documents.

Please advise if you have any questions or if I can provide any additional information.

235 S. Topeka Boulevard, Topeka, Kansas 66603-3068
Voice 785-296-7413 Fax 785-296-0852 www.ksbha.org

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BEFORE THE BOARD OF HEALING ARTS
OF THE STATE OF KANSAS

In that Matter of Krishna Rajanna, M.D. Kansas License No. 04-15624	Docket No. 05-HA-

CONSENT ORDER

COMES NOW, the Kansas State Board of Healing Arts ("Board"), by and through Stacy L. Cook, Litigation Counsel ("Petitioner"), and Krishna Rajanna, M.D. ("Licensee"), and move the Board for approval of a Consent Order. The parties stipulate and agree to the following:

1. Licensee's last known address to the Board is 838 W. 39th Terrace, Kansas City, Missouri 64111.

2. Licensee is or has been entitled to engage in the practice of medicine and surgery in the State of Kansas, having been issued License No. 04-15624 on approximately June 10, 1972. Licensee's license is active.

3. The Board is the sole and exclusive administrative agency in the State of Kansas authorized to regulate the practice of the healing arts, specifically the practice of medicine and surgery. K.S.A. 65-2869.

4. This Consent Order and the filing of such document are in accordance with applicable law and the Board has jurisdiction to enter into the Consent Order as provided by K.S.A. 65-2838. Upon approval, these stipulations shall constitute the findings of the Board, and this Consent Order shall constitute the Board's Final Order.

5. The Kansas Healing Arts Act is constitutional on its face and as applied in this case.

6. Licensee agrees that, in considering this matter, the Board is not acting beyond its jurisdiction as provided by law.

7. Licensee voluntarily and knowingly waives his right to a hearing. Licensee voluntarily and knowingly waives his right to present a defense by oral testimony and documentary evidence, to submit to rebuttal evidence, and to conduct cross-examination of witnesses. Licensee voluntarily and knowingly agrees to waive all possible substantive and procedural motions and defenses that could be raised if an administrative hearing were held.

8. The terms and conditions of the Consent Order are entered into between the undersigned parties and are submitted for the purpose of allowing these terms and conditions to become an Order of the Board. This Consent Order shall not be binding on the Board until an authorized signature is affixed at the end of this document. Licensee specifically acknowledges that counsel for the Board is not authorized to sign this Consent Order on behalf of the Board.

9. Licensee failed to maintain adequate cleanliness in his clinic, including but not limited to the following: (1) Licensee had carpeting on the floor of a surgical procedure room; (2) the trash cans in the clinic did not have lids; (3) sharps containers were overflowing; (4) human tissue was stored on a counter in the utility room for a time and was then stored in the freezer in a refrigerator where food was also kept; and (5) the clinic had an overall appearance of clutter and disarray.

10. Licensee did not properly dispose of sharp objects and human tissue/medical waste.

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11. Licensee drew medications in syringes and kept the syringes in the refrigerator for future use. The syringes were not marked or labeled.

12. Licensee maintained in the office several expired medications.

13. Licensee did not properly label medications he dispensed.

14. Licensee did not follow the Practice Guidelines For Sedation And Analgesia By Non-Anesthesiologists when using conscious sedation in the office.

15. Pursuant to K.S.A. 65-2836(b) and K.S.A. 65-2836(k), the Board has grounds to revoke, suspend, limit, censure, or impose a fine on Licensee's license.

16. According to K.S.A. 65-2838(b), the Board has authority to enter into this Consent Order without the necessity of proceeding to a formal hearing.

17. In lieu of the conclusion of formal proceedings, Licensee, by signature affixed to this Consent Order, hereby voluntarily agrees to the following disciplinary action and limitations on his license to engage in the practice of medicine and surgery:

a. Licensee shall not practice medicine and surgery unless he complies with each of the following:

(i) Licensee agrees to follow the 1996 American Society of Anesthesiologist's (ASA) Guidelines for Sedation and Analgesia by Non-Anesthesiologists ("Guidelines") and subsequent revisions and/or amendments. Compliance with the guidelines shall be documented in the patient records;

(ii) Licensee shall become certified in Advanced Cardiac Life Support on or before May 12, 2005. Licensee has until the

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end of August 2005 to complete certification if he can demonstrate that a course is not available until this time;

(iii) Licensee shall instruct all patients who receive conscious sedation to remain in his clinic at least one hour following the procedure. The Guidelines shall be followed during this time and with all patients until they are dismissed from the clinic;

(iv) The parties agree to adopt the Guidelines for Office-Based Surgery and Special Procedures ("Guidelines for OBS") approved by the Board as recommendations on October 12, 2002, a copy of which is attached. The parties agree that Licensee shall meet these guidelines in his practice of medicine and surgery. This means that the recommendations, however worded in the Guidelines for OBS; are mandatory. The requirement for accreditation for a nationally recognized accrediting agency shall be accomplished within one year following the date of this agreement. Meeting the standards adopted by any one of the organizations appearing on Guideline for OBS Appendix B shall satisfy the requirements of this agreement. Licensee shall appear before the Board at the April 2005 meeting to identify the standards promulgated by an organization appearing on Guideline for OBS Appendix B that he will

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follow, and a time period for meeting those standards will be adopted by the Board.

b. Licensee shall pay a fine of $1,000.00. Such fine is due and payable to the Board within thirty (30) days of the filing of the Consent Order; and

c. The Board will conduct at least two unannounced office inspections within the next six months to ensure that Licensee is properly disposing of waste, handling and maintaining medications in an appropriate manner, and maintaining a clean clinic. Prior to the inspection, a Board investigator will meet with Licensee and provide Licensee with the guidelines regarding the Board's expectations for the three items for inspection.

18. Licensee's failure to comply with the provisions of the Consent Order may result in the Board taking further disciplinary action as the Board deems appropriate according to the Kansas Administrative Procedure Act.

19. Nothing in this Consent Order shall be construed to deny the Board jurisdiction to investigate alleged violations of the Healing Arts Act, or to investigate complaints received under the Risk Management Law, K.S.A. 64-4921 *et seq.*, that are known or unknown and are not covered under this Consent Order, or to initiate formal proceedings based upon known or unknown allegations of violations of the Healing Arts Act.

20. Licensee hereby releases the Board, its individual members (in their official and personal capacity), attorneys, employees and agents, hereinafter collectively

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referred to as "Releasees", from any and all claims, including but not limited to, those alleged damages, actions, liabilities, both administrative and civil, including the Kansas Act for Judicial Review and Civil Enforcement of Agency Actions, K.S.A. 77-601 *et seq.* arising out of the investigation and acts leading to the execution of this Consent Order. This release shall forever discharge the Releasees of any and all claims or demands of every kind and nature that Licensee has claimed to have had at the time of this release or might have had, either known or unknown, suspected or unsuspected, and Licensee shall not commence to prosecute, cause or permit to be prosecuted, any action or proceeding of any description against the Releasees.

21. Licensee further understands and agrees that upon signature by Licensee, this document shall be deemed a public record and shall be reported to the National Practitioner Databank, Federation of State Medical Boards, and any other reporting entities requiring disclosure of the Consent Order.

22. This Consent Order, when signed by both parties, constitutes the entire agreement between the parties and may only be modified or amended by a subsequent document executed in the same manner by the parties.

23. Licensee agrees that all information maintained by the Board pertaining to the nature and result of any complaint and/or investigation may be fully disclosed to and considered by the Board in conjunction with the presentation of any offer of settlement, even if Licensee is not present. Licensee further acknowledges that the Board may conduct further inquiry as it deems necessary before the complete or partial acceptance or rejection of any offer of settlement.

24. Licensee, by signature to this document, waives any objection to the participation of the Board members, including the Disciplinary Panel, in the consideration of this offer of settlement and agrees not to seek the disqualification or recusal of any Board member in any future proceedings on the basis that the Board member has received investigative information from any source which otherwise may not be admissible or admitted as evidence.

25. Licensee acknowledges that he has read this Consent Order and fully understands the contents.

26. Licensee acknowledges that this Consent Order has been entered into freely and voluntarily.

27. All correspondence or communication between Licensee and the Board relating to the Consent Order shall be by certified mail addressed to the Kansas State Board of Healing Arts, Attn: Stacy L. Cook, 235 S. Topeka Blvd., Topeka, Kansas 66603-3068.

28. Licensee shall obey all federal, state and local laws and rules governing the practice of medicine and surgery in the State of Kansas that may be in place at the time of execution of the Consent Order or may become effective subsequent to the execution of this document.

29. Upon execution of this Consent Order by affixing a Board authorized signature below, the provisions of this Consent Order shall become an Order under K.S.A. 65-2838. This Consent Order shall constitute the Board's Order when filed with the office of the Executive Director for the Board and no further Order is required.

30. The Board may consider all aspects of this Consent Order in any future matter regarding Licensee.

IT IS THEREFORE ORDERED that the Consent Order and agreement of the parties contained herein is adopted by the Board as findings of fact and conclusions of law.

IT IS FURTHER ORDERED that :

a. Licensee shall not practice medicine and surgery unless he complies with each of the following:

(i) Licensee agrees to follow the 1996 American Society of Anesthesiologist's (ASA) Guidelines for Sedation and Analgesia by Non-Anesthesiologists ("Guidelines") and subsequent revisions and/or amendments. Compliance with the guidelines shall be documented in the patient records. ;

(ii) Licensee shall become certified in Advanced Cardiac Life Support on or before May 12, 2005. Licensee has until the end of August 2005 to complete certification if he can demonstrate that a course is not available until this time;

(iii) Licensee shall instruct all patients who receive conscious sedation to remain in his clinic at least one hour following the procedure. The Guidelines shall be followed during this time and with all patients until they are dismissed from the clinic;

(iv) The parties agree to adopt the Guidelines for Office-Based Surgery and Special Procedures ("Guidelines for OBS")

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approved by the Board as recommendations on October 12, 2002, a copy of which is attached. The parties agree that Licensee shall meet these guidelines in his practice of medicine and surgery. This means that the recommendations, however worded in the Guidelines for OBS, are mandatory. The requirement for accreditation for a nationally recognized accrediting agency shall be accomplished within one year following the date of this agreement. Meeting the standards adopted by any one of the organizations appearing on Guideline for OBS Appendix B shall satisfy the requirements of this agreement. Licensee shall appear before the Board at the April 2005 meeting to identify the standards promulgated by an organization appearing on Guideline for OBS Appendix B that he will follow, and a time period for meeting those standards will be adopted by the Board.

b. Licensee shall pay a fine of $1,000.00. Such fine is due and payable to the Board within thirty (30) days of the filing of the Consent Order; and

c. The Board will conduct at least two unannounced office inspections within the next six months to ensure that Licensee is properly disposing of waste, handling and maintaining medications in an appropriate manner, and maintaining a clean clinic. Prior to the

inspection, a Board investigator will meet with Licensee and provide Licensee with the guidelines regarding the Board's expectations for the three items for inspection.

IT IS SO ORDERED on this 2nd day of February, 2005.

FOR THE KANSAS STATE
BOARD OF HEALING ARTS:

Lawrence T. Buening, Jr.
Executive Director

PREPARED AND APPROVED BY:

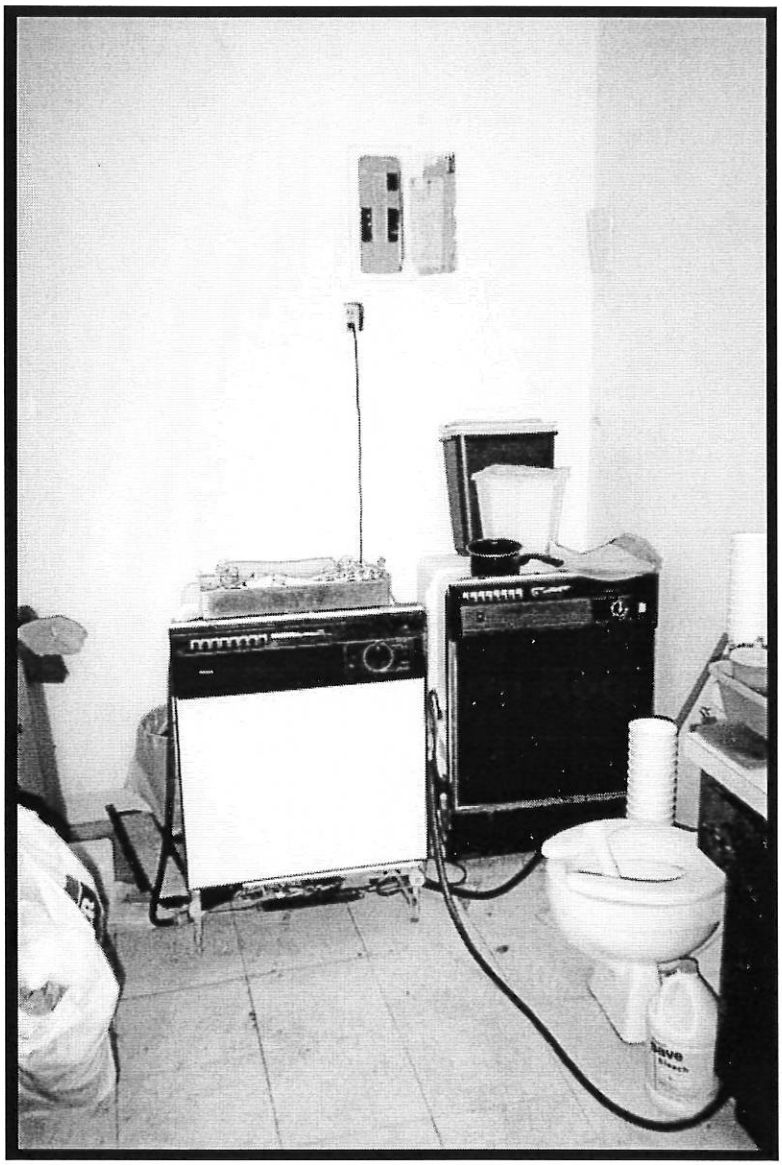
Stacy L. Cook #16385
Litigation Counsel
Kansas State Board of Healing Arts
235 S. Topeka Boulevard
Topeka, Kansas 66603-3065

AGREED TO BY:

Krishna Rajanna, M.D.
Licensee

Krishna Rajanna

Sterilization Room/Staff-Patient Bathroom

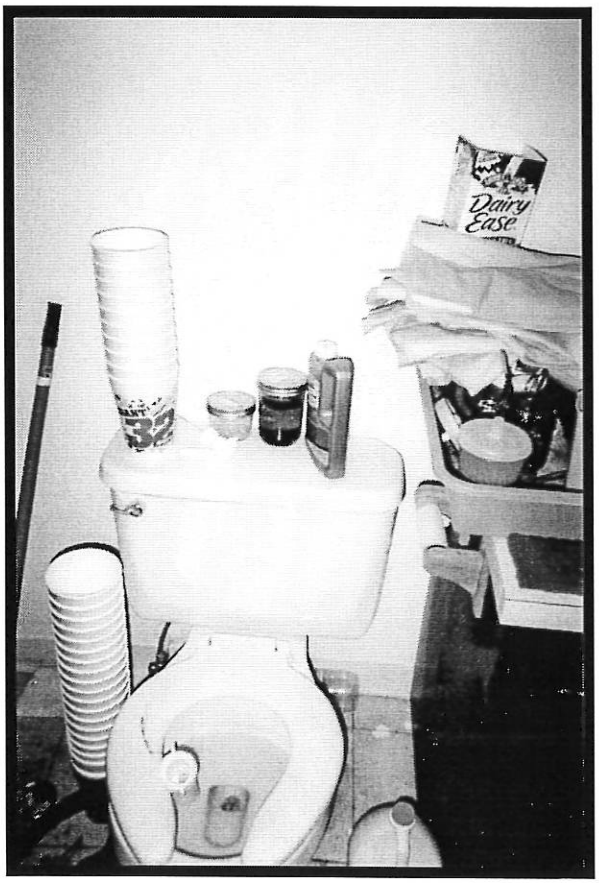


The "bio-hazard" area contains two dishwashers, one of which drains into a vanity (partially seen in picture).

Atop one of the dishwashers is a tray of supposedly sterile surgical instruments adjacent to a pot of moldy food and open trash containers.

Beside the dishwashers is a blood stained, dirty toilet with a strainer attached for emptying fetal remains from a suction machine.

The stack of cups is for fetal storage (see refrigerator pictures). Trash bags are open. Bleach is also seen, which a staffer claimed was often substituted for sterilization of the surgical instruments.

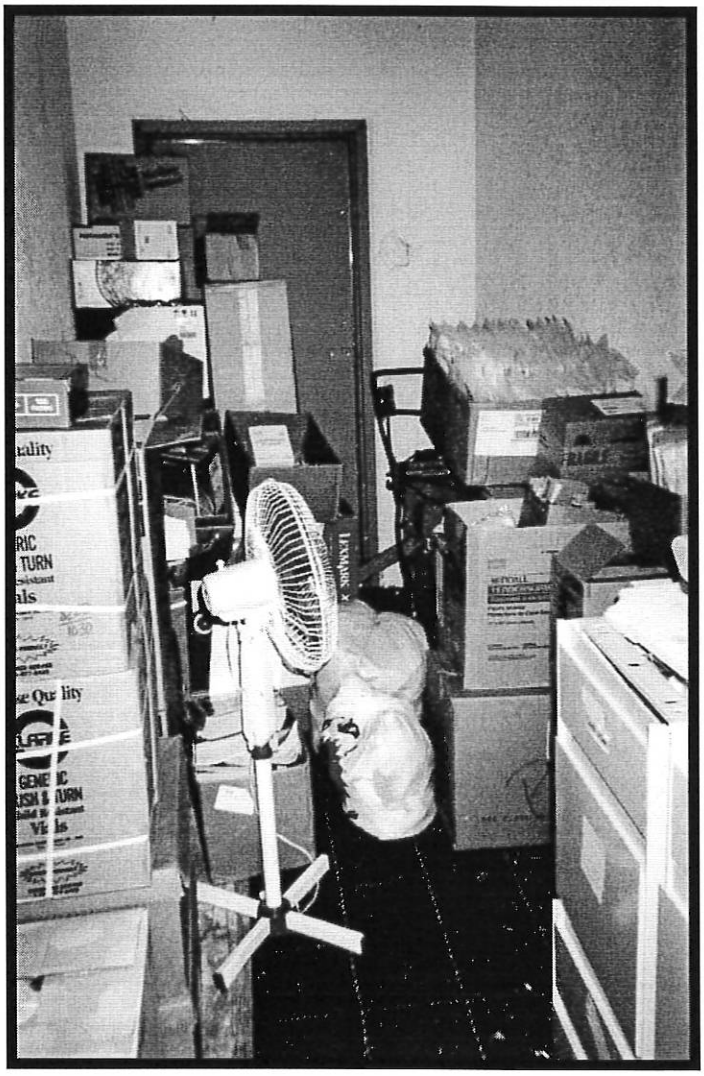


Krishna Rajanna

Abortion Clinic Back Door/Fire Exit

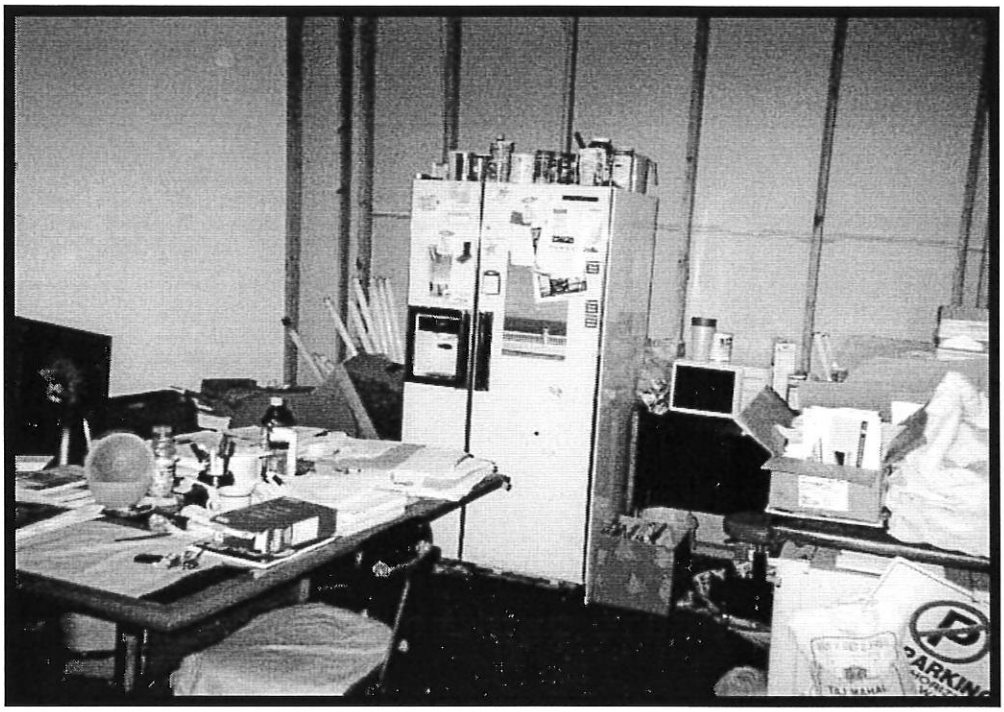
The back door/fire exit is blocked with bio-hazardous trash, open drugs, and a gas lawn mower.

One Attorney-General affidavit from a physician compares these areas of extreme clutter and disarray (see break room and "biohazard" area pictures) as the kind found in the homes of those who suffer from hoarding syndrome.



Krishna Rajanna

Abortion Clinic Break Room/Doctor's Office



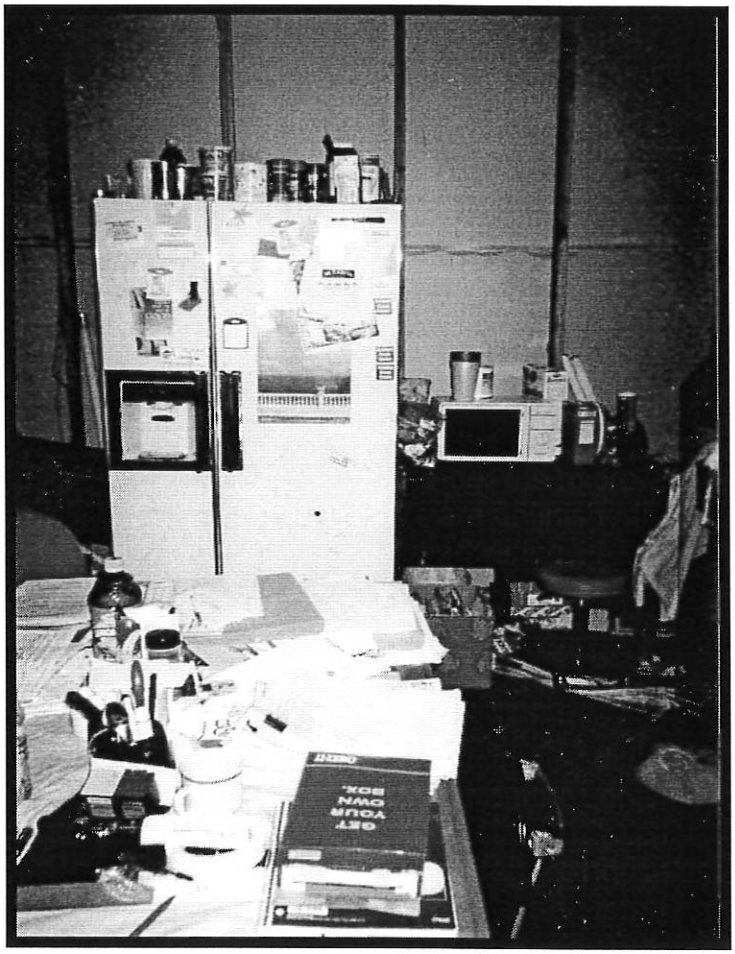
Rajanna's desk/ lunch table is covered with paperwork and empty food and drink containers.

The refrigerator houses food, drugs, and fetal parts (see refrigerator pictures)

Above the refrigerator are caustic chemicals and food. File boxes are adjacent to the refrigerator and under the microwave. Walls are unfinished with exposed wiring.

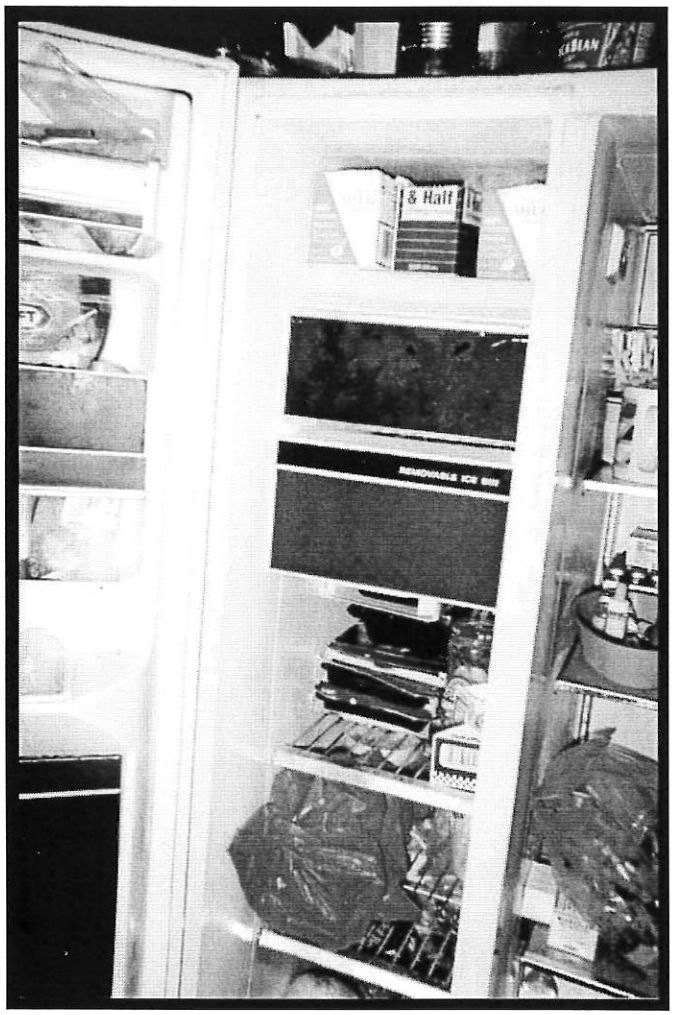
What one doctor told the Attorney General's Inspector about his reaction to the clinic's photos:

DoctorLC: "There are multiple partitions to divide areas instead of walls… Unfinished walls devoid of sheetrock with exposed wiring… Impressive lack of sanitation (and inability to be sanitized)… items are seen piled, stacked, and crammed on most available surfaces… in the procedure room, biohazard room, storage room and the breakroom/Dr. office…."



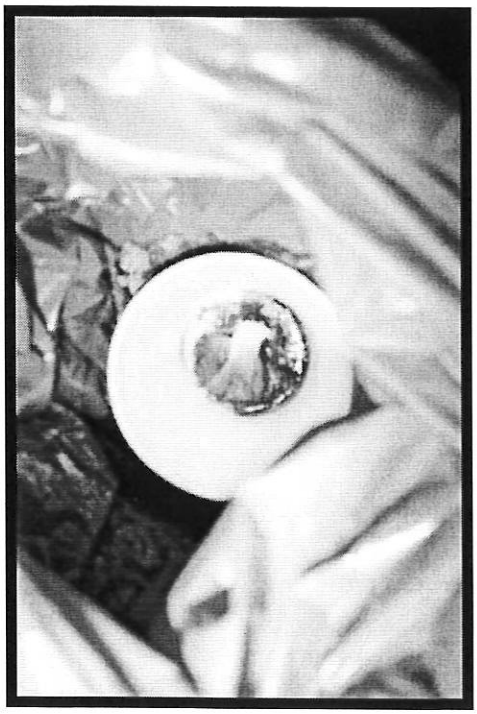
Krishna Rajanna

Abortion Clinic Refrigerator



Against OSHA regulations, refrigerators in the clinic commingle food, drugs, injectables, biological tissue and fluids.

Most fetal parts are kept in cut-off milk cartons and disposable drinking cups stored inside plastic bags.



Rajanna Abortion Clinic

RAJANNA ABORTION CLINIC — *FAILS* -- Kansas Administrative Regulations for Veterinary premises

disorderly, dirty rooms, roaches on counters, lawn mower & trash block exit ; abortionist clothing stained and dirty	70-6-1-1A All areas, apparatus and apparel to be clean, sanitary, inoffensive, orderly and disinfected at all times
food mixed with drugs, needles, cleansers, fetal remains	70-6-1-2-D Adequate sanitary storage
rugs & open, unfinished walls can't be disinfected	70-6-1-6-G Floors & walls regularly disinfected; 70-6-1-7-A Flooring must be of impervious material
plastic bag and non-lidded bio-medical trash	70-6-1-6-G Metal or plastic leak-proof, tight-lidded waste cans
instruments uncovered near open toilet where dishwashers or bleach water substituted for sterilizing	70-6-1-8 Articles for surgery to be sterilized by gas or steam
bio-trash into Rajanna's car, left for residential pickup	70-6-1-13-A Dead animals & tissue contained in plastic bags & picked up for disposal 70-6-1-13-B Needles & syringes destroyed or disposed properly 70-7-1-A Clean, orderly, protective storage for drugs, supplies, equipment

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RAJANNA ABORTION CLINIC -- *FAILS* -- Planned Parenthood published standards [PPFA January 2000]

no monitoring machines in recovery	II-B-3 Pulse oximeter machine in procedure & recovery rooms
ride-on mower behind building as back-up generator	II-B-5 Back-up power systems
no CPR or medically trained staff maintenance	II-B-6 Resuscitative medications & equipment available w/ staff trained in
patient's friend attends patient in recovery	III-A-3 Licensed, credentialed, health professionals to supervise recovery
vitals not taken after procedure starts	IX-B-4 Constant oximeter monitoring when I-Vs used; vitals taken more than just initially
no nurse on staff	IX-B-5 Physician & recovery nurse must be current in CPR and airway management
aborted baby parts strained at toilet- tissue placed in milk cartons& plastic cups stored in refrigerator w/food.	X-A-1 Gross exam of tissue recorded on chart
no vitals, blood flow check or exam before departure	X-A-3 Discharge summary of vitals, bleeding, general condition

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RAJANNA ABORTION CLINIC – *FAILS* -- BOHA office-based surgery guidelines [October 2002]

non-high school grads without medical training, no nurse, CNA sometimes hired	I.a. Trained, certified personnel; #8 [Essentials for anesthesia] Qualified, trained staff dedicated solely to patient monitoring
no medical waste pickup, nor proper disposal in office	II a. Proper medical waste disposal
improper sterilization, dirty & messy clinic	II c. Premises neat & clean, materials sterilized

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(Hand-delivered) Feb.21, 2005

Dear Mr. Buening:

Your letter of February 14 summarizes the disciplinary action taken against abortionist Krishna Rajanna on Feb.12, 2005. Since Kansans for Life was the agent that allowed evidence to get recognized by you (where law enforcement and Wyandotte DA had failed) KFL would certainly have attended that meeting had your office notified me or posted it on the online BOHA agenda. We monitor your site and, although other practitioners' names were listed for Feb. 12, Rajanna's was not.

Additionally, as I am now Kansans for Life Director of Legislative Research, our new State Legislative Director Dan Williams wrote you in early January requesting an update as to the status of the Rajanna inquiry. He has received no reply.

When I attended your June 2005 meeting, it was plain to me that the Board was ignorant of the Rajanna clinic scandal. I appreciated the chance to speak for a few minutes and sent an informational follow-up letter to each Board member. Amazingly, I received not one response, nor even a short email acknowledging receipt of my letter by any member.

In my follow-up letter, I requested that the Board authorize you to tell the legislature that the Board Guidelines for Office-Based Surgery (OBS) were not equivalent to the vetoed clinic licensure bill which has passed federal court scrutiny 5 times. For at least 2 years, abortion supporters have claimed that your Guidelines sufficiently protect women in abortion clinics, but this Rajanna disciplinary action proves the contrary.

We are deeply disappointed, though unfortunately not surprised, at the results of your 1-year probe. Rajanna remains open today, operating without life-saving certification or accredited facility approval. According to your findings, KFL was right, and the AG was right, that a licensed practitioner has been operating a sub-standard, deficient, filthy clinic.

Despite your findings that Rajanna was, and is today, unable to guarantee life-saving services, he is still doing abortions as he "slides into" OBS compliance. Women are in jeopardy up until February 2006 at the Rajanna clinic. This is what BOHA intervention amounts to!

KFL has strenuously opposed this pattern of protecting abortionists rather than protecting the safety of women, as witnessed in your dealings with Rajanna's former co-employees Kristin Neuhaus and Malcolm Knarr. You permitted Neuhaus to stay in business when she was practically unable to viably practice medicine due to DEA restrictions. You allowed women access to Neuhaus while she was under random drug testing and prescription supervision. You described her deficient at every level of patient care: intake, monitoring, and recovery. Like Rajanna, she persisted in keeping pre-drawn syringes and was not certified in resuscitation.

Your stubborn resistance to removing admitted drug addict and felon Knarr was so appalling it personally lead me to this "hobby" of monitoring abortionists and malpractice in Kansas. The charges in the whistleblower affidavit that nailed Knarr incredibly "matches" the information of the Rajanna whistleblower 11years later! (see enclosed chart)

It is hard not to see politics, rather than logic and true professionalism, at work here. If there are other licensed practitioners "living on the edge" by doing risky procedures in their offices instead of licensed facilities, why not honestly address those problems separately? This is not a situation where you must treat all licensed practitioners equally because the U.S. Supreme Court has said Abortion is unique and unlike other medical practices. For over 30 years, litigation has clearly outlined the specific needs of abortion clinics, based on numerous, continuing cases of abortionists, like Rajanna, cutting corners.

Law enforcement officers who visited Rajanna's clinic were disgusted, yet they were not able to find a state regulatory agency willing to close it. They saw roaches, bloodied floors and young women without medical training, much less a high school diploma, running an assembly-line nightmare. (As has been validated by New York Times, abortion clinics are notorious for employing impoverished untrained staffers.)

Your agency is ineffective at closing such a place without a statutory licensing authority. KDHE is also ineffective at forcing compliance from the Planned Parenthood clinic voluntarily licensed as an ASC. The abortion clinic licensing bill ALONE has the teeth to secure compliance from abortionists who are violating their own industry standards with impunity.

Additionally, the abortion clinic licensing bill mandates a clinic director with responsibility for monitoring the staff AND the abortionist. Your Guidelines do not. Kansas-licensed Leroy Carhart worked at a Humedco abortion clinic in Nebraska where the medical director charged him with using his cell phone and falling asleep during abortions, as well as breaking safety protocols. Even if Carhart has been issued a copy of your Guidelines, how are they monitored or enforced?

The disciplinary action mandating cardiac life-support training indicates Rajanna has not possessed the necessary emergency skills during this year, nor is he required to be certified as such until August 2005, while he continues to operate. Based on information from several sources in 2003 and 2004, Rajanna did not have the necessary monitoring equipment, trained staff, nor medical procedures in place to follow these guidelines. He did not have one person dedicated to monitoring the patient under analgesia & sedatives. He did not have a properly outfitted and manned recovery room.

In January, a pro-life citizen tried to help a foreign-born woman who was observed vomiting in Rajanna's parking lot, and although dizzy, would be driving herself home. Why should we believe your "intervention" with Rajanna has changed anything? Yours is a reactive agency, and there are no signs posted, or public awareness campaigns conducted, on how to report deficient assembly-line abortion clinics.

This disciplinary action for Rajanna raises many troubling questions, specifically:

1.Regular observers at Rajanna's clinic see him bring black garbage bags out of the office and into his car, and have followed him as he deposited this medical waste in various private housing dumpsters. How does the Board action secure daily compliance for medical waste disposal or any other mandate?

2.When will the OSHA requirements be enforced, a complaint that the clinic whistleblower said he ignored ?

3. Why is such a small fine incurred when so much expensive tax-funded manpower is involved?

4. Why do you not use the full force of your authority to close him until he passes OBS inspections and achieves life-support certification?

5. Kansas' six abortion clinics belong in an inspection-based licensing program with legally tested standards. Why will you not relinquish them when you have neither the expertise nor the budget to micro-manage them?

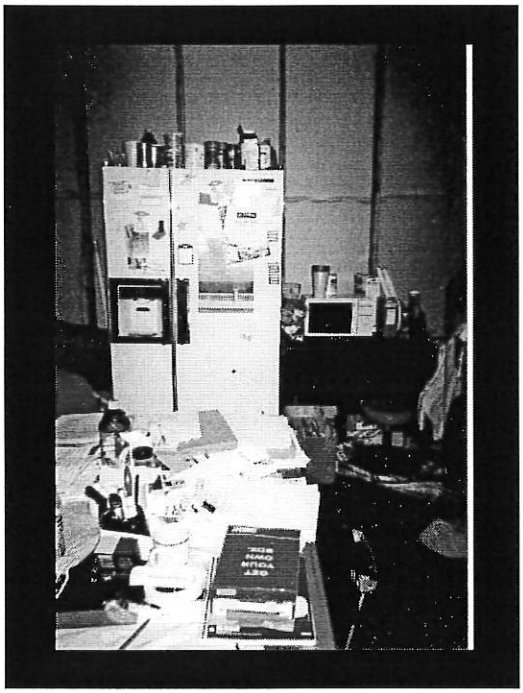
I await your reply.
Sincerely,
Kathy Ostrowski, KFL Legislative Research Director

PRESS RELEASE
Tuesday March 8, 2005
TOPIC: Joint press conference of Kansans for Life and Kansas legislators

Contact: Jeanne Gawdun, KFL
785-383-8636

Legislators want Answers from Board of Healing Arts

State legislators want explanations from the State Board of Healing Arts about the Board's Feb.12, 2005 disciplinary action against Kansas City abortionist Krishna Rajanna. Based on whistleblower testimony brought forward by Kansans for Life, a complaint against Rajanna was formally registered Feb.18, 2004, accompanied by disturbing photos of the clinic's interior. The legislators are concerned that the Board has allowed the clinic to stay open for business, despite grave findings of fact that Rajanna did not dispute:



- the clinic was unclean, and in disarray
- medications were expired
- human tissue was stored on counters and then into freezers and refrigerators filled with food
- syringes were preloaded (not drawn and measured individually for each patient)
- bio-hazardous trash was mishandled and disposed improperly
- dispensed medications were mislabeled (action for which the Board had previously fined him)

In an open letter dated Feb.21, 2005, Kansans for Life wrote to Larry Buening, Executive Director of the Board,

> "Rajanna remains open today, operating without life-saving certification or accredited facility approval. According to your findings, KFL was right, and the AG was right, that a licensed practitioner has been operating a sub-standard, deficient, filthy clinic. Despite your findings that Rajanna was, and is today, unable to guarantee life-saving services, he is still doing abortions as he "slides into" compliance with Board orders."

Two weeks have passed, but Kansans for Life has not received any answer from Buening.

The Board ordered that Rajanna must obey both the Anesthesia and the Office Based-Surgery (OBS) Guidelines. Based on information from several sources in 2003 and 2004, Rajanna did not have the necessary monitoring equipment, trained staff, or medical procedures in place that are required by both the Anesthesia and Office Based-Surgery (OBS) Guidelines. He did not have one person dedicated to monitoring the patient under analgesia and sedatives. He did not have a properly outfitted and manned recovery room. The staff consisted of women without high school diplomas or medical training.

Kansas legislators and the public want the Board to answers these questions:

Hand- delivered to the Board of Healing Arts, March 8, 2005
Dear Mr. Buening,
Concerning the Board's Feb.12, 2005 disciplinary matter of Krishna Rajanna, please address the following questions:

1.Since you have found Rajanna to be deficient, and women are at risk TODAY, why do you not close his doors until he complies with requirements?

2.Rajanna is not Advanced Cardiac Life Support (ACLS) certified, why have you allowed him to work this way until August 2005? (Kansas abortion patient Erna Fisher died in March 1988 when she was not resuscitated by Kansas abortionist Dennis Miller; Kansas-licensed abortionist Robert Crist was not certified ACLS in April 1997 when his St. Louis abortion patient Nichole Williams died in a cardiac event.)

3.His clinic has not passed the national accreditation you have ordered; why have you allowed him to do abortions until February 2006 in a proven sub-standard facility?

4. How are the 2002 Office-Based Surgery (OBS) Guidelines ordinarily promulgated, and to which practitioners?

5. How are the OBS Guidelines monitored or enforced?

6. What concrete improvements has Rajanna accomplished, and how do you prove that? In January, a pro-life citizen observed a foreign-born woman vomiting for 20 minutes in Rajanna's parking lot, and although dizzy, would be driving herself home.

7. Whose responsibility is it to check if Rajanna has been inspected by, and is in compliance with, OSHA and CLIA ?

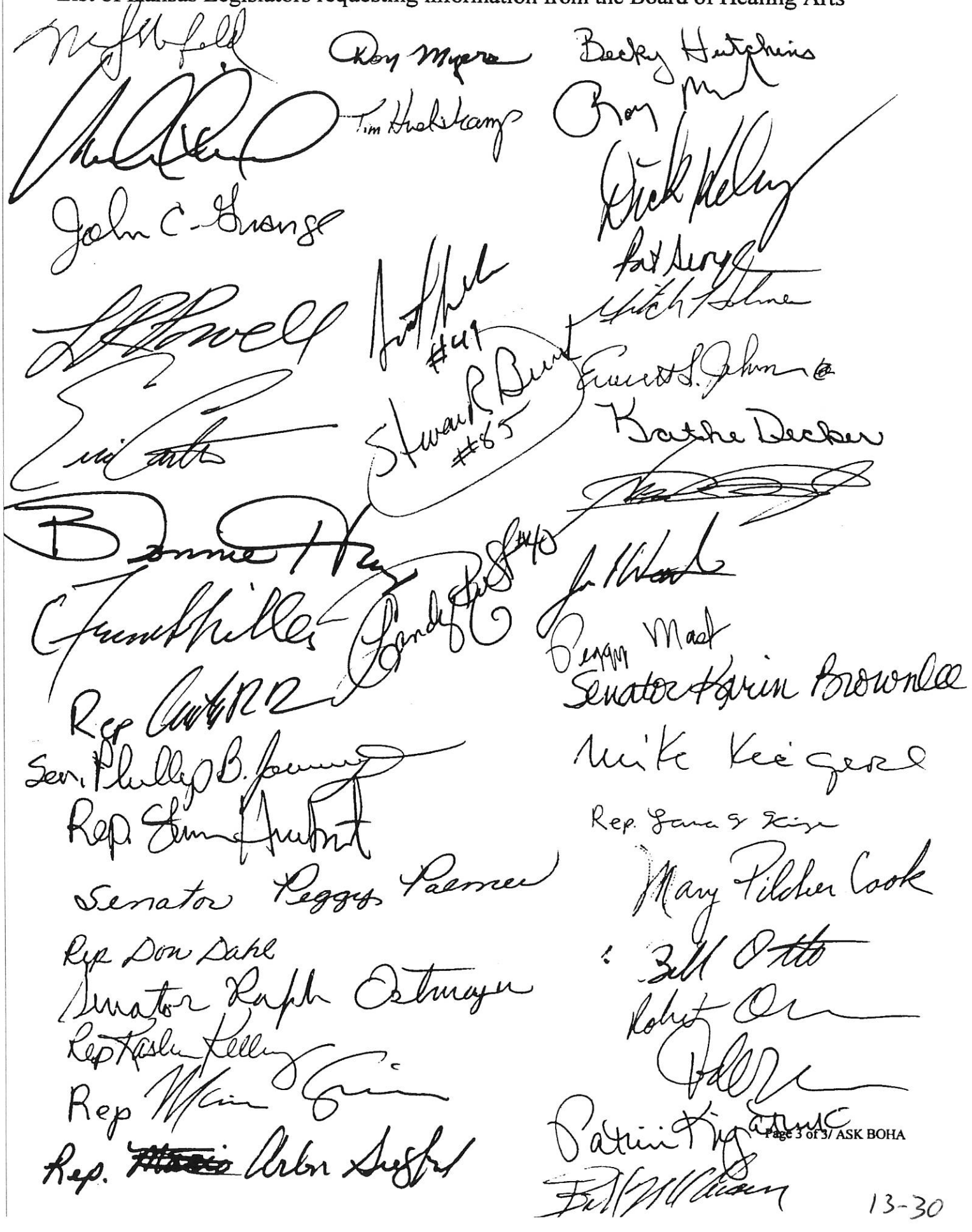
8. Aside from moral culpability, will you not suffer legal liability if a woman should suffer injury or death at his clinic?

9. How does the Board action secure daily compliance for medical waste disposal or any other mandate? Regular observers see Rajanna bring black garbage bags out of the office and into his car, and have seen him deposit this medical waste in various private housing dumpsters.

10. Why is such a small fine levied (equivalent to the price of 3 abortions) when so much expensive tax-funded manpower is involved?

Thank you. We await your prompt response. (List of signatories attached)

List of Kansas Legislators requesting information from the Board of Healing Arts



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Gov.Sebelius vetoed abortion clinic licensure in 2003, claiming Kansas enjoys the highest medical standards. Two abortion employee whistleblowers, 11 years apart, describe just the opposite.

How an abortion clinic employee in 1992 described the operation of a Kansas abortionist, W. Malcolm Knarr.
"Susie's"document on file at BOHA. For summary see http://www.abortionviolence.com/VIOL-KS.HTM

Cash discounts
Knarr's abortion seekers at 720 Central, were given discounts for traveling a certain number of miles and on certain days. *(item 6, pg 2)*

Violated informed consent
Knarr staff violated the 1992 abortion law about information delivered to woman 8 hours prior to procedure. *(item 7, pg 3)* Knarr avoided full info disclosure. *(item 8, pg 3)*

Improper counseling
1992 abortion counseling provisions were violated and hidden. No RN, LPN or licensed social worker provided counseling. *(item 12, pg 4)*

Medically untrained staff
A receptionist without medical training was doing IVs within first month of employment *(item 2-pg 1)* and was told to comfort crying women in pain. *(item 27, pg 8)*

Important test mishandled
RhoGAM given improperly.*(item 13, pg 5)*

Fetal tissue mishandled
Knarr never reassembled fetal parts to see if any remained in woman. The solid contents of suction abortions, caught in a gauze bag, were put into cups. *(item 21, pg 7)*

Med waste mishandled
The bloody pads & drapes from under the aborted women, and the used rubber gloves, were thrown into garbage. *(item 22, pg 7)*

Sink used for blood
Knarr had blood drawn in kitchen with blood poured down the sink. *(item 35, pg 10)*

How an abortion clinic employee in 2003 described the operation of a Kansas abortionist, Krishna Rajanna.
"Ruby" told her story to law officers and the DA, who found her to be credible. Ruby took photos.

Cash discounts
Rajanna, 1030 Central, gave discounts on Wednesdays. Knarr's former partner, abortionist Zaremski, 720 Central, advertised for discounts on Tuesday and Thursdays.

Violated informed consent
Rajanna violated proper information delivery as ordered in 1997 Women's Right to Know law.

Improper counseling
Minors were counseled via phone at Rajanna's. No RN, LPN or licensed social worker was onsite. A CNA was sometimes employed.

Medically untrained staff
Ruby was hired as a receptionist, but within days was brought into surgical room to do IVs, witness abortions and help calm upset women.

Important test mishandled
Rh factor test done by Rajanna staffer who was not taught procedure variants that invalidate results.

Fetal tissue mishandled
Rajanna never reassembled fetal parts to see if any remained in woman. He stored abortion contents in cartons and cups in refrigerator, next to needles, drugs, and open food.

Med waste mishandled
The bloody pads & drapes from under the aborted women, used rubber gloves, blood test specimens & other medical waste were thrown into garbage. Rajanna placed trash in his car each night. No bio-hazardous waste containers were inside clinic.

Sink used for blood
Rajanna dishwasher output from bloody instruments pours into sink, not floor drain.

OSHA violations
Knarr's offices were cited by OSHA for violations, which he did not correct. *(item 36, pg 10*

Poor personal hygiene
Knarr was always disheveled with dirty fingers and stained coat. *(item 25, pg 8)*

Chaotic clinic
Knarr's office was generally disorganized with no clearly defined manager. There was fighting over petty matters. *(item 30, pg 9)*

Rushed assembly-line
After the procedure, Knarr would shout at the staff to get patients up and out ASAP. *(item 27, pg 9)*

Life-saving training deficient
Life support equipment for constant monitoring required for drugs Knarr utilized was not onsite and staffers were not CPR trained. *(item 34, pg10*

Violations drug protocol
Knarr violated drug sample usage. *(item 39, pg 11)*

No follow-up
80% of Knarr patients did not return for mandatory follow-up exam. *(item 26, pg 8))*

Staffers unpaid
Knarr summarily withheld money owed to staffers, claiming it was legal. *(item 37, pg 11)*

Whistleblower framed
"Susie" felt Knarr tried to frame her, using open drug vial. *(item 42, pg 12)*

-

Knarr hired Rajanna from Feb.1994 til Jan.1995
Rajanna was then fired by Knarr, in part, because Rajanna was unable to obtain hospital privileges. *[Civil action 99C462, Wyandotte County, Div.3]*
Knarr and Rajanna are not Ob/Gyn doctors.

OSHA violations
Rajanna's office has hazardous cleaners not kept in closed storage; exposed wiring; a gas lawn mower inside premises; passageways and exit blocked

Poor personal hygiene
Rajanna was always disheveled with dirty fingers and stained coat.

Chaotic clinic
Rajanna's office (which was the kitchen) was disorganized with the premises looking like a trashed frat house. Staff kept own record of hours worked, with arguments about proper pay.

Rushed assembly-line
After each abortion, Rajanna staff quickly removes IV, pulling client's slacks back up (with pad) and helping her stand and walk haltingly, groggily to "recovery couch". No attendant, no wheelchair, no final doctor contact or exam.

Life-saving training deficient
Rajanna staff was not CPR certified, and necessary resuscitative equipment is not onsite. Vitals are checked before procedure and once after wards, but not during procedure or recovery as is proper.

Violations drug protocol
Rajanna drug closet accessible to staff, who were never asked for criminal record or job references

No follow-up
3/4ths of Rajanna patients never returned for mandated checkup.

Staffers unpaid
Rajanna summarily withheld money owed to staffers.

Whistleblower framed
"Ruby" feels she was "framed" in a false police report of theft.

-

Susie and Ruby don't know each other. Ruby has never heard about Susie's report, and vice-versa.

Both women were financially strapped, needed the job, but finally felt they had to tell someone about conditions. Neither woman was paid or coerced.

2-21-05 For more information call Kansans for Life at 1-800-928-5433

TIMELINE: **Kansas State Board of Healing Arts** in the Matter of **ANN K. NEUHAUS, M.D.** (Lic. 04-21596)

June 29, 1993- First record of Neuhaus practicing in Topeka (License application renewal for 1993-1994).

Jan. 18, 1994- Neuhaus, medical director of abortion clinic in KCK, locks herself and 5 employees in clinic, because of a dispute with employee Malcolm Knarr. (See Topeka Capital Journal article, 1-19-94)

June 30, 1996- last Kansas license application renewal for Neuhaus with clean disciplinary record.

Oct. 18, 1999- KBHA STIPULATION, AGREEMENT & ENFORCEMENT ORDER **Neuhaus breaks DEA regulations for controlled substances** including failure to keep complete and accurate records. Board restricts her to use of only 1 drug (Valium) and requires administration log with duplicate prescription copies reviewed monthly by outside pharmacist. They also order random drug testing of her entire staff & security guards and that Neuhaus not hire anyone with a substance abuse history.

Aug. 12, 2000- KBHA MEETING, Administrative proceeding V, closed session to discuss refusal to grant Neuhaus' request for permission to use additional drug. Issue emergency order classifying Neuhaus as **imminent danger to public**.

Aug. 14, 2000- FINAL ORDER: Board reacts to Neuhaus' testimony that she relies heavily on staff to manage complications; that she is not certified in cardiac life support; that she neglects to insert IV lines during sedation.

Aug. 29, 2000- KBHA EMERGENCY ORDER-states that Neuhaus is an immediate threat, not limited to the likelihood of patient injury; she is **not following the standards of care** for non-anesthesiologists when giving sedation. Specifically, she **omits the following**: a proper patient history (including adverse drug reactions), focused exam, monitoring of vital signs, patient dismissal evaluation & an accurate medication record.

Sept. 7, 2000- KBHA RESPONSE from counsel issued to Neuhaus request to terminate limitations. Request is without comprehensive account of how she exactly plans to address deviations of standards of care. There is no evidence that Neuhaus' staff is competent in resuscitation. Board requests a hearing and monitoring of Neuhaus concerning deviations of care.

Sept. 11, 2000- KBHA TERMINATION OF EMERGENCY ORDER: Neuhaus promises to complete a course in Advanced Cardiac Life Support training and staff will complete basic Life Support course; Board will monitor compliance. **Allowed back in full practice.**

Dec. 4, 2000- PETITION TO REVOKE, SUSPEND or OTHERWISE LIMIT LICENSE: Patients A.B. & S.D. were not evaluated, examined, monitored, recorded & discharged properly; informed consent gestational information not conveyed to them 24 hrs. prior to procedure. Patients C.L. & H.S. allege all the same as A.B. & S.D. plus failure to obtain written documents. Patient A.G. gave limited consent to abortion without sedation. When she **withdrew consent and tried to leave, Neuhaus & staff sedated her and aborted her**. A.G.'s informed consent was violated and

all the proper protocols omitted from the above patients were also omitted from her. **Neuhaus kept unmarked pre-drawn syringes** in her practice, contrary to standards of care.

Feb. 2, 2001- AMENDED PETITION restates Dec.4 petition with minor correction

March 15, 2001- MOTION TO CONTINUE April 11-13 hearing, based on an undocumented, non-specific "threat" coupled with the assertion that Neuhaus had experienced hostilities in a prior Holy Week. That such assertion is patently false as can be demonstrated from KBHA records along with police & media reports. (See attached letter from KFL to KBHA.)

April 4, 2001- MOTION GRANTED, continued until June 20-21, 2001

April 28, 2001- Settlement offer to avoid trial presented (per Mark Stafford, Disciplinary Counsel.)

May 10, 2001- Neuhaus announces closing Wichita office

June 15, 2001- AGREED INITIAL ORDER maintains the facts and conclusions of 8/29/00 and 9/11/00 that Neuhaus deviated from the standard of care regarding informed consent, sedation and monitoring of patients. The limitations described on 10/18/99 remain in force, such that Neuhaus must: 1) dedicate one staffer to monitoring sedation and addressing emergencies; 2) improve record-keeping; 3) have a printed, dated sonogram as part of every medical record; 4) improve the informed consent form, and have it signed, dated, timed and witnessed during appointment for procedures; 5) meet with patients outside of procedure room, reviewing informed consent prior to patient's physical preparation for procedure.

Aug. 24, 2001- FINAL ORDER. Board adopts June 15, 2001 order as final

Sept. 10, 2002- one year later, Neuhaus announces closing Lawrence office

NATIONAL ABORTION FEDERATION

Safety of Surgical Abortion

Surgical abortion is one of the safest types of medical procedures. Complications from having a first trimester abortion are considerably less frequent and less serious than those associated with giving birth.

Illegal Abortion Is Unsafe Abortion

Abortion has not always been so safe. Between the 1880's and 1973, abortion was illegal in all or most states, and many women died or had serious medical problems as a result. Women often made desperate and dangerous attempts to induce their own abortions or resorted to untrained practitioners who performed abortions with primitive instruments or in unsanitary conditions. Women streamed into emergency rooms with serious complications -- perforations of the uterus, retained placentas, severe bleeding, cervical wounds, rampant infections, poisoning, shock, and gangrene.

Around the world, in countries where abortion is illegal, it remains a leading cause of maternal death. An estimated 78,000 women worldwide die each year from unsafe abortions[1]. Many of the doctors who perform abortions in the United States today are committed to providing this service under medically safe conditions because they witnessed and still remember the tragic cases of women who appeared in hospitals after botched, illegal abortions.

Evaluating the Risk of Complications

Since the Supreme Court re-established legal abortion in the U.S. in the 1973 Roe v. Wade decision, women have benefited from significant advances in medical technology and greater access to high quality services[2]. Generally, the earlier the abortion, the less complicated and safer it is.

Serious complications arising from surgical abortions performed before 13 weeks are quite unusual. About 88% of the women who obtain abortions are less than 13 weeks pregnant[3]. Of these women, 97% report no complications; 2.5% have minor complications that can be handled at the medical office or abortion facility; and less than 0.5% have more serious complications that require some additional surgical procedure and/or hospitalization[4]. Complication rates are somewhat higher for abortions performed between 13 and 24 weeks. General anesthesia, which is sometimes used in abortion procedures, carries its own risks.

In addition to the length of the pregnancy, significant factors that can affect the possibility of complications include:

- the kind of anesthesia used;
- the abortion method used;
- the woman's overall health; and
- the skill and training of the provider.

Complications from Legal Abortion

The largest, most comprehensive studies of abortion complications were conducted in the 1970's, when modern abortion techniques were still being developed. Experts agree that with advances in technology and increased experience with these technologies, complication rates have almost certainly declined since then[5,6]. Although rare, possible complications from a surgical abortion procedure include:

- blood clots accumulating in the uterus, requiring another suctioning procedure, which occur in less than 0.2% of cases[7];
- infections, most of which are easily identified and treated if the woman carefully observes follow-up instructions, which in studies in North America occur in 0.1-2% of cases[7];
- a tear in the cervix, which may be repaired with stitches, which occurs in 0.6-1.2% of cases[8];
- perforation (a puncture or tear) of the wall of the uterus and/or other organs occurs in less than 0.4% of cases[6,7]. This may heal itself or may require surgical repair or, rarely, hysterectomy;
- missed abortion, which does not end the pregnancy and requires the abortion to be repeated, which occurs in less than 0.3% of cases[7];
- incomplete abortion, in which tissue from the pregnancy remains in the uterus, and requires a repeat suction procedure, which occurs in 0.3-2% of cases[7];
- excessive bleeding requiring a blood transfusion, which occurs in 0.02-0.3% of cases[6,8].

Death occurs in 0.0006% of all legal abortions (one in 160,000 cases). These rare deaths are usually the result of such things as adverse reactions to anesthesia, embolism, infection, or uncontrollable bleeding[7]. In comparison, a woman's risk of death during pregnancy and childbirth is ten times greater[5].

Signs of a Post-Abortion Complication

If a woman has any of the following symptoms after having a surgical abortion, she should immediately contact the facility that provided the abortion for follow-up care[7]:

- severe or persistent pain;
- chills or fever with an oral temperature of 100.4° or more;

Attachment 14
HHS 3-15-05

- bleeding that is twice the flow of her normal menstrual period or that soaks through more than one sanitary pad per hour for two hours in a row;
- foul-smelling discharge or drainage from her vagina; or
- continuing symptoms of pregnancy.

Doctors and clinics that offer abortion services should provide a 24-hour number to call in the event of complications or reactions that the patient is concerned about.

Preventing Complications

There are some things women can do to lower their risks of complications. The most important thing is not to delay the abortion procedure. Generally, the earlier the abortion, the safer it is.

Asking questions is also important. Just as with any medical procedure, the more relaxed a person is and the more she understands what to expect, the better and safer her experience usually will be.

In addition, any woman choosing abortion should:

- find a good clinic or a qualified, licensed practitioner. For referrals, call NAF's toll-free hotline, 1-800-772-9100;
- inform the practitioner of any health problems, current medications or street drugs being used, allergies to medications or anesthetics, and other health information;
- follow post-operative instructions; and
- return for a follow-up examination.

Anti-Abortion Propaganda

Anti-abortion activists claim that having an abortion increases the risk of developing breast cancer and endangers future childbearing. They claim that women who have abortions without complications are more likely to have difficulty conceiving or carrying a pregnancy, develop ectopic (outside of the uterus) pregnancies, deliver stillborn babies, or become sterile. However, these claims have been refuted by a significant body of medical research. In February 2003, a panel of experts convened by the National Cancer Institute to evaluate the scientific data concluded that studies have clearly established that "induced abortion is not associated with an increase in breast cancer risk." [9] Furthermore, comprehensive reviews of the data have concluded that a vacuum aspiration procedure in the first trimester poses virtually no risk to future reproductive health[10].

Women's Feelings after Abortion

Women have abortions for a variety of reasons, but in general they choose abortion because a pregnancy at that time is in some way wrong for them. Such situations often cause a great deal of distress, and although abortion may be the best available option, the circumstances that led to the problem pregnancy may continue to be upsetting.

Some women may find it helpful to talk about their feelings with a family member, friend, or counselor. Feelings of loss or of disappointment, resulting, for example, from a lack of support from the spouse or partner, should not be confused with regret about the abortion. Women who experience guilt or sadness after an abortion usually report that their feelings are manageable.

The American Psychological Association has concluded that there is no scientifically valid support or evidence for the so-called "post-abortion syndrome" of psychological trauma or deep depression. The most frequent response women report after having ended a problem pregnancy is relief, and the majority are satisfied that they made the right decision for themselves.

References

1 Unsafe abortion: Global and regional estimates of incidence of a mortality due to unsafe abortion with a listing of available country data-Third edition. Geneva: World Health Organization, 1997.

2 AMA Council Report. Induced Termination of Pregnancy Before and After Roe v. Wade. Journal of the American Medical Association, 1992, 268: 3231.

3 Elam-Evans LD, Strauss LT, Herndon J, Parker WY, Whitehead S, Berg CJ. Abortion Surveillance-United States, 1999. Morbidity and Mortality Weekly Report 2002; 51 (SS09): 1-28.

4 Tietze C, Henshaw SK. Induced abortion: A worldwide review, 1986. Third edition. New York: Alan Guttmacher Institute, 1996.

5 Henshaw SK. Unintended pregnancy and abortion: A public health perspective. In Paul M, Lichtenberg ES, Borgatta L, Grimes DA, Stubblefield PG. *A Clinician's Guide to Medical and Surgical Abortion*. New York: Churchill Livingstone, 1999, pp. 11-22.

6 Haskell WM, Easterling TR, Lichtenberg ES. Surgical abortion after the first trimester. In Paul M, Lichtenberg ES, Borgatta L, Grimes DA, Stubblefield PG. A *Clinician's Guide to Medical and Surgical Abortion*. New York: Churchill Livingstone, 1999, pp. 123-138.

7 Lichtenberg ES, Grimes DA, Paul M. Abortion complications: Prevention and management. In Paul M, Lichtenberg ES, Borgatta L, Grimes DA, Stubblefield PG. *A Clinician's Guide to Medical and Surgical Abortion*. New York: Churchill Livingstone, 1999, pp. 197-216.

8 Hern WM. Abortion Practice. Philadelphia: J.B. Lipincott Company, 1990.

9 Summary Report: Early Reproductive Events and Breast Cancer Workshop, National Cancer Institute, http://www.nci.nih.gov/cancerinfo/ere-workshop-report

10 Rowland Hogue CJ, Boardman LA, Stotland NL, Peipert JF. Answering questions about long-term outcomes. In Paul M, Lichtenberg ES, Borgatta L, Grimes DA, Stubblefield PG. *A Clinician's Guide to Medical and Surgical Abortion*. New York: Churchill Livingstone, 1999, pp. 217-228.

For More Information

For information or referrals to qualified abortion providers, call the National Abortion Federation's toll-free hotline: 1-800-772-9100.
Weekdays, 8:00AM-10:00PM
Weekends 9:00AM-5:00PM Eastern time.

National Abortion Federation
1755 Massachusetts Avenue NW, Suite 600
Washington, DC 20036
202-667-5881
www.prochoice.org

Writers: Susan Dudley, PhD

Revised 2003.

Table 16
Maternal Deaths by Number and Rate*
Kansas, 1916-present

Year	Number	Rate *	Year	Number	Rate *
1916....	286	69.5	1963....	15	3.3
1917....	259	67.1	1964....	8	1.8
1918....	308	80.2	1965....	12	3.1
1919....	246	68.3	1966....	10	2.8
1920....	258	63.9	1967....	7	2.0
1921....	262	61.7	1968....	9	2.5
1922....	272	68.9	1969....	5	1.3
1923....	246	62.0	1970....	5	1.3
1924....	204	53.3	1971....	7	1.9
1925....	209	55.4	1972....	2	0.6
1926....	247	69.3	1973....	5	1.6
1927....	206	58.5	1974....	6	1.8
1928....	243	71.8	1975....	6	1.8
1929....	201	61.2	1976....	1	0.3
1930....	235	69.2	1977....	4	1.1
1931....	192	58.0	1978....	8	2.2
1932....	172	54.2	1979....	3	0.8
1933....	154	49.4	1980....	4	1.2
1934....	181	55.5	1981....	6	1.5
1935....	166	53.5	1982....	3	0.7
1936....	155	50.7	1983....	4	1.0
1937....	121	41.3	1984....	4	1.0
1938....	115	38.9	1985....	2	0.5
1939....	101	34.7	1986....	1	0.3
1940....	102	35.5	1987....	1	0.3
1941....	74	24.5	1988....	4	1.0
1942....	82	24.6	1989....	3	0.8
1943....	74	21.0	1990....	5	1.3
1944....	57	16.3	1991....	1	0.3
1945....	52	16.5	1992....	2	0.5
1946....	57	14.7	1993....	3	0.8
1947....	46	10.3	1994....	2	0.5
1948....	34	8.0	1995....	2	0.5
1949....	25	5.7	1996....	2	0.5
1950....	27	6.1	1997....	5	1.3
1951....	34	7.2	1998....	3	0.8
1952....	34	6.8	1999....	4	1.0
1953....	22	4.2	2000....	3	1.0
1954....	29	5.4	2001....	1	0.3
1955....	26	4.9	2002	2	0.5
1956....	18	3.4	2003	0	0.0
1957....	12	2.3			
1958....	12	2.3			
1959....	13	2.5			
1960....	9	1.8			
1961....	13	2.6			
1962....	12	2.5			

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* Rate per 10,000 live births
1916 - 1943: Occurrence data
1944 - present: Residence data
Source: Kansas Vital Statistics

*ICD Codes: 1974-1978 Maternal Death
1979-1998 Maternal Death
1999-present Maternal Death IC

Table of CAUSEDS by DYEAR

CAUSEDS	DYEAR												
Frequency	1990	1992	1993	1995	1996	1997	1998	1999	2000	2001	2002	2003	Total
8700 - SURGICAL OPERATION	1	1	1	1	0	0	3	0	0	0	0	0	7
8704 - ENDOSCOPIC EXAMINATION	0	1	0	2	0	3	0	0	0	0	0	0	6
8705 - ASPIRATION OF FLUID OR TISSUE PUNCTURE	1	0	0	0	0	0	0	0	0	0	0	0	1
8706 - HEART CATHETERIZATION	0	1	0	0	0	0	0	0	0	0	0	0	1
8708 - OTHER	1	1	0	0	1	0	2	0	0	0	0	0	5
8741 - INFUSION AND TRANSFUSION	0	0	0	1	0	1	0	0	0	0	0	0	2
8760 - MISMATCHED BLOOD IN TRANSFUSION	1	0	0	0	0	0	0	0	0	0	0	0	1
8768 - OTHER SPECIFIED MISADVENTURES	1	1	0	0	1	1	0	0	0	0	0	0	4
Y604 - DURING ENDOSCOPIC EXAMINATION	0	0	0	0	0	0	0	0	0	0	0	1	1
Y658 - OTHER SPECIFIED MISADVENTURES DURING	0	0	0	0	0	0	0	0	1	1	0	1	3
Y818 - MISCELLANEOUS DEVICES NOT ELSEWHERE	0	0	0	0	0	0	0	1	0	0	0	0	1
Y831 - SURGICAL OPERATION WITH IMPLANT OF	0	0	0	0	0	0	0	1	1	4	4	5	15
Y832 - SURGICAL OPERATION WITH ANASTOMOSIS	0	0	0	0	0	0	0	1	2	3	1	4	11
Y833 - SURGICAL OPERATION WITH FORMATION OF	0	0	0	0	0	0	0	1	2	3	3	1	10
Y834 - OTHER RECONSTRUCTIVE SURGERY	0	0	0	0	0	0	0	2	0	1	0	0	3
Y835 - AMPUTATION OF LIMB(S)	0	0	0	0	0	0	0	1	5	0	1	1	8
Y836 - REMOVAL OF OTHER ORGAN (PARTIAL)	0	0	0	0	0	0	0	0	1	3	1	2	7
Y838 - OTHER SURGICAL PROCEDURES	0	0	0	0	0	0	0	2	2	3	0	4	11
Y839 - SURGICAL PROCEDURE UNSPECIFIED	0	0	0	0	0	0	0	8	2	9	7	5	31
Total	5	5	1	4	2	5	5	25	19	35	21	25	152

(Continued)

Misadventures to Patients during Surgical & Medical Care
ICD-9 Codes 870-876/ICD-10 Codes Y60-Y84
Kansas Occurrence Data
Source: KDHE Center for Health and Environmental Statistics
SPECIAL ANALYSIS - MULTI YEAR DEATH 021003.sas

Appendix A

U.S. Standard Certificate of Death

U.S. STANDARD CERTIFICATE OF DEATH

LOCAL FILE NO. **STATE FILE NO.**

For use by physician or institution

To Be Completed/Verified By: FUNERAL DIRECTOR

1. DECEDENT'S LEGAL NAME (Include AKA's if any) (First, Middle, Last): John Leonard Palmer
2. SEX: Male
3. SOCIAL SECURITY NUMBER: 123-45-6789
4a. AGE-Last Birthday (Years): 92
4b. UNDER 1 YEAR: Months / Days
4c. UNDER 1 DAY: Hours / Minutes
5. DATE OF BIRTH (Mo/Day/Yr): April 23, 1911
6. BIRTHPLACE (City and State or Foreign Country): San Francisco, CA
7a. RESIDENCE-STATE: Maryland
7b. COUNTY: Frederick
7c. CITY OR TOWN: Thurmont
7d. STREET AND NUMBER: 245 Lone View Road
7e. APT. NO.:
7f. ZIP CODE: 20212-1234
7g. INSIDE CITY LIMITS? ☐ Yes ■ No
8. EVER IN US ARMED FORCES? ■ Yes ☐ No
9. MARITAL STATUS AT TIME OF DEATH: ■ Married ☐ Married, but separated ☐ Widowed ☐ Divorced ☐ Never Married ☐ Unknown
10. SURVIVING SPOUSE'S NAME (If wife, give name prior to first marriage): Sheila Marie Sonner
11. FATHER'S NAME (First, Middle, Last): Stanley Leonard Palmer
12. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last): Lorraine Ellen Russell
13a. INFORMANT'S NAME: Sheila Marie Palmer
13b. RELATIONSHIP TO DECEDENT: Wife
13c. MAILING ADDRESS (Street and Number, City, State, Zip Code): 245 Lone View Road, Thurmont, MD 20212-1234
14. PLACE OF DEATH (Check only one; see instructions)
IF DEATH OCCURRED IN A HOSPITAL: ■ Inpatient ☐ Emergency Room/Outpatient ☐ Dead on Arrival
IF DEATH OCCURRED SOMEWHERE OTHER THAN A HOSPITAL: ☐ Hospice facility ☐ Nursing home/Long term care facility ☐ Decedent's home ☐ Other (Specify):
15. FACILITY NAME (If not institution, give street & number): Mountain Memorial Hospital
16. CITY OR TOWN, STATE, AND ZIP CODE: Frederick
17. COUNTY OF DEATH: Frederick
18. METHOD OF DISPOSITION: ■ Burial ☐ Cremation ☐ Donation ☐ Entombment ☐ Removal from State ☐ Other (Specify):
19. PLACE OF DISPOSITION (Name of cemetery, crematory, other place): Wesley Memorial Cemetery
20. LOCATION-CITY, TOWN, AND STATE: Frederick
21. NAME AND COMPLETE ADDRESS OF FUNERAL FACILITY: Boone and Sons Funeral Home, 475 E. Main Street, Frederick, Maryland 20216-3456
22. SIGNATURE OF FUNERAL SERVICE LICENSEE OR OTHER AGENT: Robert J. Boone
23. LICENSE NUMBER (Of Licensee): 2569114

To Be Completed By: MEDICAL CERTIFIER

ITEMS 24-28 MUST BE COMPLETED BY PERSON WHO PRONOUNCES OR CERTIFIES DEATH

24. DATE PRONOUNCED DEAD (Mo/Day/Yr): June 20, 2003
25. TIME PRONOUNCED DEAD: 0310
26. SIGNATURE OF PERSON PRONOUNCING DEATH (Only when applicable): Julia R. Kovar, M.D.
27. LICENSE NUMBER: 624998075
28. DATE SIGNED (Mo/Day/Yr): June 20, 2003
29. ACTUAL OR PRESUMED DATE OF DEATH (Mo/Day/Yr) (Spell Month): June 20, 2003
30. ACTUAL OR PRESUMED TIME OF DEATH: 0300
31. WAS MEDICAL EXAMINER OR CORONER CONTACTED? ☐ Yes ■ No

CAUSE OF DEATH (See instructions and examples)

32. PART I. Enter the chain of events—diseases, injuries, or complications—that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE. Enter only one cause on a line. Add additional lines if necessary.

		Approximate interval: Onset to death
IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. Pulmonary embolism	Minutes
Sequentially list conditions, if any, leading to the cause listed on line a. Enter the	Due to (or as a consequence of): b. Congestive heart failure	4 days
UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST	Due to (or as a consequence of): c. Acute myocardial infarction	7 days
	Due to (or as a consequence of): d. Chronic ischemic heart disease	8 years

PART II. Enter other significant conditions contributing to death but not resulting in the underlying cause given in PART I: Diabetes mellitus, Hypertension

33. WAS AN AUTOPSY PERFORMED? ☐ Yes ■ No
34. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? ☐ Yes ■ No
35. DID TOBACCO USE CONTRIBUTE TO DEATH? ☐ Yes ☐ Probably ☐ No ■ Unknown
36. IF FEMALE: ☐ Not pregnant within past year ☐ Pregnant at time of death ☐ Not pregnant, but pregnant within 42 days of death ☐ Not pregnant, but pregnant 43 days to 1 year before death ☐ Unknown if pregnant within the past year
37. MANNER OF DEATH: ■ Natural ☐ Homicide ☐ Accident ☐ Pending Investigation ☐ Suicide ☐ Could not be determined
38. DATE OF INJURY (Mo/Day/Yr) (Spell Month)
39. TIME OF INJURY
40. PLACE OF INJURY (e.g., Decedent's home; construction site; restaurant; wooded area)
41. INJURY AT WORK? ☐ Yes ☐ No
42. LOCATION OF INJURY: State: City or Town: Street & Number: Apartment No.: Zip Code:
43. DESCRIBE HOW INJURY OCCURRED
44. IF TRANSPORTATION INJURY, SPECIFY: ☐ Driver/Operator ☐ Passenger ☐ Pedestrian ☐ Other (Specify)
45. CERTIFIER (Check only one)
■ Certifying physician- To the best of my knowledge, death occurred due to the cause(s) and manner stated.
☐ Pronouncing & Certifying physician- To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner stated.
☐ Medical Examiner/Coroner- On the basis of examination, and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) and manner stated.
Signature of certifier: Edward M. Stone, M.D.
46. NAME, ADDRESS, AND ZIP CODE OF PERSON COMPLETING CAUSE OF DEATH (Item 32): Edward Matthew Stone, M.D., 23 Porter Drive, Frederick, Maryland 29885-6789

14-5

MEDICAL CERTIFIER INSTRUCTIONS for selected items on U.S. Standard Certificate of Death (See *Physicians' Handbook* or *Medical Examiners' and Coroners' Handbook on Death Registration and Fetal Death Reporting* for instructions on all items.)

ITEMS ON WHEN DEATH OCCURRED
Items 24–25 and 29–31 should always be completed. If the facility uses a separate pronouncer or other person to indicate that death has taken place with another person more familiar with the case completing the remainder of the medical portion of the death certificate, the pronouncer completes items 24–28. If a certifier completes items 24–25 as well as items 29–49, items 26–28 may be left blank.

ITEMS 24–25, 29–30 DATE AND TIME OF DEATH
Spell out the name of the month. If the exact date of death is unknown, enter the approximate date. If the date cannot be approximated, enter the date the body is found and identify as date found. Date pronounced and actual date may be the same. Enter the exact hour and minutes according to a 24-hour clock; estimates may be provided with "Approx." placed before the time.

ITEM 32–CAUSE OF DEATH (See attached examples)
Take care to make the entry legible. Use a computer printer with high resolution, typewriter with good black ribbon and clean keys, or print legibly using permanent **black** ink in completing the cause of death section. **Do not abbreviate** conditions entered in section.

Part I (Chain of events leading directly to death)

- Only **one** cause should be entered on each line. Line (a) **MUST ALWAYS** have an entry. **DO NOT** leave blank. Additional lines may be added if necessary.
- If the condition on Line (a) resulted from an underlying condition, put the underlying condition on Line (b) and so on, until the full sequence is reported. **ALWAYS** enter the **underlying cause of death** on the lowest used line in Part I.
- For each cause indicate the best estimate of the interval between the presumed onset and the date of death. The terms "unknown" or "approximately" may be used. General terms, such as minutes, hours, or days, are acceptable, if necessary. **DO NOT** leave blank.
- The terminal event (for example, cardiac arrest or respiratory arrest) should not be used. If a mechanism of death seems most appropriate to you for line (a), then you must always list its cause(s) on the line(s) below it (for example, cardiac arrest **due to** coronary artery atherosclerosis *or* cardiac arrest **due to** blunt impact to chest).
- If an organ system failure such as congestive heart failure, hepatic failure, renal failure, or respiratory failure is listed as a cause of death, always report its etiology on the line(s) beneath it (for example, renal failure **due to** Type I diabetes mellitus).
- When indicating neoplasms as a cause of death, include the following: 1) primary site *or* that the primary site is unknown, 2) benign or malignant, 3) cell type *or* that the cell type is unknown, 4) grade of neoplasm, and 5) part or lobe of organ affected. (For example, a primary well-differentiated squamous cell carcinoma, lung, left upper lobe.)
- Always report the fatal injury (for example, stab wound of chest), the trauma (for example, transection of subclavian vein), and impairment of function (for example, air embolism).

PART II (Other significant conditions)

- Enter all diseases or conditions contributing to death that were not reported in the chain of events in Part I and that did not result in the **underlying cause of death.** See attached examples.
- If two or more possible sequences resulted in death, or if two conditions seem to have added together, report in Part I the one that, in your opinion, most directly caused death. Report in Part II the other conditions or diseases.

CHANGES TO CAUSE OF DEATH

Should additional medical information or autopsy findings become available that would change the cause of death originally reported, the original death certificate should be amended by the certifying physician by **immediately** reporting the revised cause of death to the State Vital Records Office.

ITEMS 33–34–AUTOPSY

- 33–Enter "Yes" if either a partial or full autopsy was performed. Otherwise enter "No."
- 34–Enter "Yes" if autopsy findings were available to complete the cause of death; otherwise enter "No." Leave item blank if no autopsy was performed.

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ITEM 35–DID TOBACCO USE CONTRIBUTE TO DEATH?
Check "Yes" if, in your opinion, the use of tobacco contributed to death. Tobacco use may contribute to deaths due to a wide variety of diseases; for example, tobacco use contributes to many deaths due to emphysema or lung cancer and some heart disease and cancers of the head and neck. Check "No" if, in your clinical judgment, tobacco use did not contribute to this particular death.

ITEM 36–IF FEMALE, WAS DECEDENT PREGNANT AT TIME OF DEATH OR WITHIN PAST YEAR?
This information is important in determining pregnancy-related mortality.

ITEM 37–MANNER OF DEATH

- Always check Manner of Death, which is important: 1) in determining accurate causes of death; 2) in processing insurance claims; and 3) in statistical studies of injuries and death.
- Indicate "Pending investigation" if the manner of death cannot be determined whether due to an accident, suicide, or homicide within the statutory time limit for filing the death certificate. This should be changed later to one of the other terms.
- Indicate "Could not be determined" **ONLY** when it is impossible to determine the manner of death.

ITEMS 38–44–ACCIDENT OR INJURY—to be filled out in all cases of deaths due to injury or poisoning.

- 38–Enter the exact month, day, and year of injury. Spell out the name of the month. **DO NOT** use a number for the month. (Remember, the date of injury may differ from the date of death.) Estimates may be provided with "Approx." placed before the date.
- 39–Enter the exact hour and minutes of injury or use your best estimate. Use a 24-hour clock.
- 40–Enter the general place (such as restaurant, vacant lot, or home) where the injury occurred. **DO NOT** enter firm or organization names. (For example, enter "factory," **not** "Standard Manufacturing, Inc.")
- 41–Complete if anything other than natural disease is mentioned in Part I or Part II of the medical certification, including homicides, suicides, and accidents. This includes all motor vehicle deaths. The item **must** be completed for decedents ages 14 years or over and may be completed for those less than 14 years of age if warranted. Enter "Yes" if the injury occurred at work. Otherwise enter "No." An injury may occur at work regardless of whether the injury occurred in the course of the decedent's "usual" occupation. Examples of injury at work and injury not at work follow:

Injury at work	**Injury not at work**
Injury while working or in vocational training on job premises	Injury while engaged in personal recreational activity on job premises
Injury while on break or at lunch or in parking lot on job premises	Injury while a visitor (not on official work business) to job premises
Injury while working for pay or compensation, including at home	Homemaker working at homemaking activities
Injury while working as a volunteer law enforcement official etc.	Student in school
Injury while traveling on business, including to/from business contacts	Working for self for no profit (mowing yard, repairing own roof, hobby)
	Commuting to or from work

- 42–Enter the complete address where the injury occurred including ZIP Code.
- 43–Enter a brief but specific and clear description of how the injury occurred. Explain the circumstances or cause of the injury. Specify **type of gun** or **type of vehicle** (e.g., car, bulldozer, train, etc.) when relevant to circumstances. Indicate if more than one vehicle involved; specify type of vehicle decedent was in.
- 44–Specify role of decedent (e.g. driver, passenger). Driver/operator and passenger should be designated for modes other than motor vehicles such as bicycles. Other applies to watercraft, aircraft, animal, or people attached to outside of vehicles (e.g. surfers).

Rationale: Motor vehicle accidents are a major cause of unintentional deaths; details will help determine effectiveness of current safety features and laws.

REFERENCES

For more information on how to complete the medical certification section of the death certificate, refer to tutorial at http://www.TheNAME.org and resources including instructions and handbooks available by request from NCHS, Room 7318, 3311 Toledo Road, Hyattsville, Maryland 20782 or at www.cdc.gov/nchs/about/major/dvs/handbk.htm.

Cause-of-death – Background, Examples, and Common Problems

Accurate cause of death information is important
- to the public health community in evaluating and improving the health of all citizens, and
- often to the family, now and in the future, and to the person setting the decedent's estate.

The cause-of-death section consists of two parts. Part I is for reporting a chain of events leading directly to death, with the immediate cause of death (the final disease, injury, or complication directly causing death) on line a and the underlying cause of death (the disease or injury that initiated the chain of events that led directly and inevitably to death) on the lowest used line. Part II is for reporting all other significant diseases, conditions, or injuries that contributed to death but which did not result in the underlying cause of death given in Part I. The cause-of-death information should be YOUR best medical OPINION. A condition can be listed as "probable" even if it has not been definitively diagnosed.

Examples of properly completed medical certifications

CAUSE OF DEATH (See instructions and examples)

32. PART I. Enter the chain of events—diseases, injuries, or complications—that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE. Enter only one cause on a line. Add additional lines if necessary.

		Approximate Interval: Onset to death
IMMEDIATE CAUSE (Final disease or condition ——> resulting in death)	a. Rupture of myocardium	Minutes
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to the cause listed on line a. Enter the UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST	b. Acute myocardial infarction	6 days
	Due to (or as a consequence of):	
	c. Coronary artery thrombosis	5 years
	Due to (or as a consequence of):	
	d. Atherosclerotic coronary artery disease	7 years

PART II. Enter other significant conditions contributing to death but not resulting in the underlying cause given in PART I

Diabetes, Chronic obstructive pulmonary disease, smoking

33. WAS AN AUTOPSY PERFORMED? ■ Yes □ No

34. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? ■ Yes □ No

35. DID TOBACCO USE CONTRIBUTE TO DEATH? ■ Yes □ Probably □ No □ Unknown

36. IF FEMALE: ■ Not pregnant within past year □ Pregnant at time of death □ Not pregnant, but pregnant within 42 days of death □ Not pregnant, but pregnant 43 days to 1 year before death □ Unknown if pregnant within the past year

37. MANNER OF DEATH: ■ Natural □ Homicide □ Accident □ Pending Investigation □ Suicide □ Could not be determined

CAUSE OF DEATH (See instructions and examples)

32. PART I. Enter the chain of events—diseases, injuries, or complications—that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE. Enter only one cause on a line. Add additional lines if necessary.

		Approximate Interval: Onset to death
IMMEDIATE CAUSE (Final disease or condition ——> resulting in death)	a. Aspiration pneumonia	2 Days
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to the cause listed on line a. Enter the UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST	b. Complications of coma	7 weeks
	Due to (or as a consequence of):	
	c. Blunt force injuries	7 weeks
	Due to (or as a consequence of):	
	d. Motor vehicle accident	7 weeks

PART II. Enter other significant conditions contributing to death but not resulting in the underlying cause given in PART I

33. WAS AN AUTOPSY PERFORMED? ■ Yes □ No

34. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? ■ Yes □ No

35. DID TOBACCO USE CONTRIBUTE TO DEATH? □ Yes □ Probably ■ No □ Unknown

36. IF FEMALE: □ Not pregnant within past year □ Pregnant at time of death □ Not pregnant, but pregnant within 42 days of death □ Not pregnant, but pregnant 43 days to 1 year before death □ Unknown if pregnant within the past year

37. MANNER OF DEATH: □ Natural □ Homicide ■ Accident □ Pending Investigation □ Suicide □ Could not be determined

38. DATE OF INJURY (Mo/Day/Yr) (Spell Month)	39. TIME OF INJURY	40. PLACE OF INJURY (e.g., Decedent's home; construction site; restaurant; wooded area)	41. INJURY AT WORK?
August 15, 2003	Approx. 2320	road side near state highway	□ Yes ■ No

42. LOCATION OF INJURY: State: Missouri — City or Town: near Alexandria — Street & Number: mile marker 17 on state route 55a — Apartment No.: — Zip Code:

43. DESCRIBE HOW INJURY OCCURRED:

Decedent driver of van, ran off road into tree

44. IF TRANSPORTATION INJURY, SPECIFY: ■ Driver/Operator □ Passenger □ Pedestrian □ Other (Specify)

Common problems in death certification

The elderly decedent should have a clear and distinct etiological sequence for cause of death, if possible. Terms such as senescence, infirmity, old age, and advanced age have little value for public health or medical research. Age is recorded elsewhere on the certificate. When a number of conditions existed in death, the physician should choose the single sequence that, in his or her opinion, best describes the process leading to death, and place any other pertinent conditions in Part II. If after careful consideration the physician cannot determine a sequence that ends in death, then the medical examiner or coroner should be consulted about conducting an investigation or providing assistance in completing the cause of death.

The infant decedent should have a clear and distinct etiological sequence for cause of death, if possible. "Prematurity" should not be entered without explaining the etiology of prematurity. Maternal conditions may have initiated or affected the sequence that resulted in infant death, and such maternal causes should be reported in addition to the infant causes on the infant's death certificate (e.g., Hyaline membrane disease due to prematurity, 28 weeks due to placental abruption due to blunt trauma to mother's abdomen).

When SIDS is suspected, a complete investigation should be conducted, typically by a medical examiner or coroner. If the infant is under 1 year of age, no cause of death is determined after scene investigation, clinical history is reviewed, and a complete autopsy is performed, then the death can be reported as Sudden Infant Death Syndrome.

When processes such as the following are reported, additional information about the etiology should be reported:

Abscess	Carcinomatosis	Disseminated intravascular coagulopathy	Hyponatremia	Pulmonary arrest
Abdominal hemorrhage	Cardiac arrest	Dysrhythmia	Hypotension	Pulmonary edema
Adhesions	Cardiac dysrhythmia	End-stage liver disease	Immunosuppression	Pulmonary embolism
Adult respiratory distress syndrome	Cardiomyopathy	End-stage renal disease	Increased intracranial pressure	Pulmonary insufficiency
Acute myocardial infarction	Cardiopulmonary arrest	Epidural hematoma	Intracranial hemorrhage	Renal failure
Altered mental status	Cellulitis	Exsanguination	Malnutrition	Respiratory arrest
Anemia	Cerebral edema	Failure to thrive	Metabolic encephalopathy	Seizures
Anoxia	Cerebrovascular accident	Fracture	Multi-organ failure	Sepsis
Anoxic encephalopathy	Cerebellar tonsillar herniation	Gangrene	Multi-system organ failure	Septic shock
Arrhythmia	Chronic bedridden state	Gastrointestinal hemorrhage	Myocardial infarction	Shock
Ascites	Cirrhosis	Heart failure	Necrotizing soft-tissue infection	Starvation
Aspiration	Coagulopathy	Hemothorax	Old age	Subdural hematoma
Atrial fibrillation	Compression fracture	Hepatic failure	Open (or closed) head injury	Subarachnoid hemorrhage
Bacteremia	Congestive heart failure	Hepatitis	Paralysis	Sudden death
Bedridden	Convulsions	Hepatorenal syndrome	Pancytopenia	Thrombocytopenia
Biliary obstruction	Decubiti	Hyperglycemia	Perforated gallbladder	Uncal herniation
Bowel obstruction	Dehydration	Hyperkalemia	Peritonitis	Urinary tract infection
Brain injury	Dementia (when not otherwise specified)	Hypovolemic shock	Pleural effusions	Ventricular fibrillation
Brain stem herniation	Diarrhea		Pneumonia	Ventricular tachycardia
Carcinogenesis				Volume depletion

If the certifier is unable to determine the etiology of a process such as those shown above, the process must be qualified as being of an unknown, undetermined, probable, presumed, or unspecified etiology so it is clear that a distinct etiology was not inadvertently or carelessly omitted.

The following conditions and types of death might seem to be specific or natural but when the medical history is examined further may be found to be complications of an injury or poisoning (possibly occurring long ago). Such cases should be reported to the medical examiner/coroner.

Asphyxia	Epidural hematoma	Hip fracture	Pulmonary emboli	Subdural hematoma
Ileus	Exsanguination	Hyperthermia	Seizure disorder	Surgery
Choking	Fall	Hypothermia	Sepsis	Thermal burns/chemical burns
Drug or alcohol overdose/drug or alcohol abuse	Fracture	Open reduction of fracture	Subarachnoid hemorrhage	

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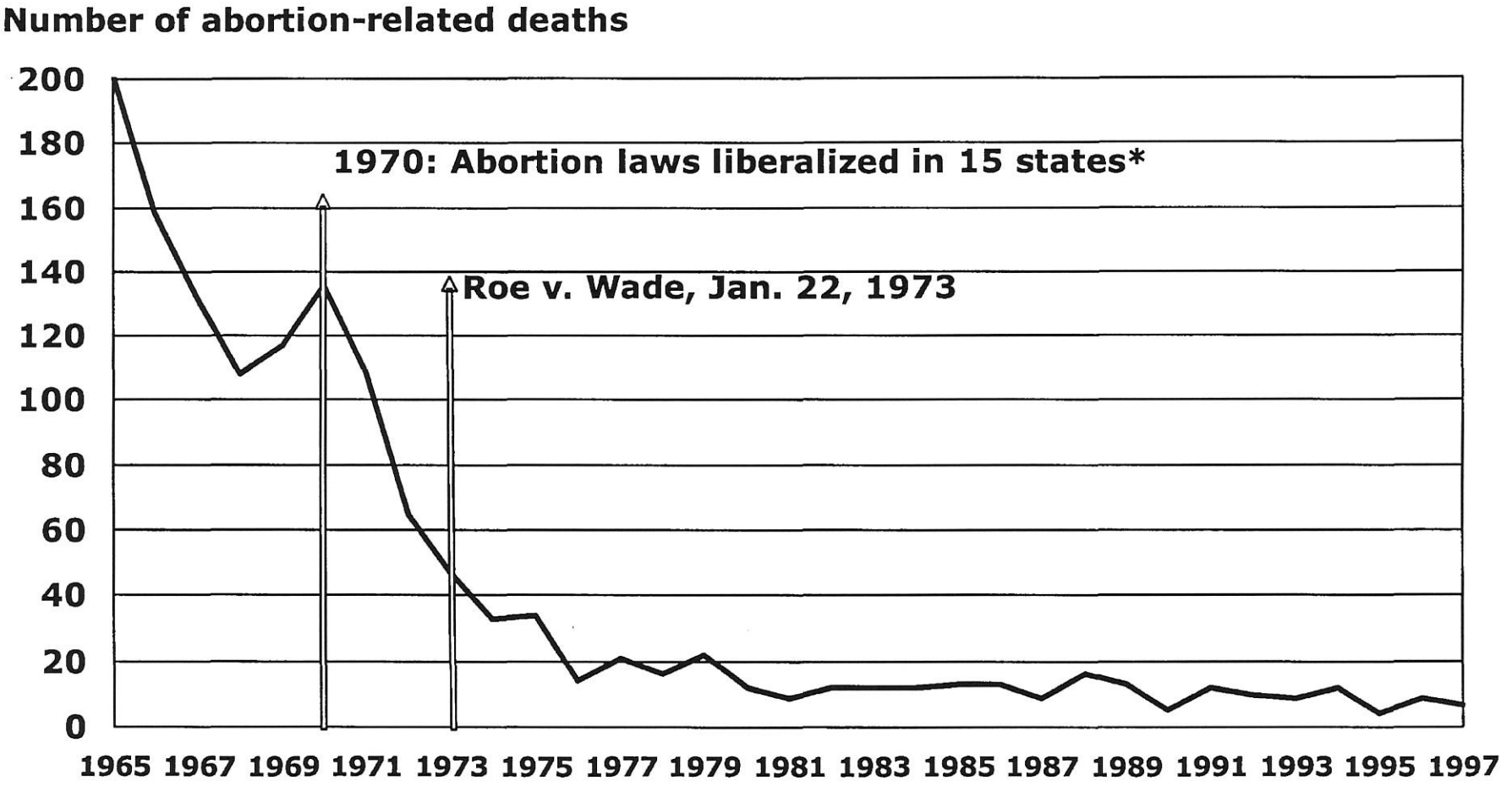
TABLE 19. Number of deaths and case-fatality rates* for abortion-related deaths reported to CDC, by type of abortion — United States, 1972–2000†

	Type of abortion				
	Induced				Case-fatality
Year	Legal	Illegal	Unknown§	Total	rate*
1972	24	39	2	65	4.1
1973	25	19	3	47	4.1
1974	26	6	1	33	3.4
1975	29	4	1	34	3.4
1976	11	2	1	14	1.1
1977	17	4	0	21	1.6
1978	9	7	0	16	0.8
1979	22	0	0	22	1.8
1980	9	1	2	12	0.7
1981	8	1	0	9	0.6
1982	11	1	0	12	0.8
1983	11	1	0	12	0.9
1984	12	0	0	12	0.9
1985	11	1	1	13	0.8
1986	11	0	2	13	0.8
1987	7	2	0	9	0.5
1988	16	0	0	16	1.2
1989	12	1	0	13	0.9
1990	9	0	0	9	0.6
1991	11	1	0	12	0.8
1992	10	0	0	10	0.7
1993	6	1	2	9	0.5
1994	10	2	0	12	0.8
1995	4	0	0	4	0.3
1996	9	0	0	9	0.7
1997	7	0	0	7	0.6
1998	10	0	0	10	—¶
1999	4	0	0	4	—¶
2000	11	0	0	11	—¶
Total	362	93	15	470	1.1**

* Legal induced abortion-related deaths per 100,000 reported legal induced abortions for the United States.
† Numbers might differ from those in previously published reports because additional information has been reported to CDC.
§ Unknown whether induced or spontaneous abortions.
¶ Case-fatality rates for 1998–2000 cannot be calculated because a substantial number of abortions occurred in nonreporting states, and the total number of abortions (the denominator) is unknown.
** Case-fatality rates computed for 1972–1997 only.

Return to top.

Deaths from abortion declined dramatically after legalization.



INPATIENT DATA SUMMARY BY DRG: 1995 - 2003												
		ICD-9 CODES FOR MISADVENTURES (see last page for key)										
		E870	E871	E872	E873	E874	E875	E876	E878	E879	TOTALS
DRG	DRG DESCRIPTION	FREQUENCIES										
1	CRANIOTOMY AGE >17 W CC	4						1	259	25	289
2	CRANIOTOMY AGE >17 W/O CC								16	5	21
3	CRANIOTOMY AGE 0-17	2				1		1	224	5	233
4	SPINAL PROCEDURES	3				1			126	12	142
5	EXTRACRANIAL VASCULAR PROCEDURES	4						2	88	23	117
6	CARPAL TUNNEL RELEASE								1		1
7	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W CC								49	6	55
8	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W/O CC								17	2	19
9	SPINAL DISORDERS & INJURIES	1							1		2
10	NERVOUS SYSTEM NEOPLASMS W CC							1	4	17	22
11	NERVOUS SYSTEM NEOPLASMS W/O CC									2	2
12	DEGENERATIVE NERVOUS SYSTEM DISORDERS								7	8	15
13	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA									7	7
14	INTRACRANIAL HEMORRHAGE & STROKE W INFARCT								23	33	56
15	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT	1							11	13	25
16	NONSPECIFIC CEREBROVASCULAR DISORDERS W CC								3	7	10
17	NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC									3	3
18	CRANIAL & PERIPHERAL NERVE DISORDERS W CC	1							11	10	22
19	CRANIAL & PERIPHERAL NERVE DISORDERS W/O CC								5	3	8
20	NERVOUS SYSTEM INFECTION EXCEPT VIRAL MENINGITIS								4	5	9
21	VIRAL MENINGITIS							1	2	5	8
23	NONTRAUMATIC STUPOR & COMA								2	6	8
24	SEIZURE & HEADACHE AGE >17 W CC				2			2	20	38	62
25	SEIZURE & HEADACHE AGE >17 W/O CC								7	42	49
26	SEIZURE & HEADACHE AGE 0-17								4	3	7
27	TRAUMATIC STUPOR & COMA, COMA >1 HR									1	1
28	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W CC								2	1	3
31	CONCUSSION AGE >17 W CC	1									1
34	OTHER DISORDERS OF NERVOUS SYSTEM W CC	3		1					64	17	85
35	OTHER DISORDERS OF NERVOUS SYSTEM W/O CC					1			58	5	64
37	ORBITAL PROCEDURES				1				5		6
39	LENS PROCEDURES WITH OR WITHOUT VITRECTOMY								1		1
40	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE >17								2		2
42	INTRAOCULAR PROCEDURES EXCEPT RETINA, IRIS & LENS								3		3
43	HYPHEMA								1		1
44	ACUTE MAJOR EYE INFECTIONS								1		1
46	OTHER DISORDERS OF THE EYE AGE >17 W CC									1	1
49	MAJOR HEAD & NECK PROCEDURES								18	7	25
50	SIALOADENECTOMY					1			9	1	11
52	CLEFT LIP & PALATE REPAIR								2	3	5
53	SINUS & MASTOID PROCEDURES AGE >17								31	2	33
54	SINUS & MASTOID PROCEDURES AGE 0-17								1		1
55	MISCELLANEOUS EAR, NOSE, MOUTH & THROAT PROCEDURES					1			12	3	16
56	RHINOPLASTY								2	1	3
57	T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17								4	1	5
59	TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17								2	2	4
60	TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0-17								3	1	4
61	MYRINGOTOMY W TUBE INSERTION AGE >17								1		1
62	MYRINGOTOMY W TUBE INSERTION AGE 0-17								6		6
63	OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES	2							10		12
64	EAR, NOSE, MOUTH & THROAT MALIGNANCY								8	9	17
65	DYSEQUILIBRIUM				1				1	1	3
68	OTITIS MEDIA & URI AGE >17 W CC								6	7	13
69	OTITIS MEDIA & URI AGE >17 W/O CC									1	1
70	OTITIS MEDIA & URI AGE 0-17								2		2
73	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE >17								3	7	10
74	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE 0-17								1		1
75	MAJOR CHEST PROCEDURES	12	1			1		1	178	44	237
76	OTHER RESP SYSTEM O.R. PROCEDURES W CC	2						4	49	33	88
77	OTHER RESP SYSTEM O.R. PROCEDURES W/O CC								7	1	8
78	PULMONARY EMBOLISM								41	9	50
79	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W CC	1						2	37	52	92
80	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W/O CC								1	4	5
81	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE 0-17								2	3	5
82	RESPIRATORY NEOPLASMS				1			1	11	73	86
83	MAJOR CHEST TRAUMA W CC									2	2
85	PLEURAL EFFUSION W CC								13	13	26
86	PLEURAL EFFUSION W/O CC									1	1
87	PULMONARY EDEMA & RESPIRATORY FAILURE								6	16	22

INPATIENT DATA SUMMARY BY DRG: 1995 - 2003											
		ICD-9 CODES FOR MISADVENTURES (see last page for key)									
		E870	E871	E872	E873	E874	E875	E876	E878	E879	TOTALS
DRG	DRG DESCRIPTION	FREQUENCIES									
88	CHRONIC OBSTRUCTIVE PULMONARY DISEASE								10	41	51
89	SIMPLE PNEUMONIA & PLEURISY AGE >17 W CC	1	1					3	52	94	151
90	SIMPLE PNEUMONIA & PLEURISY AGE >17 W/O CC									2	2
91	SIMPLE PNEUMONIA & PLEURISY AGE 0-17	2							4	2	8
92	INTERSTITIAL LUNG DISEASE W CC								1	10	11
94	PNEUMOTHORAX W CC	4						4	21	63	92
95	PNEUMOTHORAX W/O CC								2	7	9
96	BRONCHITIS & ASTHMA AGE >17 W CC								4	9	13
97	BRONCHITIS & ASTHMA AGE >17 W/O CC								1	1	2
98	BRONCHITIS & ASTHMA AGE 0-17								3	4	7
99	RESPIRATORY SIGNS & SYMPTOMS W CC								14	4	18
100	RESPIRATORY SIGNS & SYMPTOMS W/O CC								2	3	5
101	OTHER RESPIRATORY SYSTEM DIAGNOSES W CC	2	1			1			107	58	169
102	OTHER RESPIRATORY SYSTEM DIAGNOSES W/O CC							1	21	4	26
103	HEART TRANSPLANT								9	1	10
104	CARDIAC VALVE & OTH MAJOR CARDIOTHORACIC PROC W CARD CATH	2							76	15	93
105	CARDIAC VALVE & OTH MAJOR CARDIOTHORACIC PROC W/O CARD CATH	1						2	144	10	157
106	CORONARY BYPASS W PTCA	5	1			1		2	70	20	99
107	CORONARY BYPASS W CARDIAC CATH	4						2	275	37	318
108	OTHER CARDIOTHORACIC PROCEDURES	5	1						87	6	99
109	CORONARY BYPASS W/O PTCA OR CARDIAC CATH	3	1					1	202	26	233
110	MAJOR CARDIOVASCULAR PROCEDURES W CC	14						3	214	71	302
111	MAJOR CARDIOVASCULAR PROCEDURES W/O CC								16	5	21
112	NO LONGER VALID	6						1	42	125	174
113	AMPUTATION FOR CIRC SYSTEM DISORDERS EXCEPT UPPER LIMB & TOE	1							68	5	74
114	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS								12	2	14
115	PRM CARD PACEM IMPL W AMI,HRT FAIL OR SHK,OR AICD LEAD OR GN	2							23	4	29
116	OTHER PERMANENT CARDIAC PACEMAKER IMPLANT	8				1		4	173	238	424
117	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT								50	12	62
118	CARDIAC PACEMAKER DEVICE REPLACEMENT								35	11	46
119	VEIN LIGATION & STRIPPING								5	1	6
120	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	1						2	244	40	287
121	CIRCULATORY DISORDERS W AMI & MAJOR COMP, DISCHARGED ALIVE	1						1	17	34	53
122	CIRCULATORY DISORDERS W AMI W/O MAJOR COMP, DISCHARGED ALIVE							1	11	9	21
123	CIRCULATORY DISORDERS W AMI, EXPIRED								4	7	11
124	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH & COMPLEX DIAG	1	1						27	53	82
125	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O COMPLEX DIAG	1						2	28	66	97
126	ACUTE & SUBACUTE ENDOCARDITIS								3	1	4
127	HEART FAILURE & SHOCK	2	1					2	64	60	129
128	DEEP VEIN THROMBOPHLEBITIS								5	4	9
130	PERIPHERAL VASCULAR DISORDERS W CC							1	121	68	190
131	PERIPHERAL VASCULAR DISORDERS W/O CC								5	4	9
132	ATHEROSCLEROSIS W CC	1							12	14	27
133	ATHEROSCLEROSIS W/O CC									1	1
134	HYPERTENSION								10		10
135	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W CC	1							7	2	10
137	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE 0-17								2	1	3
138	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W CC	1			2			1	48	44	96
139	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC								11	7	18
140	ANGINA PECTORIS								3	2	5
141	SYNCOPE & COLLAPSE W CC							1	8	17	26
142	SYNCOPE & COLLAPSE W/O CC							1	1	2	4
143	CHEST PAIN	1	1					1	9	20	32
144	OTHER CIRCULATORY SYSTEM DIAGNOSES W CC	3				1			624	399	1027
145	OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC							1	66	19	86
146	RECTAL RESECTION W CC	8							54	14	76
147	RECTAL RESECTION W/O CC									1	1
148	MAJOR SMALL & LARGE BOWEL PROCEDURES W CC	200	2		2			5	798	126	1133
149	MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC								12	15	27
150	PERITONEAL ADHESIOLYSIS W CC	7						1	169	21	198
151	PERITONEAL ADHESIOLYSIS W/O CC	1						1	11		13
152	MINOR SMALL & LARGE BOWEL PROCEDURES W CC								43	1	44
153	MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC								4		4
154	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W CC	43	3			1		2	197	24	270
155	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W/O CC							1	18	3	22
156	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE 0-17	2							15		17
157	ANAL & STOMAL PROCEDURES W CC	1							34	5	40
158	ANAL & STOMAL PROCEDURES W/O CC								7	3	10
159	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W CC	2							148	12	162

INPATIENT DATA SUMMARY BY DRG: 1995 - 2003											
		ICD-9 CODES FOR MISADVENTURES (see last page for key)									
		E870	E871	E872	E873	E874	E875	E876	E878	E879	TOTALS
DRG	DRG DESCRIPTION	FREQUENCIES									
160	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W/O CC								9		9
161	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W CC	4							34	5	43
162	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W/O CC								1		1
163	HERNIA PROCEDURES AGE 0-17	1							4	1	6
164	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W CC	2						1	129	10	142
165	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC								1	1	2
166	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W CC	6						2	138	3	149
167	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC								8		8
168	MOUTH PROCEDURES W CC	1							6	2	9
169	MOUTH PROCEDURES W/O CC									4	4
170	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W CC	3						1	68	13	85
171	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC								13	2	15
172	DIGESTIVE MALIGNANCY W CC	5							10	15	30
173	DIGESTIVE MALIGNANCY W/O CC									1	1
174	G.I. HEMORRHAGE W CC	6				1		3	29	58	97
175	G.I. HEMORRHAGE W/O CC	1						1	1	6	9
176	COMPLICATED PEPTIC ULCER								2	7	9
179	INFLAMMATORY BOWEL DISEASE	2							4	8	14
180	G.I. OBSTRUCTION W CC	2			1			1	20	47	71
181	G.I. OBSTRUCTION W/O CC	2							2	6	10
182	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W CC	2			1			2	98	195	298
183	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W/O CC								32	11	43
184	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE 0-17							1	11	3	15
185	DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE >17				1					27	28
187	DENTAL EXTRACTIONS & RESTORATIONS		1						1		2
188	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W CC	3			1			3	417	189	613
189	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W/O CC								91	22	113
190	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 0-17								31	9	40
191	PANCREAS, LIVER & SHUNT PROCEDURES W CC	6							92	13	111
193	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W CC	24						1	37	2	64
195	CHOLECYSTECTOMY W C.D.E. W CC	8	1						27	3	39
196	CHOLECYSTECTOMY W C.D.E. W/O CC									1	1
197	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W CC	26						1	73	6	106
198	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W/O CC								2		2
199	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR MALIGNANCY								2	1	3
200	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR NON-MALIGNANCY	1							9		10
201	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES								4	4	8
202	CIRRHOSIS & ALCOHOLIC HEPATITIS	1							1	4	6
203	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS	1						1	8	12	22
204	DISORDERS OF PANCREAS EXCEPT MALIGNANCY	2							29	24	55
205	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W CC	1							76	13	90
206	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W/O CC								35	1	36
207	DISORDERS OF THE BILIARY TRACT W CC	2							31	15	48
208	DISORDERS OF THE BILIARY TRACT W/O CC	1							1	1	3
209	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF LOWER EXTREMITY	12	4			4		14	1498	78	1610
210	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W CC	3				1		3	216	23	246
211	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W/O CC								35	4	39
212	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 0-17	1	1						14	2	18
213	AMPUTATION FOR MUSCULOSKELETAL SYSTEM & CONN TISSUE DISORDERS								127	2	129
214	NO LONGER VALID	23						1	87	2	113
215	NO LONGER VALID								28		28
216	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE		1						10	4	15
217	WND DEBRID & SKN GRFT EXCEPT HAND,FOR MUSCSKELET & CONN TISS DIS								321	23	344
218	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE >17 W CC	2				1			86	8	97
219	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE >17 W/O CC	1							39	2	42
220	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE 0-17								18		18
221	NO LONGER VALID								12		12
222	NO LONGER VALID							1	4	1	6
223	MAJOR SHOULDER/ELBOW PROC, OR OTHER UPPER EXTREMITY PROC W CC								21	3	24
224	SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC, W/O CC								9		9
225	FOOT PROCEDURES								16		16
226	SOFT TISSUE PROCEDURES W CC	1							13	3	17
227	SOFT TISSUE PROCEDURES W/O CC								8		8
228	MAJOR THUMB OR JOINT PROC,OR OTH HAND OR WRIST PROC W CC							1	5		6
230	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES OF HIP & FEMUR	1							47	1	49
231	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES EXCEPT HIP & FEMUR	1						1	263	17	282
233	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W CC								25	6	31
234	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC								19	3	22
235	FRACTURES OF FEMUR								2	1	3

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		ICD-9 CODES FOR MISADVENTURES (see last page for key)									
		E870	E871	E872	E873	E874	E875	E876	E878	E879	TOTALS
DRG	DRG DESCRIPTION	FREQUENCIES									
236	FRACTURES OF HIP & PELVIS								7	3	10
238	OSTEOMYELITIS								10	4	14
239	PATHOLOGICAL FRACTURES & MUSCULOSKELETAL & CONN TISS MALIGNANCY								12	25	37
240	CONNECTIVE TISSUE DISORDERS W CC								5	1	6
241	CONNECTIVE TISSUE DISORDERS W/O CC									1	1
242	SEPTIC ARTHRITIS								3	1	4
243	MEDICAL BACK PROBLEMS	2							31	23	56
244	BONE DISEASES & SPECIFIC ARTHROPATHIES W CC								8	5	13
245	BONE DISEASES & SPECIFIC ARTHROPATHIES W/O CC									3	3
247	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE								15	3	18
248	TENDONITIS, MYOSITIS & BURSITIS		1					1	2	1	5
249	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE							1	246	7	254
251	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W/O CC								1		1
253	FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE >17 W CC								1		1
255	FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE 0-17									1	1
256	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES					1			40	3	44
257	TOTAL MASTECTOMY FOR MALIGNANCY W CC								69	6	75
258	TOTAL MASTECTOMY FOR MALIGNANCY W/O CC								1		1
259	SUBTOTAL MASTECTOMY FOR MALIGNANCY W CC							1	5	1	7
261	BREAST PROC FOR NON-MALIGNANCY EXCEPT BIOPSY & LOCAL EXCISION							1	34	2	37
262	BREAST BIOPSY & LOCAL EXCISION FOR NON-MALIGNANCY								3		3
263	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W CC								50	22	72
264	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W/O CC								1	5	6
265	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W CC								32	4	36
266	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W/O CC								3	5	8
267	PERIANAL & PILONIDAL PROCEDURES									1	1
268	SKIN, SUBCUTANEOUS TISSUE & BREAST PLASTIC PROCEDURES								13	3	16
269	OTHER SKIN, SUBCUT TISS & BREAST PROC W CC	1						1	21	12	35
270	OTHER SKIN, SUBCUT TISS & BREAST PROC W/O CC								1		1
271	SKIN ULCERS								5	7	12
272	MAJOR SKIN DISORDERS W CC							1	2		3
274	MALIGNANT BREAST DISORDERS W CC									3	3
276	NON-MALIGANT BREAST DISORDERS									3	3
277	CELLULITIS AGE >17 W CC	2						1	36	26	65
278	CELLULITIS AGE >17 W/O CC	1							4	6	11
279	CELLULITIS AGE 0-17								4	4	8
280	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W CC							2	2		4
281	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W/O CC									1	1
282	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE 0-17								1		1
283	MINOR SKIN DISORDERS W CC								4	8	12
284	MINOR SKIN DISORDERS W/O CC				2				1		3
285	AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DISORDERS								5	1	6
286	ADRENAL & PITUITARY PROCEDURES	3							11		14
287	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DISORDERS								10	4	14
288	O.R. PROCEDURES FOR OBESITY	2							24	1	27
289	PARATHYROID PROCEDURES								6		6
290	THYROID PROCEDURES								19	4	23
292	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W CC	1						1	13	4	19
294	DIABETES AGE >35				1				8	6	15
295	DIABETES AGE 0-35								5	4	9
296	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W CC	1	1		1			1	50	122	176
297	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W/O CC				1				2	3	6
298	NUTRITIONAL & MISC METABOLIC DISORDERS AGE 0-17	1							15	10	26
299	INBORN ERRORS OF METABOLISM				1				1	5	7
300	ENDOCRINE DISORDERS W CC							1	2	5	8
301	ENDOCRINE DISORDERS W/O CC								2	3	5
302	KIDNEY TRANSPLANT								58	5	63
303	KIDNEY,URETER & MAJOR BLADDER PROCEDURES FOR NEOPLASM	18	1						118	10	147
304	KIDNEY,URETER & MAJOR BLADDER PROC FOR NON-NEOPL W CC	17	2					1	183	26	229
305	KIDNEY,URETER & MAJOR BLADDER PROC FOR NON-NEOPL W/O CC								35	2	37
306	PROSTATECTOMY W CC								20	6	26
307	PROSTATECTOMY W/O CC									1	1
308	MINOR BLADDER PROCEDURES W CC	11							53	22	86
309	MINOR BLADDER PROCEDURES W/O CC								34	2	36
310	TRANSURETHRAL PROCEDURES W CC	6	1						30	48	85
311	TRANSURETHRAL PROCEDURES W/O CC									2	2
312	URETHRAL PROCEDURES, AGE >17 W CC	1						1	12	1	15
313	URETHRAL PROCEDURES, AGE >17 W/O CC								20	2	22
315	OTHER KIDNEY & URINARY TRACT O.R. PROCEDURES	4						1	160	28	193

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		ICD-9 CODES FOR MISADVENTURES (see last page for key)									
		E870	E871	E872	E873	E874	E875	E876	E878	E879	TOTALS
DRG	DRG DESCRIPTION	FREQUENCIES									
316	RENAL FAILURE	1						1	35	19	56
317	ADMIT FOR RENAL DIALYSIS									1	1
318	KIDNEY & URINARY TRACT NEOPLASMS W CC								3	2	5
320	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W CC	1						1	31	37	70
321	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W/O CC									1	1
322	KIDNEY & URINARY TRACT INFECTIONS AGE 0-17								2	1	3
323	URINARY STONES W CC, &/OR ESW LITHOTRIPSY	2	2					1	14	15	34
324	URINARY STONES W/O CC								1	2	3
325	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W CC	1							6	7	14
326	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W/O CC								3	2	5
328	URETHRAL STRICTURE AGE >17 W CC									3	3
331	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W CC	4			1			2	222	181	410
332	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W/O CC								61	11	72
333	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE 0-17	1						2	37	2	42
334	MAJOR MALE PELVIC PROCEDURES W CC	12						1	89	9	111
335	MAJOR MALE PELVIC PROCEDURES W/O CC								1	1	2
336	TRANSURETHRAL PROSTATECTOMY W CC	7							81	14	102
337	TRANSURETHRAL PROSTATECTOMY W/O CC								1	3	4
338	TESTES PROCEDURES, FOR MALIGNANCY								6	2	8
339	TESTES PROCEDURES, NON-MALIGNANCY AGE >17								4		4
341	PENIS PROCEDURES	1							10	1	12
342	CIRCUMCISION AGE >17								1		1
344	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES FOR MALIGNANCY	1							6		7
345	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXCEPT FOR MALIGNANCY								2	3	5
346	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W CC									1	1
348	BENIGN PROSTATIC HYPERTROPHY W CC								1	3	4
350	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM				1						1
352	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES								2		2
353	PELVIC EVISCERATION, RADICAL HYSTERECTOMY & RADICAL VULVECTOMY	1							16	2	19
354	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W CC	11							91	3	105
355	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC								1	1	2
356	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES	18							72	6	96
357	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY	10							36	2	48
358	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC	214	3					5	689	31	942
359	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC	3							14	2	19
360	VAGINA, CERVIX & VULVA PROCEDURES	14						2	44	13	73
361	LAPAROSCOPY & INCISIONAL TUBAL INTERRUPTION	8							3		11
362	ENDOSCOPIC TUBAL INTERRUPTION								2		2
363	D&C, CONIZATION & RADIO-IMPLANT, FOR MALIGNANCY	1							4	3	8
364	D&C, CONIZATION EXCEPT FOR MALIGNANCY								1		1
365	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES	9						1	23	4	37
366	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W CC								4	4	8
368	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM								5	3	8
369	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS	1							4	4	9
370	CESAREAN SECTION W CC	30	4					1	82	15	132
371	CESAREAN SECTION W/O CC	4						1	13	11	29
372	VAGINAL DELIVERY W COMPLICATING DIAGNOSES	1						1	1	14	17
373	VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	2							5	23	30
374	VAGINAL DELIVERY W STERILIZATION &/OR D&C	7						1	6	2	16
375	VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C								3		3
376	POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE								14	3	17
377	POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE	9	1						12	3	25
378	ECTOPIC PREGNANCY	1							14	1	16
379	THREATENED ABORTION									1	1
381	ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	1							5	1	7
383	OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS	1						1	13	10	25
384	OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS	1						1	2	1	5
385	NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	1						1	3	2	7
386	EXTREME IMMATURITY				1				3	7	11
387	PREMATURITY W MAJOR PROBLEMS	1			1				3	3	8
389	FULL TERM NEONATE W MAJOR PROBLEMS	7	1					1	16	16	41
390	NEONATE W OTHER SIGNIFICANT PROBLEMS	7				1		2	3	13	26
391	NORMAL NEWBORN									6	6
392	SPLENECTOMY AGE >17	2							12	2	16
393	SPLENECTOMY AGE 0-17								1	1	2
394	OTHER O.R. PROCEDURES OF THE BLOOD AND BLOOD FORMING ORGANS	1							6		7
395	RED BLOOD CELL DISORDERS AGE >17	1			1				17	45	64
396	RED BLOOD CELL DISORDERS AGE 0-17								9	4	13
397	COAGULATION DISORDERS					1	1		6	13	21

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		E870	E871	E872	E873	E874	E875	E876	E878	E879	TOTALS
DRG	DRG DESCRIPTION	FREQUENCIES									
398	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W CC	1						1	50	34	86
399	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC								2	2	4
400	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE	3							23	7	33
401	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W CC	1							17	2	20
403	LYMPHOMA & NON-ACUTE LEUKEMIA W CC								28	40	68
404	LYMPHOMA & NON-ACUTE LEUKEMIA W/O CC								1	2	3
405	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE 0-17								11	7	18
406	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W CC	3							23	4	30
407	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W/O CC	1								1	2
408	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R.PROC	2							9	8	19
409	RADIOTHERAPY									6	6
410	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS	1				1		2	43	21	68
413	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W CC	1							3	5	9
415	O.R. PROCEDURE FOR INFECTIOUS & PARASITIC DISEASES	12						6	751	70	839
416	SEPTICEMIA AGE >17	1						2	89	84	176
417	SEPTICEMIA AGE 0-17								3	2	5
418	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS					1		2	1028	91	1122
419	FEVER OF UNKNOWN ORIGIN AGE >17 W CC								4	9	13
420	FEVER OF UNKNOWN ORIGIN AGE >17 W/O CC									1	1
421	VIRAL ILLNESS AGE >17								7	3	10
422	VIRAL ILLNESS & FEVER OF UNKNOWN ORIGIN AGE 0-17					1			3	1	5
423	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES								12	34	46
424	O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS								5	2	7
425	ACUTE ADJUSTMENT REACTION & PSYCHOSOCIAL DYSFUNCTION								3	6	9
426	DEPRESSIVE NEUROSES	1							1	2	4
427	NEUROSES EXCEPT DEPRESSIVE									1	1
428	DISORDERS OF PERSONALITY & IMPULSE CONTROL									2	2
429	ORGANIC DISTURBANCES & MENTAL RETARDATION								7	3	10
430	PSYCHOSES							2	10	20	32
439	SKIN GRAFTS FOR INJURIES							1	62	6	69
440	WOUND DEBRIDEMENTS FOR INJURIES	1						1	264	15	281
441	HAND PROCEDURES FOR INJURIES								4		4
442	OTHER O.R. PROCEDURES FOR INJURIES W CC	101	6					6	391	79	583
443	OTHER O.R. PROCEDURES FOR INJURIES W/O CC	26	5					1	292	29	353
444	TRAUMATIC INJURY AGE >17 W CC							1	2	2	5
445	TRAUMATIC INJURY AGE >17 W/O CC									1	1
446	TRAUMATIC INJURY AGE 0-17									1	1
447	ALLERGIC REACTIONS AGE >17	1							1	2	4
448	ALLERGIC REACTIONS AGE 0-17									4	4
449	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W CC								5	4	9
452	COMPLICATIONS OF TREATMENT W CC	37	3			2		6	551	216	815
453	COMPLICATIONS OF TREATMENT W/O CC	12	1					1	276	87	377
454	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W CC									9	9
455	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W/O CC							2		2	4
456	NO LONGER VALID								1		1
458	NO LONGER VALID								2		2
460	NO LONGER VALID							1		1	2
461	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES	1							37	4	42
462	REHABILITATION		1					2	315	59	377
463	SIGNS & SYMPTOMS W CC								8	3	11
464	SIGNS & SYMPTOMS W/O CC								2		2
465	AFTERCARE W HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS								2	1	3
466	AFTERCARE W/O HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS	1							29	7	37
467	OTHER FACTORS INFLUENCING HEALTH STATUS								4	2	6
468	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	19	2					3	373	80	477
470	UNGROUPABLE								2		2
471	BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY		1						34	2	37
472	NO LONGER VALID									1	1
473	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE >17								16	7	23
475	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT	1						1	22	42	66
476	PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	2							10	11	23
477	NON-EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	3	1					2	194	38	238
478	OTHER VASCULAR PROCEDURES W CC	14	1					1	633	126	775
479	OTHER VASCULAR PROCEDURES W/O CC								105	13	118
480	LIVER TRANSPLANT							1	59	4	64
481	BONE MARROW TRANSPLANT								25	14	39
482	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES	1							110	22	133
483	TRAC W MECH VENT 96+HRS OR PDX EXCEPT FACE,MOUTH & NECK DX OSES	10			2			1	105	41	159
484	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA								1	1	2

INPATIENT DATA SUMMARY BY DRG: 1995 - 2003											
		ICD-9 CODES FOR MISADVENTURES (see last page for key)									
		E870	E871	E872	E873	E874	E875	E876	E878	E879	TOTALS
DRG	DRG DESCRIPTION	FREQUENCIES									
485	LIMB REATTACHMENT, HIP AND FEMUR PROC FOR MULTIPLE SIGNIFICANT TRA								8	2	10
486	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA		1		1				22	3	27
487	OTHER MULTIPLE SIGNIFICANT TRAUMA	1							1	1	3
488	HIV W EXTENSIVE O.R. PROCEDURE								4	2	6
489	HIV W MAJOR RELATED CONDITION								5	4	9
490	HIV W OR W/O OTHER RELATED CONDITION								4		4
491	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF UPPER EXTREMITY	2							21	2	25
492	CHEMOTHERAPY W ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS								13	14	27
493	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC	17						1	216	20	254
494	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC								10	2	12
495	LUNG TRANSPLANT	1							12	2	15
496	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION	1							35		36
497	SPINAL FUSION EXCEPT CERVICAL W CC	52	1	1		1		1	205	12	273
498	SPINAL FUSION EXCEPT CERVICAL W/O CC							1	88	1	90
499	BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W CC	95						2	125	17	239
500	BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W/O CC								22	1	23
501	KNEE PROCEDURES W PDX OF INFECTION W CC								31	1	32
502	KNEE PROCEDURES W PDX OF INFECTION W/O CC								19	2	21
503	KNEE PROCEDURES W/O PDX OF INFECTION	1							48	1	50
504	EXTENSIVE 3RD DEGREE BURNS W SKIN GRAFT								3		3
506	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W CC OR SIG TRAUMA								3	1	4
508	FULL THICKNESS BURN W/O SKIN GRFT OR INHAL INJ W CC OR SIG TRAUMA								1	1	2
510	NON-EXTENSIVE BURNS W CC OR SIGNIFICANT TRAUMA								1	1	2
512	SIMULTANEOUS PANCREAS/KIDNEY TRANSPLANT				1						1
513	PANCREAS TRANSPLANT								1		1
514	CARDIAC DEFIBRILLATOR IMPLANT W CARDIAC CATH	1							13	5	19
515	CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH	1							6	4	11
516	PERCUTANEOUS CARDIOVASC PROC W AMI							1	20	58	79
517	PERC CARDIO PROC W NON-DRUG ELUTING STENT W/O AMI	6							68	132	206
518	PERC CARDIO PROC W/O CORONARY ARTERY STENT OR AMI	3							45	30	78
519	CERVICAL SPINAL FUSION W CC	2							9	3	14
520	CERVICAL SPINAL FUSION W/O CC								7		7
521	ALCOHOL/DRUG ABUSE OR DEPENDENCE W CC								1	1	2
524	TRANSIENT ISCHEMIA									3	3
525	HEART ASSIST SYSTEM IMPLANT								4		4
526	PERCUTNEOUS CARDIOVASULAR PROC W DRUG ELUTING STENT W AMI	1						1		2	4
527	PERCUTNEOUS CARDIOVASULAR PROC W DRUG ELUTING STENT W/O AMI								5	14	19
529	VENTRICULAR SHUNT PROCEDURES W CC.								2		2
531	SPINAL PROCEDURES W CC								3		3
532	SPINAL PROCEDURES W/O CC								1		1
533	EXTRACRANIAL PROCEDURES W CC								1		1
536	CARDIAC DEFIB IMPLANT W CARDIAC CATH W/O AMI/HF/SHOCK.								1		1
537	LOCAL EXCIS & REMOV OF INT FIX DEV EXCEPT HIP & FEMUR W CC.								7	1	8
538	LOCAL EXCIS & REMOV OF INT FIX DEV EXCEPT HIP & FEMUR W/O CC.								6	1	7
539	LYMPHOMA & LEUKEMIA W MAJOR OR PROCEDURE W CC.								1		1
TOTALS		1442	62	2	28	27	1	196	21195	6393	29346

ICD-9 CODE	DESCRIPTION
E8700	ACCIDENTAL CUT, PUNCTURE, PERFORATION, OR HEMORRHAGE DURING MED CARE
E8710	FOREIGN OBJECT LEFT IN BODY DURING PROCEDURE
E8720	FAILURE OF STERILE PRECAUTIONS DURING PROCEDURE
E8730	FAILURE IN DOSAGE
E8740	MECHANICAL FAILURE OF INSTRUMENT OR APPARATUS DURING PROCEDURE
E8750	CONTAMINATED OR INFECTED BLOOD, OTHER FLUID, DRUG, OR BIOLOGICAL SUBSTANCE
E8760	OTHER AND UNSPECIFIED MISADVENTURE DURING MED CARE
E8780	SURG OP AND OTHER SURG PROC AS CAUSE OF ABNORMAL REACTION OF PATIENT, OR LATER COMP, WO MENTION OF MISAD AT TIME OF OP
E8790	OTHER PROC, WO MENT OF MISAD AT TIME OF PROC, AS CAUSE OF ABNORMAL REACTION OF PATIENT, OR OF LATER COMP.