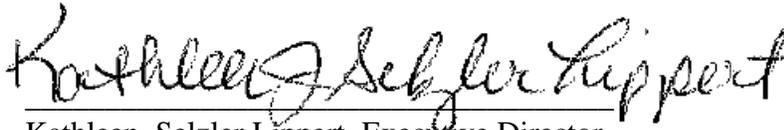


**Kansas State Board of Healing Arts
Index of Guidance Documents**

The Kansas State Board of Healing Arts hereby designates the following as “guidance Documents” as defined by K.S.A. 77-438(a)(2).

Pursuant to K.S.A. 77-438(d), I hereby certify that the Guidance Document Index has been filed with the Secretary of State. I further certify that the Guidance Document Index and all included guidance documents are available to the public via the Kansas State Board of Healing Arts’ website: www.ksbha.org



Kathleen, Selzler Lippert, Executive Director
Kansas State Board of Healing Arts

KSBHA GUIDANCE DOCUMENT INDEX

<u>POLICY NO.</u>	<u>DESCRIPTION</u>	<u>YEAR ISSUED OR LAST REVISED</u>
15-03	Scheduling of Conference Hearings	2015
15-01	Standard for Evaluations of Applicants and Licensees Regulated by the Healing Arts Act, Podiatry Act and/or Physician Assistant Licensure Act	2014
14-01	Standard Care for School Physicals	2014
13-01	Use of Ultrasound and Lasers for Fat Reduction	2013
11-03	Board Member Conflict of Interest Policy	2011
04-01	Guidelines for Imposing Discipline Relating to Practice on a Cancelled License	2011
11-02	Process for Handling Complaints Alleging a Violation of the Healing Arts Act or Podiatry Act Involving Members and Former Members of the Board of Healing Arts	2011
11-01	Delinquent Fines and/or Costs Policy	2011
97-01	Federation Credentials Verification Services (FCVS)	2011
10-03	Use of Propofol (Diprivan) in Office Based Surgery	2010
10-02	Petition for Reconsideration – Delegated Authority	2010
10-01	10 Year USMLE Completion Rule	2010
08-03	Guidelines for Imposing Discipline for Failure to Respond to a Continuing Education and Licensure Audit Request	2009
09-02	Labeling and Storage of Pre-Drawn Syringes	2009
08-05	Interpretation and Enforcement of K.A.R. 100-73-9 involving the performance of radiologic technology procedures.	2008
08-04	Interpretation and Enforcement of K.S.A. 65-2387(b)(32) as Amended by Senate Bill No. 285 Involving Anatomic Pathology Services	2008
05-05	Victims of Natural Disaster	2008
	Guidelines for the Imposition of Disciplinary Sanctions	2008

	Policy Statement Regarding Experimental Treatments	2008
08-02	Cancellation of Licenses by Request	2008
08-01	Hearing Officer Panel	2008
05-04	Guidelines for Imposing Penalties for Deficient Continuing Education Units	2007
06-04	Pain Patient's Quality of Care Act	2006
06-02	Continuing Education Credit	2006
06-01	Refund of Fees	2006
05-06	Election of Officer	2005
05-03	Continuing Education Credit	2005
05-02	Use of Marijuana	2005
05-01	Payment of Subpoenaed From Non-Party Organizations	2005
	Naturopathic Issues	2003
03-01	Performance of Manipulation by Doctors of Naturopathy	2003
	Guidelines for Opioid Addiction Treatment in the Medical Office	2002
	Nursing and Pharmacy on Use of Controlled Substances for the Treatment of Pain	2002
02-01	Guidelines for Office-Based Surgery and Special Procedures	2002
	<ul style="list-style-type: none"> • Essentials for Office-Based Anesthesia 	2002
	<ul style="list-style-type: none"> <ul style="list-style-type: none"> ○ Appendix A Definitions 	2002
	<ul style="list-style-type: none"> <ul style="list-style-type: none"> ○ Appendix B Accrediting Organizations for Office-Based Surgery 	2002
	<ul style="list-style-type: none"> • KMS Office-Based Surgery Task Force 	2002
	<ul style="list-style-type: none"> • Report of the Special Committee on Outpatient (Office-Based) Surgery 	2002
	Supplemental Open Records Policy	2002
	<ul style="list-style-type: none"> ○ Appendix II Records Deemed Confidential 	2002
	<ul style="list-style-type: none"> • Amendment to Open Records Policy 	2002
	<ul style="list-style-type: none"> • Open Records Policy 	2002
	<ul style="list-style-type: none"> <ul style="list-style-type: none"> ○ Requesting Information 	2002
	<ul style="list-style-type: none"> <ul style="list-style-type: none"> ○ Fees 	2002
	<ul style="list-style-type: none"> <ul style="list-style-type: none"> ○ Restrictions on Access 	2002
	<ul style="list-style-type: none"> <ul style="list-style-type: none"> ○ Appendix I 	2002
	<ul style="list-style-type: none"> <ul style="list-style-type: none"> ○ Appendix III 	2002
00-03	Review of Initial Orders	2000
00-02	Designation of Local Freedom of Information Officer	2000
	Candidate Review of Test Performance	2000
00-01	Delegation of Authority to Executive Director to Rule on Requests for Continuance	2000
93-03	Approved Examinations for License to Practice Medicine and Surgery	1999
	Guidelines for the Use of Controlled Substances for the Treatment of Pain	1998
	Kansas Podiatric Licensure for Foreign Medical Graduates	1998
	Respiratory Therapist Transcripts	1997
96-03	Evidence of Graduation From Healing Arts School	1996
93-05	Laser Surgery by Optometrists	1993
93-04	Interpretation of K.S.A. 65-2898a	1993
93-03	Approved Examinations for License to Practice Medicine	1993
92-01	Policy Fifth Pathway	1992

Kansas State Board of Healing Arts	
Policy Title: Scheduling of Conference Hearings	Policy Number: 15-03
Author: Reese Hays, Litigation Counsel	Effective Date: February 13, 2015
Date Authored: February 10, 2015	Last Modified:----
Responsible for Updates:	Pending Executive Director Approval: Yes <input checked="" type="checkbox"/> No

Purpose:

The purpose of this policy is to ensure that the Conference Hearing proceedings before the Kansas State Board of Healing Arts (“Board”) pursuant to the Kansas Administrative Procedure Act (“KAPA”), K.S.A. 77-501, *et seq.*, are conducted by the Board and its staff in an effective and efficient manner while ensuring that due process is provided to applicants and licensees of this Board.

Authority:

K.S.A. 65-2801, *et seq.*, K.S.A. 65-2838, K.A.R. 100-19-1, K.S.A. 65-2001, *et seq.*, K.S.A. 65-2005, 65-28a01, *et seq.*, K.S.A. 65-28a12, K.S.A. 65-5401, *et seq.*, K.S.A. 65-5410, K.S.A. 65-5501, *et seq.*, K.S.A. 65-5510, K.S.A. 65-6901, *et seq.*, K.S.A. 65-6912, K.S.A. 65-7201, *et seq.*, K.S.A. 65-7217, K.S.A. 77-501, *et seq.*

Policy:

The Kansas State Board of Healing Arts (“Board”) regularly conducts Conference Hearings pursuant to KAPA on applications for licensure, disciplinary petitions and other matters requiring adjudication that are within the Board’s jurisdiction. In order to ensure Conference Hearings are conducted in an effective and efficient manner, the Board adopts the following guidance document to provide binding instructions to Board staff members.

Board Meetings

- (a) Board staff shall schedule Board Meetings to occur on the second Friday of every other month starting in February of each year.
- (b) All initial pleadings requesting Board action, i.e. Petitions for Discipline, Applications, Motions for Modification, etc..., filed at least forty-five (45) calendar days prior to the next scheduled Board Meeting shall be set for an administrative hearing at that next scheduled Board Meeting. If the pleading is filed less than forty-five (45) days prior to the next regularly scheduled Board Meeting, it will be set for the subsequent scheduled Board Meeting.
- (c) If an adverse party files a response to the initial pleadings or motions and it is received at least thirty (30) days prior to the next scheduled Board Meeting, the matter will remain scheduled for hearing at the next scheduled Board Meeting.

(d) If an adverse party files a response to the initial pleading or motion and it is received by the Board twenty-nine (29) days or less prior to the next scheduled Board Meeting, Board staff will move the matter to the subsequent scheduled Board Meeting.

(e) The Executive Director for the Board may exercise their discretion to waive or modify the above timeframes to ensure public protection and due process.

Approved by the Kansas State Board of Healing Arts this 13 day of Feb, 2015.


Kathleen Selzler Lippert, Executive Director

Kansas State Board of Healing Arts	
Policy Title: Standard For Evaluations of Applicants and Licensees Regulated by the Healing Arts Act, Podiatry Act and/or Physician Assistant Licensure Act	Policy Number: 15-01
Author:	Effective Date: December 12, 2014
Date Authored:	Last Modified: ----
Responsible for Updates:	Pending Executive Director Approval: Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

Purpose:

The purpose of this policy is to delineate the Board of Healing Arts' minimal requirements for the independent forensic evaluations used to determine the professional fitness of those individuals licensed or applying for licensure under the Healing Arts Act, Podiatry Act, and/or Physician Assistant Licensure Act. The Board adopts this policy in furtherance of its purpose to protect the public and its desire to strengthen the professions.

Authority:

K.S.A. 65-2801, *et seq.*, K.S.A. 65-2001, *et seq.*, and K.S.A. 65-28a01, *et seq.*

Policy:

The Kansas Board of Healing Arts ("Board") is at times presented with licensees and applicants for licensure where there is a reasonable suspicion that the individual does not have the requisite qualifications, fitness, character, competence or may have an inability to practice their profession with reasonable skill and safety to patients by reason of a physical or mental illness, or condition or use of alcohol, drugs or controlled substances. In such circumstances, the Board has the authority to compel and/or request a licensee or applicant to submit to a mental or physical examination, substance abuse evaluation or drug screen, or any combination thereof to ensure they are safe to practice their profession with reasonable skill and safety.

The Board regularly uses diagnostic evaluations for health professionals who may have a physical or mental impairment. Similarly, the use of diagnostic evaluations when handling a complaint regarding impairment provides significant information that may not otherwise be revealed during the initial phase of a case. A thorough and complete evaluation is imperative for making evidence based decisions that protect the public and ensure licensees or applicants have confidence in quality decisions affecting licensure.

The purpose of an evaluation is not to determine findings of fact but rather to assess and define the nature and scope of the behavior, identify any contributing illness or underlying conditions that may have contributed to the licensee or applicants conduct or condition that might put patients at risk in the future. An evaluation is valuable in determining whether or not patients are at risk or what, if any, mechanisms are necessary to protect the public.

If a complaint or investigation reveals a probability that impairment exists, the Board has the authority to order an evaluation of the licensee or applicant. The licensee or applicant is required to consent to the release to the Board all information gathered as a result of the evaluation. The evaluation of the licensee or applicant follows the investigation/intervention process but usually precedes a formal hearing. The following guidelines should be considered by the Board when considering whether an evaluation is sufficient:

1. Evaluators should be licensed health care professionals who have demonstrated knowledge, based upon education, training, and supervised experience in the realm of impairment and recognition of the characteristic of medical professionals who have impairment issues.
2. The evaluation should be conducted by an independent multidisciplinary evaluator team to avoid a conflict of interest.
3. There should be no prior professional or personal relationship between the evaluator(s) and the licensee or applicant being evaluated.
4. Evaluator(s) should be approved in advance by the Board or by the appropriate Impaired Provider Program (IPP) or Physician Health Program (PHP). Any evaluation not approved in advance is expected to comply with the standards and expectations of a thorough and complete evaluation as outlined in this policy.

The evaluation of a licensee or applicant for impairment issues is complex. It requires a multidisciplinary approach and should contain the following elements:

The general goals of the evaluation:

1. An evaluation shall be an independent multidisciplinary forensic evaluation for fitness to practice. An evaluation is expected to identify, if present, the nature and severity of any psychiatric, psychological, medical, or cognitive impairment.
2. An evaluation should help medical boards and IPP or PHP understand any contributory factors that may have contributed or impacted the conduct. This understanding does not excuse the conduct but may help parties involved understand, in part, why the conduct occurred in order to inform treatment and possibly the nature of disciplinary action (e.g. history of antisocial behavior or severe personality disorder(s), bipolar illness, cognitive impairment, addiction disorder(s), professional burnout resulting in depression and poor judgment, etc).
3. The role of the evaluator(s) shall be one to provide the Board with an expert opinion in relation to matters of psychological and psychiatric fitness to practice. Estimate the licensee or applicant's risk to safely practice and formulate an opinion regarding the licensee or applicant's rehabilitative potential. The fitness evaluator shall not be an advocate, therapist, or a finder of fact. The evaluator(s) goal shall be to provide an objective assessment of the licensee's or applicant's risk; function; pathology; insight; capacity for learning and changing attitude; appreciation of professional duty, traits, and the necessity of accountability.
4. An evaluator who has either provided a past clinical role in the licensee's or applicant's past treatment or is currently providing a clinical role in the individual's current

treatment shall be precluded from performing an initial independent multidisciplinary forensic evaluation for fitness to practice. The very nature of a clinician/patient relationship does not allow for the neutrality required for an independent evaluation. The requirements between the forensic role of an evaluator and the confidential therapeutic alliance with a treating clinician differ significantly. This would not preclude any previous independent multidisciplinary forensic evaluator from performing a subsequent or follow-up evaluation.

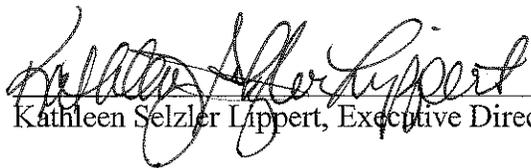
5. Conclusions regarding fitness to practice and treatment if appropriate.

Elements of the evaluation process:

1. Comprehensive medical evaluation with appropriate laboratory studies, medical history, and toxicology screens for substances of abuse. The forensic assessment shall also utilize drug screenings in the form of hair, urine, blood, and/or any other necessitated biological sample to determine licensee's or applicant's use of alcohol, drugs or controlled substances.
2. The evaluation should include a review of all collateral materials believed pertinent by the evaluation team including, but not limited to, the board's investigative file; prior applicable diagnoses and courses of treatment; information from any IPP or PHP; police reports, work colleagues, spouses or significant others, and if available, the results of any prior medical, social, psychiatric evaluations and psychological testing. The forensic evaluation shall utilize a sufficient number of collateral sources to provide a balanced evaluation that is not dependent on a licensee or applicants self-report. The licensee or applicant shall be required to execute authorizations for release of information from the board and other collateral sources to facilitate provide the evaluation team access to collateral information.
3. Comprehensive psychiatric evaluation and history including a mental status examination.
4. Alcohol and drug history that includes ruling out the presence or history of substance abuse.
5. Psychosocial/development history if evaluator deems appropriate.
6. Comprehensive psychological testing and clinical interview following a forensic protocol. Within the context of the component the evaluation, the examiner will employ valid and reliable psychological instruments and clinical means to rule out cognitive / neuropsychological deficits, latent or frank psychosis, affect/mood instability, bipolar spectrum, depression, impulse-control, anxiety, paraphilic, and thought disorders. Based on these findings, the examiner(s) will describe the nature and severity of difficulties, if present, and determine their impact on future risk to patient safety.
7. Comprehensive history that includes ruling out the presence of compulsive behavior.
8. Forensic polygraph examination if indicated (questions need to be clearly focused on past behavior and not intent).
9. Multidisciplinary team meeting where all members involved in the evaluation can present clinical data, review collateral information, explore personal and professional biases, challenge each other's conceptualizations, and arrive at a consensus regarding the licensee or applicant's psychiatric, psychological, medical, and cognitive disposition.

10. A report summarizing all the elements of assessment.
11. Evaluation by a psychiatrist and/or doctoral level psychologist for the presence or absence of an Axis I or Axis II disorder(s).
12. Conclusions: A medical/psycho-legal determination regarding the licensee or applicant's psychiatric, psychological, medical, and cognitive disposition and fitness to practice. Statement regarding the physician's risk to reoffend and rehabilitative potential.
13. Recommendations (may include IPP or PHP monitoring, extensive treatment, further evaluations, e.g. neuropsychological testing, MRI, MRA, SPECT, PET, additional laboratory studies, etc).
14. The evaluation of a licensee or applicant for impairment should be contingent upon agreement by the independent evaluator to release to the board all records pertaining to the identity, diagnosis, prognosis, and treatment of the licensee or applicant. Such records should include but not be limited to those records maintained in connection with the performance of any program or activity relating to substance abuse education, prevention, training, treatment, rehabilitation, or research. The licensee or applicant shall be required to execute authorizations for release of information to the Board in connection with the evaluation, the results, and opinions. Upon completion of the evaluation, results must be released to the medical Board. A failure of the licensee or applicant to execute the authorizations deemed appropriate by the evaluation(s) will cause the evaluation to cease until the authorizations are executed. Furthermore, the authorizations shall provide the Board with direct access to all evaluation materials and reports. The evaluator will provide all reports to the Board and if appropriate, to the licensee or applicant.
15. Any final report and addendums shall contain the findings of any actuarial assessment of risk, mental status examination, psychological test(s), a summary with an explanatory hypothesis, any diagnoses to include the nature and severity of the diagnoses, and the evaluators' conclusions and recommendations, including but not limited to issues of accountability, treatment, and monitoring if needed.

Approved by the Kansas State Board of Healing Arts this 12 day of December, 2014.


Kathleen Selzler Lippert, Executive Director

Kansas State Board of Healing Arts	
Policy Title: Standard of Care for School Physicals	Policy Number: 14-01
Author: Dan Riley, Disciplinary Counsel	Effective Date: August 8, 2014
Date Authored: August 8, 2014	Last Modified: ----
Responsible for Updates:	Pending Executive Director Approval: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Purpose:

The purpose of this policy is to describe the Board of Healing Arts' current interpretation of the standard of care for the performance of school physicals and provide guidance to healing arts professionals. The Board adopts this policy in furtherance of its purpose to protect the public.

Authority:

K.S.A. 65-2801, *et seq.*

Policy:

The Kansas Board of Healing Arts licenses many health care professionals who perform school physicals as part of their scope of practice. The Board considers school physicals to be a significant and important patient encounter since some students may not have ready access to routine medical care for basic evaluation. The following fundamental elements should be included in ALL school physicals:

1. Collection, review, and documentation of entire medical history, including age-appropriate immunizations.
2. Review of family history.
3. Accurate vital signs obtained and documented, with re-evaluation of any abnormal findings.
4. Complete physical examination, with documentation of all remarkable findings.
5. Written protocol for referral to student's primary care provider or appropriate specialist, if indicated, for problems or conditions identified during the school physical.
6. Creation and retention of a complete medical record documenting all of the above, with a copy provided to the student's primary care provider or, if none exists, to the student's parents or guardians.

Kansas State Board of Healing Arts	
Policy Title: Use of Ultrasound and Lasers for Fat Reduction	Policy Number: 13-01
Author: Kelli Stevens, General Counsel	Effective Date: Feb. 8, 2013
Date Authored: Feb. 2013	Last Modified: ----
Responsible for Updates: ----	Pending Executive Director Approval: <u> </u> Yes <u> </u> No

Purpose:

The Board recognizes that the use of ultrasound and laser devices is within the scope of practice for multiple professions for various diagnostic and/or therapeutic purposes. The purpose of this policy is to describe the agency's current interpretation of law and provide guidance to the public and to the professions regulated by the agency regarding the use of ultrasound and lasers for fat reduction. The Board adopts this policy in furtherance of its purpose to protect the public while the agency develops regulations specifying the requirements for its licensees who use ultrasound and/or lasers for the purpose of fat reduction.

Authority:

K.S.A. 65-2801, *et seq.*

Policy:

It is the position of the Kansas State Board of Healing Arts that the use of ultrasound and laser devices for the purpose of fat reduction constitutes the practice of surgery. Such use is limited to physicians holding a license to practice medicine and surgery and to individuals to whom such a physician has lawfully delegated such practice. Prior to engaging in any laser or ultrasound procedure for the purpose of fat reduction, a physician shall receive appropriate training in the indications for, performance of and complications from such procedures. All such procedures shall be performed in a setting which meets the requirements of K.A.R. 100-25-2. All delegation of and supervision of such procedures shall comply with K.S.A. 65-28,127. All delegation of and supervision of laser procedures shall further comply with K.A.R. 100-27-1. All laser and ultrasound devices used for fat reduction shall be FDA-approved for that use.

Approved by the Kansas State Board of Healing Arts on this 13 day of February, 2013.



 Kathleen Selzer Lippert, Executive Director

Approved by the Kansas State Board of Healing Arts this 8th day of August, 2014.


Kathleen Selzler Lippert, Executive Director

Kansas State Board of Healing Arts	
Policy Title: Board Member Conflict of Interest Policy	Policy Number: 11-03
Author: Kelli Stevens, General Counsel	Effective Date: August 15, 2011
Date Authored: August 12, 2011	Last Modified: ----
Responsible for Updates: KJS	Pending Executive Director Approval: Yes No

Purpose:

The purpose of this policy is to prevent the professional and personal interests of the individual members of the Kansas State Board of Healing Arts and members of Board committees (Members) from influencing the performance of their official duties on behalf of the Kansas State Board of Healing Arts. The Board adopts this policy in order to assure fair and impartial decision-making and integrity in its processes.

Authority:

- K.S.A. 65-2801
- K.S.A. 65-2812
- K.S.A. 65-2813
- K.S.A. 65-2817
- K.S.A. 65-2840c
- K.S.A. 65-28a11
- K.S.A. 65-2903
- K.S.A. 65-5404
- K.S.A. 65-5504
- K.S.A. 65-6912
- K.S.A. 65-7214
- K.S.A. 65-7310

Definitions:

“Member,” as used in this policy, shall include a Board member or member of a Board committee, including a professional council or review committee.

“Licensee,” as used in this policy, shall include an applicant for licensure, a licensee, a permit holder, a registrant, or a certificate holder.

“Case,” as used in this policy, means an investigation, review of application or administrative proceeding in which the Board may render a decision to grant or deny licensure, revoke, suspend, limit, censure, place on probation, fine, find probable cause, or otherwise act on an application for licensure or issue disciplinary or remedial sanctions.

“Conflict of interest,” as used in this policy, means a professional or personal interest which might actually affect, or might reasonably appear to affect, the judgment or conduct of any Member in the performance of his or her official duties. A conflict of interest includes, but is not limited to, circumstances where:

A Member has prior knowledge of the facts or allegations in an applicant’s or licensee’s case which affects the Member’s impartiality in a pending matter;

A Member lacks impartiality or may reasonably appear to lack impartiality because of a family, personal, financial or professional relationship or other involvement with an applicant or licensee who is the subject in a case; and

A Member may receive a benefit or may reasonably appear to receive a benefit based on the Board’s decision or outcome of a matter.

“Recuse,” as used in this policy, means to voluntarily disqualify oneself from participation during any discussion, deliberation and vote on a matter or in a hearing.

Policy:

This policy does not have the force and effect of law, and does not suggest any intent to create binding precedent in any case.

Each Member shall meet and maintain the qualifications for membership as set by law. A member should strive to achieve and project the highest standards of professional conduct. Such standards include:

A Member should not accept or solicit any benefit that might influence the Member in the discharge of official duties or that the Member knows or should know is being offered with the intent to influence official conduct.

A Member should not disclose confidential Board information acquired by reason of the official position as a Member in any non-Board employment, business, personal or professional activity.

A Member should not intentionally or knowingly solicit, accept, or agree to accept any benefit for having exercised the Member’s official powers or performed the Member’s official duties in favor of another.

A Member should be fair and impartial in the conduct of the business of the Board. A Member should project such fairness and impartiality in all meetings and hearings.

A Member should be diligent in preparing for meetings and hearings. It is the duty of each Member to ascertain if a conflict of interest exists or potentially exists.

If a conflict of interest should occur, a Member should recuse himself or herself from participating in any matter before the Board that could be affected by the conflict.

A Member should avoid the use the Member's official position to imply professional superiority or competence.

A Member should avoid the use of the Member's official position as an endorsement in any health care related matter.

A Member should not serve as a party's expert witness in any case in which the Board is a party. If providing expert testimony in any other matter, a Member should state that any opinion of the Member is not on behalf of or approved by the Board and should not claim special expertise because of Board or Board committee membership.

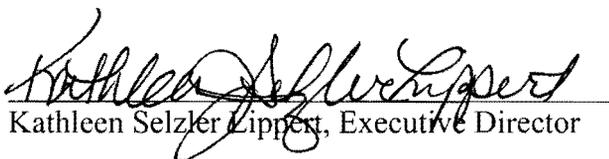
A Member should refrain from making any statement that implies that the Member is speaking for the Board if the Board has not voted on an issue or unless the Board has given the Member such authority.

Procedure:

Documentation of Conflict Disclosures: The minutes of the meetings of the Board, its committees and councils shall reflect any conflict of interest which was disclosed and that the conflicted Member was recused from participation during any discussion, deliberation and vote on a matter or in a hearing.

New Appointment and Annual Certification Process: This Policy shall be distributed to and reviewed by all new Members upon appointment and annually by existing members. Upon appointment of a Member and annually thereafter, the Executive Director shall be responsible for or shall delegate such responsibility for having each Member complete a Certification form attesting to receipt, review and understanding of the Policy and his or her agreement to comply with the Policy.

Approved by the Kansas State Board of Healing Arts this 18th day of August, 2011.


Kathleen Selzler Lippert, Executive Director

Kansas State Board of Healing Arts	
Policy Title: Guidelines for Imposing Discipline Relating to Practice on a Cancelled License	Policy Number: 04-01
Author: General Counsel	Effective Date: Oct. 2004; Rev. June 8, 2007; Rev. April 25, 2008; Aug. 12, 2011
Date Authored: Oct. 2004; June 2007; Apr. 2008; Aug. 1, 2011	Last Modified: Aug. 1, 2011
Responsible for Updates: General Counsel	Pending Executive Director Approval: NO

Purpose:

The purpose of this policy is to establish guidelines and procedures for the Kansas State Board of Healing Arts regarding the initiation of disciplinary action against a Licensee for practicing the healing arts for more than six (6) months after the license expiration date.

Authority:

K.S.A. 65-2803(a) makes it unlawful for any person to engage in the practice of the healing arts without a license.

K.S.A. 65-2803(b) clarifies that it is not unlawful for a person licensed by the board to practice on an expired license if that license is reinstated within six months following the date of expiration.

K.S.A. 65-2836 allows the Board to publicly censure a licensee for violations of the Kansas Healing Arts Act.

K.S.A. 65-2863a authorizes the Board to impose administrative fines against a licensee for violations of the Kansas Healing Arts Act.

Definitions:

(none)

Policy:

When considering disciplinary action against a licensee for the continued practice of the healing arts for more than six (6) months following expiration of a license, the Board intends to follow a predictable pattern of imposing fines that is based upon the length of time that the licensee practices on an expired license. The purpose of this policy is to create a fair and consistent procedure for imposing disciplinary sanctions in proportion to the scope of the violation.

This policy does not have the force and effect of law, and it does not suggest any intent to create binding precedent in any case. By adopting this policy statement, the Board does not

limit itself to any form of disciplinary order, and may depart from this policy statement as it desires and without giving notice. The discipline suggested in this policy statement is in addition to, and not in lieu of, any other disciplinary order that the Board may impose in its discretion. Fines are limited to \$5,000 for the first violation, \$10,000 for the second violation, and \$15,000 for subsequent violations.

A violation occurs when a Licensee practices the healing arts for more than six (6) months after the expiration of his or her license and does not reinstate the license. Renewal of a license after the expiration date requires payment of a late fee. A fine assessed for practicing for more than six (6) months after the expiration date of a license is in addition to the late fee. The six-month grace period shall apply to the healing art professions and podiatrists, but shall not apply to non-healing arts professions regulated by the Board.

Procedure:

Upon notification of a violation to which this policy applies, Board staff shall issue a summary order imposing the following discipline in accordance with the Kansas Administrative Procedures Act:

A. Healing Arts Professions and Podiatrists:

<u>Days practiced with cancelled license</u>	<u>Discipline</u>
Six (6) months – 365 days.....	Public Censure and \$500 Fine

B. All other Non-Healing Arts Professions:

<u>Days practiced with cancelled license</u>	<u>Fine</u>
1 - 60	\$150
61 - 150	\$250
151 - 365	\$350

Approved by the Kansas State Board of Healing Arts this _____ day of August, 2011.



Myron Leinwetter, D.O.
President
Kansas State Board of Healing Arts

Kansas State Board of Healing Arts	
Policy Title: Process for Handling Complaints Alleging a Violation of the Healing Arts Act or Podiatry Act Involving Members and Former Members of the Board of Healing Arts	Policy Number: 11-02
Author: Kelli Stevens, General Counsel	Effective Date: June 17, 2011
Date Authored: June 7, 2011	Last Modified: ----
Responsible for Updates: ----	Executive Director Approval: Yes No

Purpose: The purpose of this policy is to establish a procedure by which complaints alleging a violation of the Healing Arts Act or Podiatry Act against current Board Member licensees or licensees who have within the past five (5) years served on the Board are processed in a manner that ensures the integrity of the disciplinary function of the agency and prevents any appearance of bias or preferential treatment to any licensee while providing full due process to all licensees.

Authority:

- K.S.A. 65-2812
- K.S.A. 65-2813
- K.S.A. 65-2817
- K.S.A. 65-2840a
- K.S.A. 65-2836 through 65-2844

Policy: It is the policy of the Kansas State Board of Healing Arts that any signed complaint alleging a violation of the Healing Arts Act or Podiatry Act received by the Board against a licensee who is a current Board member or a licensee who has served on the Board in the past five (5) years will be handled in a manner that 1) maintains the reliability of the Board’s functions and processes; 2) prevents an actual conflict or appearance of a conflict of interest of agency staff; and 3) is within the Board’s standard disciplinary procedures set forth for a complaint filed against a licensee who is not so situated.

Procedure:

When a complaint alleges a violation of the Kansas Healing Arts Act or Podiatry Act by a current member of the Board, the complaint will be reviewed by the Disciplinary Counsel and assigned for investigation if the acts alleged would constitute a violation of the Healing Arts Act or Podiatry Act. Once assigned, the matter shall be investigated by a Board investigator. Upon completion of the investigation, if the matter involves a standard of care issue, the Disciplinary Counsel shall first refer the investigation to a Review Committee and then to the Disciplinary Panel for consideration. If the matter involves a conduct issue, the Disciplinary

Counsel shall refer the investigation directly to the Disciplinary Panel. In accordance with the Board's standard disciplinary procedures, if at any point in the process it becomes evident that the investigation evidence clearly fails to support a prima facie indication of a violation of the Healing Arts Act or Podiatry Act, the investigation may be closed.

When an investigation is referred to the Disciplinary Panel, the Litigation Counsel shall request an Assistant Attorney General from the Kansas Attorney General's Office or other approved outside counsel to be assigned to represent the Disciplinary Panel in its review and consideration of the matter. The Assistant Attorney General or other approved outside counsel shall provide representation at all subsequent stages regarding the complaint, including any proceedings before the Board and any actions under the Kansas Judicial Review Act.

If action is authorized by the Disciplinary Panel to initiate disciplinary proceedings, the Assistant Attorney General or other approved outside counsel shall regularly consult with the Litigation Counsel and/or the Disciplinary Counsel in determining appropriate procedures for carrying out the Board's disciplinary proceedings, but shall retain all prosecutorial discretion. Nothing in this policy shall prohibit the Litigation Counsel/Disciplinary Counsel from assigning an independent expert consultant to review a clinical standard of care issue as deemed appropriate.

All other standard disciplinary procedures for handling a complaint by the agency will apply. These include, but are not limited to, the Review Committee and Disciplinary Panel processes, timeframes for investigation completion, issuance of any and all letters, notification of the licensee and complainant of Board's decisions, and the confidentiality of the complaint and investigation as set forth in the Healing Arts Act.

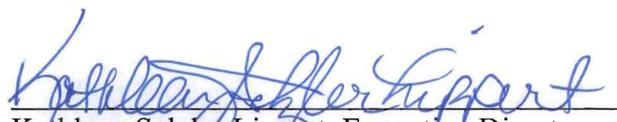
If a Board disciplinary action is initiated against a Board member, the Executive Director may ask the member to recuse him or herself from participation in all Board activities, including meetings and hearings, until the matter is resolved.

If a disciplinary action against a Board member is heard by the Board or any members of the Board as presiding officers, an Assistant Attorney General or other approved outside counsel shall be assigned to advise the Board in any hearing proceedings and any other consideration of the matter in place of Board General Counsel staff.

If disciplinary action is taken against a Board member, the Executive Director shall contact the Board member regarding the disciplinary action's ramifications to their continued service as a Board member which may include their voluntary resignation or possible removal from their appointed Board position by the Governor of the State of Kansas.

When a complaint alleges a violation of the Kansas Healing Arts Act or Podiatry Act by a licensee who has served on the Board within the past five (5) years and the investigation is referred to the Disciplinary Panel, the Litigation Counsel shall perform a conflict assessment of the Board attorney staff to determine if there is an attorney who may appropriately handle the case. If all attorney staff are conflicted, the procedure outlined above shall be followed.

Approved by the Kansas State Board of Healing Arts this 17th day of June, 2011.


Kathleen Selzler Lippert, Executive Director

Kansas State Board of Healing Arts	
Policy Title: Delinquent Fines and/or Costs Policy	Policy Number: 11-01
Author: Kelli Stevens, General Counsel	Effective Date: April 15, 2011
Date Authored: April 15, 2011	Last Modified: ----
Responsible for Updates: ----	Pending Executive Director Approval: Yes No

Purpose:

The purpose of this policy is to establish guidelines and procedures for the Kansas State Board of Healing Arts. This policy is intended to assist the Board in considering appropriate disciplinary action against licensees who are delinquent in excess of ninety (90) days or are in arrears for \$2,000.00 or greater in their Board ordered payment of fines and/or costs. The Board desires, in most cases, to follow a predictable and consistent pattern of imposing fines and penalties. The Board adopts this policy in an effort to treat all licensees fairly.

Authority:

K.S.A. 65-2836(k)
 K.S.A. 65-2006(a)(12)
 K.S.A. 65-28a05(f)
 K.S.A. 65-2912(a)(5)
 K.S.A. 65-5410(a)(4)
 K.S.A. 65-5510(a)(4)
 K.S.A. 65-6911(a)(10)
 K.S.A. 65-7208(a)(4)
 K.S.A. 65-7313(a)(8)

Definitions:

Licensee, as used in this policy, shall include a licensee, permit holder, registrant, or certificate holder.

Policy:

This policy does not have the force and effect of law, and does not suggest any intent to create binding precedent in any case. By adopting this policy statement, the Board does not limit itself to any form of disciplinary order, and may depart from this policy without providing notice as the Board deems necessary. The discipline suggested in this policy statement is in addition to, and not in lieu of, any other disciplinary order that the Board may impose in its discretion.

In instances where a licensee is delinquent in excess of ninety (90) days or where the licensee is in arrears for \$2,000.00 or greater in their Board ordered payment of fines and/or costs, the Executive Director is hereby authorized to issue a Summary Order imposing a suspension of

licensure whereby the licensee's license is suspended after fifteen (15) days unless the licensee requests a hearing.

The suspension shall continue in effect until such time as the licensee remits sufficient payment to become current on all fines and/or costs due and owing to the Board. The suspension may be lifted upon satisfactory payment of all delinquent amounts.

Procedure:

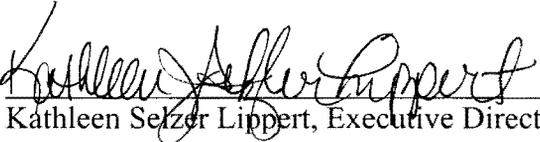
When a licensee becomes delinquent in excess of ninety (90) days or in arrears for \$2,000.00 or greater in their Board ordered payment of fines and/or costs, a Summary Order will be issued imposing a licensure suspension. The licensee's license will be suspended after fifteen (15) days unless the licensee requests a hearing. The suspension shall continue in effect until such time as the licensee remits sufficient payment to become current on all fines and/or costs due and owing to the Board. The suspension may be lifted upon satisfactory payment of all delinquent amounts.

If the licensee remits sufficient payment within the 15 days after the Summary Order is issued, a Journal Entry shall be entered stating the findings of facts and conclusions regarding licensee's compliance with the original order imposing the fine and/or costs.

If the licensee fails to remit sufficient payment within the 15 days after the Summary Order is issued and they request a hearing, the matter will be set for a hearing.

If the licensee fails to remit sufficient payment within the 15 days after the Summary Order is issued and no hearing is requested, a Journal Entry imposing suspension will be issued.

Approved by the Kansas State Board of Healing Arts this 15th day of April, 2011.


Kathleen Selzer Lippert, Executive Director

Kansas State Board of Healing Arts	
Policy Title: Federation Credentials Verification Service (FCVS)	Policy Number: 97-01
Author: Katy Lenahan	Effective Date:
Date Authored: February 25, 2011	Last Modified: April 5, 1997
Responsible for Updates: ----	Pending Executive Directory Approval: Yes No

Purpose:

The purpose of this policy is to clarify which documents the Board will accept from FCVS for licensure applications.

Authority: N/A

Policy:

Licensure applicants may voluntarily submit the following documents through FCVS to fulfill the application document requirements:

Medical School Verifications

Medical School Transcripts

Medical School Diploma

Verifications of Postgraduate Medical Education

Verification of Fifth Pathway

ECFMG Certification

ECFMG Certification Status Report

Federation Board Action History Report

Examination Scores

Disciplinary Information Submitted by the Medical Schools

Disciplinary Information Submitted by the Postgraduate Training Programs.

Procedure: N/A

Approved by the Kansas State Board of Healing Arts this 8th day of March, 2011


Kathleen Selzer Lippert, Executive Director

April 5, 1997

By: Charlene K. Abbott, Licensing Administrator

FEDERATION CREDENTIALS VERIFICATION SERVICE
(FCVS)

F.C.V.S is being offered to medical boards through the Federation of State Medical Boards to facilitate the verification process of core credentials necessary for medical licensure.

Fees for this service will be paid for by the physicians.

Application fees range from \$125 to \$200. Additional costs could include translation fees of \$40 per page plus \$15 handling fee. Score report fees range from \$40 to \$100.

The above fees do not include Kansas application fees.

The Federation is asking boards to either require on an exclusive basis the documents from F.C.V.S or for states to accept F.C.V.S.-verified credentials as part of their licensing process.

Three states (Oklahoma, Ohio and Utah) have agreed to accept the F.C.V.S. on an exclusive basis.

Twenty-three medical boards (Arizona, California, Florida, Georgia, Guam, Hawaii, Idaho, Indiana, Kentucky, Louisiana, Maryland, Massachusetts, Montana, New Hampshire, New Mexico, Oklahoma Osteopathic, Oregon, Rhode Island, Texas, Virginia, Washington, Washington Osteopathic and Wyoming) have agreed to accept F.C.V.S documents.

It is my recommendation to the board that we do not accept F.C.V.S on an exclusive basis; however, I would recommend we accept the following F.C.V.S.-verified documents:

FCVS Verification of Medical Education Form to satisfy
Section X of our application.

Transcripts

Diploma

FCVS Verification of Post Graduate Medical Education Form

FCVS Verification of Fifth Pathway Form

ECFMG Certification

Federation Board Action History Report

The following would be required by the applicant and not acceptable from F.C.V.S.:

Photo

Professional Activities

Examination Scores

Address and Practice Information

Recommendations

Affidavit

Release

Specialty Information

Discipline Section

Previous Licensure Information

Verification from other states

Kansas State Board of Healing Arts	
Policy Title: Use of Propofol (Diprivan) in Office Based Surgery	Policy Number: 10-03
Author: Dan Riley	Effective Date: August 20, 2010
Date Authored: August 2, 2010	Last Modified:
Responsible for Updates: ----	Pending Executive Directory Approval: Yes No

Purpose:

To assure the use of Propofol (diprivan) in Office Based Surgery is administered in a safe manner.

Authority:

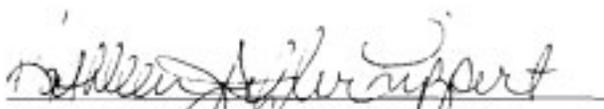
K.A.R. 100-25-3

Policy:

Propofol(diprivan) should not be used in an Office Based Surgery setting unless the following guidelines and protocols are followed **in addition to, or in excess of** the current regulatory guidelines. In all instances propofol must be administered by a licensed CRNA or anesthesiologist with expert training in its administration. **Continuous monitoring** of ECG, pulse oximetry, heart rate, respiration rate and blood pressure must be performed. Patients must be on continuous flow oxygen.

Procedure:

Approved by the Kansas State Board of Healing Arts this 20th day of August, 2010


 Kathleen Solzler Lippert, Executive Director

Kansas State Board of Healing Arts	
Policy Title: Petition for Reconsideration – Delegated Authority	Policy Number: 10-02
Author: Zachary Anshutz, Assistant General Counsel	Effective Date: Aug. 20, 2010
Date Authored: July 2, 2010	Last Modified: ----
Responsible for Updates: ----	Pending Executive Director Approval: <i>Yes No</i>

Purpose: The purpose of this policy is to provide the Executive Director and the President of the Board the authority to grant or deny Petitions for Reconsideration in order to comply with the statutory timeframe of K.S.A. 77-529(b).

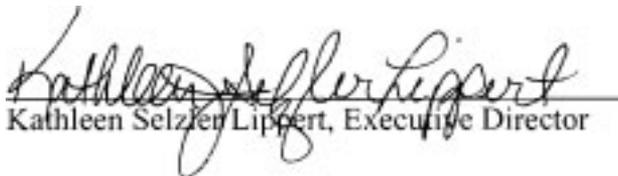
Authority: K.S.A. 77-529(b); K.S.A. 77-514(g)

Policy: In order for the Board to comply with the twenty (20) day timeframe for ruling on a Petition for Reconsideration ("Petition") set forth in K.S.A. 77-529(b), the Executive Director is hereby authorized to work in conjunction with the President of the Board ("President") to determine whether to grant or deny a Petition. After reviewing a Petition, the Executive Director shall make a recommendation to the President concerning the granting or denial of the Petition. The President shall then determine whether the Petition will be granted or denied. The President's ruling on the Petition shall be vested with the full authority of the Board.

If the President is unable to make a determination on a Petition due to unavailability or any circumstance which may prevent the President from carrying out the duties set forth herein, the Vice President of the Board shall fulfill the President's duties in making a determination to grant or deny a Petition. The Vice President's ruling shall be vested with the full authority of the Board when acting during the President's absence or unavailability.

Procedure:

Approved by the Kansas State Board of Healing Arts this 20th day of August, 2010.


 Kathleen Selzer Lippert, Executive Director

Policy Title: 10 year USMLE completion Rule		Policy Number: 10-01
Author: Greg Arnett		Effective Date: June 18, 2010
Date Authored: March 29, 2010		Last Modified: June 18, 2010
Responsible for Updates: ----		Pending Executive Directory Approval: Yes No

Purpose:

The purpose of this policy is to clarify when the Board will sponsor applicants to retake portions of the USMLE that they have already passed.

Authority:

K.A.R. 100-7-1(b)

Policy:

In order for applicants to comply with the regulation requiring that all three steps of the USMLE be passed within ten years of each other, the Board may sponsor some individuals to retake a step of the exam. The Board will only do so if the individual has an application on file with the Board's licensing department and does not qualify for licensure by endorsement. Qualified applicants may still request licensure by endorsement in appropriate cases.

Procedure:

Approved by the Kansas State Board of Healing Arts this 18th day of June, 2010


 Kathleen Selzler Lippert, Executive Director

Kansas State Board of Healing Arts	
Policy Title: Guidelines for imposing discipline for failure to respond to a continuing education or malpractice insurance licensure audit request	Policy Number: 08-03
Author: General Counsel; Litigation Counsel	Effective Date: April 26, 2008; Amended June 19, 2009
Date Authored: April 2008	Last Modified: June 2009
Responsible for Updates: General or Litigation Counsel	Pending Executive Director Approval: <input type="checkbox"/> Yes <input type="checkbox"/> No

Purpose:

The purpose of this policy is to establish guidelines and procedures for the Kansas State Board of Healing Arts. This policy is intended to assist the Board in considering disciplinary action against a licensee for failing to respond to an audit request by the Board for proof of continuing education (CE) and/or malpractice insurance coverage or compliance with the Kansas Health Care Stabilization Fund (KHCSF) which is required by Kansas law. The Board desires, in most cases, to follow a predictable and consistent pattern of imposing fines and penalties. The Board adopts this policy in an effort to treat all licensees fairly.

Authority:

- KSA 65-2809(b), KAR 100-15-4, 100-15-5, 100-15-6 (Healing Arts CME)
- KSA 65-2809(c) (Healing Arts malpractice insurance)
- KSA 65-2836 (discipline for violating Healing Arts Act)
- KSA 65-2863(a) fine for Healing Arts
- KSA 65-2809(b), 65-2010, KAR 100-49-8 (Podiatry CME)
- KSA 65-2005(d) (Podiatry malpractice insurance)
- KSA-65-2006 (discipline for violating podiatry act)
- KSA 65-2015 (fine for violating Podiatry Act)
- KSA 65-28a04(c), KAR 100-28A-5 (PA CME)
- KSA 65-28a05 (discipline for violating Physician Assistant Act)
- KSA 65-2910(b), KAR 100-29-9, 100-29-11(a)(8) (PT CME)
- KSA 65-2910(c), 65-2920, KAR 100-29-15 (PT malpractice insurance)
- KSA 65-2912 (discipline for violating Physical Therapy Act)
- KSA 65-2916(c) (fine for violating Physical Therapy Act)
- KSA 65-5412, KAR 100-54-6(d)(2), 100-54-7 (OT CME)
- KSA 65-5410 (discipline for violating Occupational Therapy Act)
- KSA 65-5410(c) (fine for violating Occupational Therapy Act)
- KSA 65-5512, KAR 100-55-6(c)(2) (RT CME)
- KSA 65-5510 (discipline for violating Respiratory Therapy Act)

KSBHA Guidelines for imposing discipline for failure to respond to a continuing education or malpractice insurance licensure audit request

- KSA 65-5510(c) (fine for violating Occupational Therapy Act)
- KAR 100-69-7(b), 100-69-10(a) (AT CME)
- KSA 65-6911 (discipline for violating Athletic Trainers Act)
- KAR 100-72-7, 100-72-7(g) (ND CME)
- KSA 65-7217, KAR 100-72-6 (ND malpractice insurance)
- KSA 65-7208 (discipline for violating Naturopathic Act)
- KSA 65-7208(c) (fine for violating Naturopathic Act)
- KAR 100-73-7, 100-73-7(e) (LRT CME)
- KSA 65-7313 (discipline for violating Radiologic Technologist Act)
- KSA 65-7313, 65-2863a (fine for violating Radiologic Technologist Act)

Definitions:

License, as used in this policy, shall include license, permit, registration, or certificate.

Licensee, as used in this policy, shall include licensee, permit holder, registrant, or certificate holder.

Policy:

This policy does not have the force and effect of law, and does not suggest any intent to create binding precedent in any case. By adopting this policy statement, the Board does not limit itself to any form of disciplinary order, and may depart from this policy as it desires and without giving notice. The discipline suggested in this policy statement is in addition to, and not in lieu of, any other disciplinary order that the Board may impose in its discretion.

In instances where a licensee fails to respond to a second audit request for continuing education (CE) hours or documentation of malpractice insurance or Kansas Health Care Stabilization Fund compliance (KHCSF) as required under Kansas law, the Executive Director is hereby authorized to issue a Summary Order imposing a fine and licensure suspension; the licensee's license shall be fined and suspended after fifteen (15) days unless the licensee requests a hearing.

The amount of the fine shall be a minimum of \$500 for the healing arts professions and \$100 for all the remaining non-healing arts professions. Prior violations or other aggravating circumstances may warrant increased fines. For any profession that does not provide the statutory authority to fine, a public censure shall be imposed in lieu of a fine.

The suspension shall continue in effect until such time as the licensee submits sufficient proof of completion of the continuing education hours that were required for renewal of licensure and if applicable sufficient documentation of malpractice insurance or compliance with the Kansas Health Care Stabilization Fund as required by Kansas law. Further, the suspension shall continue in effect until all fines or costs have been remitted to the Board. The suspension may be lifted upon completion of all requirements.

KSBHA Guidelines for imposing discipline for failure to respond to a continuing education or malpractice insurance licensure audit request

Procedure:

After the date of cancellation for non-renewal of a profession, licensing will verify compliance with CE and/or malpractice insurance and/or Kansas Health Care Stabilization Fund (KHCSF) requirements through a random audit process.

Licensing will select up to 20% of renewals from a profession for CE and/or malpractice insurance and/or KHCSF compliance. The renewals selected may be based on previous non-compliance issues or may be selected at random.

Licensing will mail a first audit request for documents to verify compliance with CE and/or malpractice insurance and/or Kansas Health Care Stabilization Fund (KHCSF) requirements. The first request will provide a minimum of thirty (30) days to comply with the first audit request.

If the licensee fails to comply with the first audit request, Licensing will mail a second audit request by certified mail for documents to verify compliance with CE and/or malpractice insurance and/or Kansas Health Care Stabilization Fund (KHCSF) requirements. The second request will provide a minimum of fifteen (15) days to comply with the second audit request.

If the licensee fails to comply with the second audit request, a Summary Order will be issued imposing a fine and licensure suspension; the licensee's license shall be fined and will be suspended after fifteen (15) days unless the licensee requests a hearing.

Calculation of fine: Generally the minimum fine will be calculated at the rate of 1.5 times the amount of the licensure renewal fees. However, the amount of the minimum fine shall be \$500 for the healing arts professions (MD, DO, DC and DPM) and \$100 for all the remaining non-healing arts professions (LRT, PT, PTA, AT, RT, OT and OTA). Prior violations or other aggravating circumstances may warrant increased fines. For any profession that does not provide the statutory authority to fine, a public censure shall be imposed in lieu of a fine.

The suspension shall continue in effect until such time as the licensee submits sufficient proof of completion of the continuing education hours that were required for renewal of licensure and if applicable sufficient documentation of malpractice insurance or compliance with the Kansas Health Care Stabilization Fund as required by Kansas law. Further, the suspension shall continue in effect until all fines or costs have been remitted to the Board. The suspension may be lifted upon completion of all requirements.

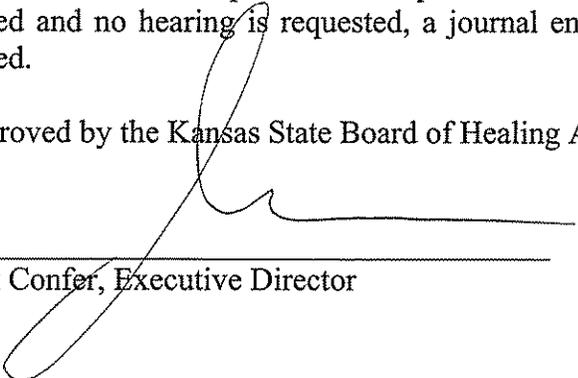
If the licensee provides the requested items within the 15 days after the summary order is issued litigation counsel may request that the fine is imposed and the suspension be stayed. Litigation counsel may enter into negotiations with licensee for an agreed journal entry for the imposition of the fine and a stay of the suspension if mitigating circumstances exist which warrant it. If the licensee agrees the matter would be closed with the agreed journal entry; if not then the case would proceed to an administrative hearing.

KSBHA Guidelines for imposing discipline for failure to respond to a continuing education or malpractice insurance licensure audit request

If the licensee fails to provide the requested items within the 15 days after the summary order is issued and they request a hearing, the petitioner will request that both the fine and suspension be imposed.

If the licensee fails to provide the requested items within the 15 days after the summary order is issued and no hearing is requested, a journal entry imposing the fine and suspension will be issued.

Approved by the Kansas State Board of Healing Arts this 19th day of June, 2009.



Jack Confer, Executive Director

Kansas State Board of Healing Arts	
Policy Title: LABELING AND STORAGE OF PRE-DRAWN SYRINGES	Policy Number: 09-02
Author: Greg Arnett	Effective Date: February 25, 2009
Date Authored: January 6, 2009	Last Modified: January 30, 2009
Responsible for Updates: ----	Pending Executive Director Approval: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

Purpose:

This policy statement is an addendum to the Guidelines for Office-Based Surgery and Special Procedures the purpose of which is to clarify the procedures for the use of syringes.

Authority:

K.S.A. 65-2865; K.A.R. 100-21-5

Policy:

Syringes should only be drawn for identifiable patients. If a syringe is not immediately used, it should be labeled by substance and dosage. Any syringe not ultimately used for the intended patient should be properly discarded.

Multiple syringes should not be pre-drawn from a common bottle and stored for later use on multiple patients as needed.

Approved by the Kansas State Board of Healing Arts this 25 day of February, 2009.



Jack Confer, Executive Director

KANSAS STATE BOARD OF HEALING ARTS

POLICY STATEMENT NO. 08-05

Subject: Interpretation and Enforcement of K.A.R. 100-73-9 involving the performance of radiologic technology procedures

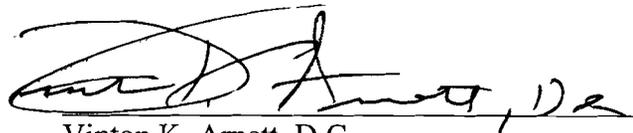
Date: August 15, 2008

This policy statement provides the Board's interpretation and enforcement of K.A.R. 100-73-9, relating to the practice of radiologic technology procedures.

Pursuant to the Radiologic Technology Practice Act, "...no person shall perform radiologic technology procedures on humans for diagnostic or therapeutic purposes unless the person possesses a valid license issued under this act." K.S.A. 65-7303(a). Individuals who are working under a licensed practitioner, who have been properly trained on the equipment, and who complete the required continuing education are exempt from licensure. K.S.A. 65-7304(f). The required continuing education is twelve (12) credit hours annually. K.A.R. 100-73-9.

If a practitioner of the healing arts delegates the performance of radiologic technology procedures for the purpose of diagnostic or therapeutic purposes to an unlicensed individual who has not obtained the required twelve (12) hours of continuing education, such practitioner could be disciplined under the Healing Arts Act for delegating professional responsibilities to an individual who is not qualified by training to perform. K.S.A. 65-2837(26) and K.S.A. 65-2837(b)(30). Additionally, a healing arts practitioner shall, (3) "direct, supervise, order, refer, enter into a practice protocol with, or delegate to such persons only those acts and functions which the responsible licensee knows or has reason to believe such person is competent and authorized by law to perform...." K.S.A. 65-28,127(a). An unlicensed individual who has not achieved the required continuing education would not qualify for the exemption to the licensure requirements under the Radiologic Technology Practice Act; therefore, the individual would not be authorized by law to perform the radiologic technology procedures.

Adopted this 15th day of August 2008.



Vinton K. Arnett, D.C.
President

KANSAS STATE BOARD OF HEALING ARTS

POLICY STATEMENT NO. 08-04

Subject: Interpretation and Enforcement of K.S.A. 65-2837(b)(32) as Amended by Senate Bill No. 285 involving Anatomic Pathology Services
Date: June 20, 2008

This policy statement provides the interpretation of the Board of K.S.A. 65-2837(b)(32), which was amended by Senate Bill No. 285, L. 2007 Ch. 66 § 1, to include the following definition of unprofessional conduct:

“Charging, billing, or otherwise soliciting payment from any patient, patient’s representative or insurer for anatomic pathology services, if such services are not personally rendered by the licensee or under such licensee’s direct supervision. As used in this subsection, ‘anatomic pathology services’ means the gross or microscopic examination of histologic processing of human organ tissue or the examination of human cells from fluids, aspirates, washings, brushings or smears, including bloodbanking services, and subcellular or molecular pathology services, performed by or under the supervision of a person licensed to practice medicine and surgery or a clinical laboratory. Nothing in this subsection shall be construed to prohibit billing for anatomic pathology services by a hospital, or by a clinical laboratory when samples are transferred between clinical laboratories for the provision of anatomic pathology services.” K.S.A. 65-2837(b)(32).

The above cited statute is current law which became effective July 1, 2007. Enforcement of the amendment is within the jurisdiction of the Kansas Board of Healing Arts. Adoption of regulations is not necessary for the enforcement of the amendment.

The legislature intended the amendment to describe unprofessional conduct, and did not adopt the amendment as directory language for the efficiency of billing. Within that context, the Board interprets the amendment to prohibit a licensee from billing for professional services that another person performed, subject to the stated exception, and does not address other services that the licensee actually performs or supervises. As a result, a physician who removes tissue to be sent to a pathologist for analysis and diagnosis would engage in unprofessional conduct by billing for the diagnosis by the pathologist, but to the extent allowed by the reimbursing entity would not engage in unprofessional conduct by billing for obtaining, preparing and conveying the laboratory specimen.

Adopted this 20th day of June 2008.



Betty McBride, Public Member
President

KANSAS STATE BOARD OF HEALING ARTS

POLICY STATEMENT NO. 05-05; Revised 6/20/08

Subject: Victims of Natural Disasters
Date: September 20, 2005; Revised June 20, 2008

Natural disasters can cause unprecedented devastation and displace people from their homes without any personal belongings or documents. Those individuals have a need to relocate elsewhere as a result of the mass devastation. Included among those displaced may be health care professionals who require expeditious licensure in order to go to work in Kansas. Those health care professionals may have obtained their education in schools that have been destroyed by the natural disaster and who cannot obtain official transcripts of their professional education.

The Board directs its staff to provide assistance to individuals who complete an application and provide a sworn statement that, as a result of a natural disaster, they cannot supply documents required for a post-graduate permit, temporary permit and/or permanent licensure. This assistance should include staff acquiring for those applicants and at no charge to them the profiles, examination scores, Board action reports, NPDB/HIPDB reports, and verification of other state licenses required by the Board's applications, rules and regulations, and policies.

Information obtained from national professional associations, the Federations and other states will be considered substantially equivalent to school transcripts and certification from a professional school for those applicants who attended professional school in an area affected by the natural disaster. Information provided by other organizations will also be considered substantially equivalent to a notarized copy of diploma and professional recommendations for individuals who resided in an area affected by a natural disaster. Further, information acquired from other organizations will be considered substantially equivalent for proof of post graduate professional training that was obtained in an institution within the area affected by the disaster.

Individuals whose credentials have been deemed substantially equivalent to those required by rule and regulation, Board application, or Board policy may be granted temporary permits allowing full practice within their profession once the application has been otherwise deemed complete. The Licensing Administrator shall provide the names of those individuals who have had their credentials determined to be substantially equivalent pursuant to this policy at the next regular meeting of the Board following the issuance of the temporary permit. The Board will then determine on a case-by-case basis which individuals should be granted a permanent license.

ADOPTED by the Kansas Board of Healing Arts this 20th day of June 2008.


Betty McBride, Public Member
President

KANSAS

KATHLEEN SEBELIUS
GOVERNOR

STATE BOARD OF HEALING ARTS

JACK CONFER
ACTING EXECUTIVE DIRECTOR

GUIDELINES FOR THE IMPOSITION OF DISCIPLINARY SANCTIONS

(August 2008)

BOARD MEMBERS: VINTON K. ARNETT, D.C., PRESIDENT, Hays - MICHAEL J. BEEZLEY, MD, VICE PRESIDENT, Lenexa
MYRA J. CHRISTOPHER, Public Member, Fairway - RAY N. CONLEY, D.C., Overland Park - GARY L. COUNSELMAN, D.C., Topeka - FRANK K. GALBRAITH, D.P.M., Wichita
MERLE J. "BOO" HODGES, M.D., Salina - SUE ICE, Public Member, Newton - M. MYRON LEINWETTER, D.O., Rossville - BETTY McBRIDE, Public Member, Columbus
CAROLINA M. SORIA, D.O., - Wichita KIMBERLY J. TEMPLETON, M.D., Leawood - ROGER D. WARREN, M.D., Hanover - NANCY J. WELSH, M.D., Topeka - RONALD N. WHITMER, D.O., Ellsworth

235 SW TOPEKA BLVD., TOPEKA, KS 66603

Voice: 785-296-7413 Toll Free: 888-886-7205 Fax: 785-296-0852 Website: www.ksbha.org

**BOARD OF HEALING ARTS OF THE
STATE OF KANSAS**

GUIDELINES FOR THE IMPOSITION OF DISCIPLINARY SANCTIONS

Table of Contents

Section I.	Introduction	2
Section II.	Instructions for Applying Sanctioning Grid and Explanations of Case Types.....	3
1.	Professional Competency.....	4
2.	Misconduct.....	6
3.	Criminal Conduct.....	7
4.	Sexual Misconduct.....	8
5.	Billing and Transactions	10
6.	Advertising.....	11
7.	Impairment.....	12
8.	Administrative Requirements	13
9.	Inappropriate Prescribing.....	14
10.	Patient Records	14
Section III.	Aggravating/Mitigating Factors.....	15
Section IV.	Definitions	17
Section V.	Sanctioning Grid	18
Section VI.	Adoption	24

Section I: *Introduction*

A licensee of the healing arts holds a respected and elevated position in society, with responsibility not only to patients, but also to the public, to colleagues, to the profession, to self, and to the health care system in general. The mission of the Board of Healing Arts is to protect the public by authorizing only those persons who meet and maintain certain qualifications to engage in the health care professions regulated by the Board, and to protect the integrity of the professions. This mission is served by creating a regulatory environment that allows competent and honorable practitioners to practice their art and science, by disciplining those who engage in professional incompetence, unprofessional conduct or other proscribed conduct, and by imposing sanctions that appropriately protect the public from immediate harm, remediate and rehabilitate when possible, or punish when necessary, but ordering the least restrictive discipline necessary to meet the proper sanctioning goals.

Inappropriate sanctions can undermine the goals of discipline. Sanctions that are too lenient or that do not adequately address the underlying causes for the violations do not deter and may result in decreased public confidence in the system. Sanctions that are too restrictive may also result in decreased confidence in the system, and may result in fewer reports of violations and create a more litigious environment. As a result, these guidelines do not establish a precise formula for calculating sanctions.

The Board recognizes the value of a predictable and consistent pattern of disciplinary sanctions. These sanctioning guidelines are intended to lend credibility to the disciplinary process, aid the Board in efficiently achieving its ultimate goal of protecting the public, and give guidance to licensees and their counsel when faced with allegations of misconduct. This theoretical framework applies in any matter when approving a Consent Order or issuing an Initial or Final Order, announcing the appropriate mitigating and aggravating factors the Board will consider in determining the level of discipline and establishing a graduated scale for multiple and repeated misconduct.

The healing arts act and related regulations both prescribe and proscribe conduct that might be grouped in general categories of administrative requirements, misconduct that is harmful to the health care system in general, failure to perform a duty regarding patient care, and other misconduct that may result in patient harm. Patient harm may be economic harm, delay of appropriate treatment, or adverse patient outcomes. These guidelines attempt to take into consideration all of these legitimate interests when determining the imposition of disciplinary action.

When the Board finds that a licensee has engaged in conduct constituting grounds for disciplinary action, the range of disciplinary authority that is available is quite broad, and includes no discipline, fine, public censure, limitation, suspension, revocation, or denial of an application. In determining which of these sanctions should be imposed, the Board should consider the goal for imposing discipline. The purpose might either be remedial, to protect the public from immediate harm, or punitive.

[The Board is also given authority under 2008 HB 2620, Sec. 1 to enter into a written agreement for a professional development plan, make written recommendations, or issue a written letter of concern to a licensee as a non-disciplinary resolution when the licensee: (1) seeks to establish continued competency for renewal of licensure, (2) has been absent from clinical practice for a substantial period of time, (3) has failed to adhere to the standard of care not rising to the level of professional incompetency, and (4) has engaged in an act or practice that is likely to result in future violations of the healing arts act. Those non-disciplinary resolutions are distinguished from disciplinary actions in that they do not impose a fine, censure, probation, limitation, suspension or revocation, and do not affect the scope or duration or effectiveness of a license.]

In general, a probation may achieve a remedial purpose by imposing conditions, such as completion of continuing education courses pertaining to professional boundaries, supervision, monitoring patient records or billing practices; required practice monitoring; evaluation for impairment from psychiatric, medical or substance abuse; clinical skills assessments and training programs; or monitoring contracts with the appropriate impaired provider program. A limitation might protect the public from harm by imposing restrictions on the scope of license, such as reducing the type of services that may be provided, or the setting in which those services may be provided.

Suspension, revocation and denial of an application might be appropriate to achieve a remedial purpose, protection, or punishment. Removing a licensee from practice protects the public from future misconduct. Additionally, removing or preventing a person from practice is appropriate when the misconduct demonstrates that the licensee lacks the necessary competence or professionalism to merit the privilege of licensure. Censure and fine are purely punitive.

These guidelines do not have the force and effect of law, and they do not create binding precedent. By adopting this policy statement, the Board does not limit itself to any form of disciplinary order and it may consider its entire range of authority. The Board may depart from this policy as it desires and without giving notice.

These guidelines are intended to supplement rather than replace the policies that have been previously adopted by the Board regarding disciplinary actions. When misconduct is addressed by those policies, those policies should be followed. Additionally, these guidelines are in addition to other provisions of law that might apply in a specific situation, including the authority of the Board to assess costs in a proceeding.

Finally, these guidelines must be reviewed regularly and updated as statutes and rules change, and when experience suggests the need for modification.

Section II: Instructions for Applying Sanctioning Grid and Explanations of case types

For purposes of these guidelines, the Board has grouped statutes and regulations under specific categories of misconduct. Descriptions in each of the categories are not intended to create grounds for discipline independent of the statutes and regulations. The following comments

guide determination when applying the presumed sanctions identified in the Sanctioning Grid (Section V).

In applying the Sanctioning Grid, the **Presumed Sanction (Grid column 5)** should be the starting point for the conduct described. When licensee is found to have committed multiple categories of offenses, consider whether the offenses are multiple ways of describing the same conduct or are separate occurrences and events. If the offenses are separate and are best described in different categories, the sanctions for each offense should be added together. If the instances of misconduct are similar sanctions, treat as multiple instances of same category and modify the decision to use the **Presumed Sanction for Multiple Instances (Grid column 5)**. If multiple categories of offenses might apply to the same instance or transaction, use only most severe sanction. Mitigating and aggravating factors should then be applied, with the resulting sanction being within the **Range when Presumed Sanction is Modified by Aggravating / Mitigating Factors (Grid column 6)**. The mitigating and aggravating factors upon which the Board relies to modify the presumed sanction should be identified in the Board's findings and conclusions.

1. Professional Competency

Sanctioning Grid Categories:

- A. Competency of Practice - Licensee; Lacks skill and judgment; engages in gross negligence
- B. Competency of Practice - Licensee; Willfully fails to exercise appropriate professional judgment or fails to utilize skill to a degree showing a lack of general competence
- C. Competency of Practice - Licensee; Generally competent but has failed to use skill or judgment
- D. Competency of Practice - Supervision; supervision is non-existent or is a sham relationship
- E. Competency of Practice - Supervision; incompetent acts of supervised person; fails to meet regulatory requirements

Statutes and regulations:

- K.S.A. 65-2836(w) (Failure to report adverse judgment)
- K.S.A. 65-2836(bb) (Failure to adequately supervise a physician assistant)
- K.S.A. 65-2837(a)(1) - (3) (Professional incompetency defined)
- K.S.A. 65-2837(b)(14) (Aiding and abetting unlicensed or incompetent practice)
- K.S.A. 65-2837(b)(24) (Repeated failure to adhere to standard of practice)
- K.S.A. 65-2837(b)(26) (Inappropriately delegating responsibility)
- K.S.A. 65-2837(b)(30) (Failure to properly supervise)
- K.S.A. 65-2837(b)(33) [~~2008 HB 2620~~] (Violating patient trust for personal gain)
- K.A.R. 100-22-7 (Improper orders to dispense medical devices)
- K.A.R. 100-25-5 (Office-based practice requirements)
- K.A. R. 100-27-1 (Standards for supervising light-based services)

Comments

The Kansas Supreme Court stated in *Kansas State Board of Healing Arts v. Foote*, 200 Kan. 447 (1968), "[n]o conduct or practice could be more devastating to the health and welfare of a patient or the public than incompetency" This category of grounds for disciplinary action relates

to the demonstrated professional skill of the licensee, and to the licensee's responsibility for services performed by others.

A licensee's professional incompetence may be established directly or indirectly. Direct indicia includes the failure to adhere to the applicable standard of care to a degree constituting gross negligence in a single instance, or to a degree constituting ordinary negligence in multiple instances or in repeated instances, or engaging in other conduct that manifests incompetency. Indirect indicia include actions taken by hospital or other peer review groups for similar conduct, or malpractice settlements or judgments. Whether directly or indirectly established, the sanction should focus on the practitioner's professional level of skill possessed and utilized in practice as indicated by demonstrated abilities and exercise of professional judgment.

A licensee is also responsible to the patient and the public when delegating to others the authority to perform professional services. This responsibility is generally described in terms of standards for supervision or delegation. Those standards are generally stated at K.S.A. 65-28,127. Additional standards pertaining to specific professions appear throughout the statutes and regulations.

While actual patient injury is not an element of professional incompetency, the reasonable likelihood of harm and the licensee's ability and willingness to acknowledge and overcome deficiencies should be large factors in determining the sanctions to be imposed based upon a finding of professional incompetence.

a. Licensee's Professional Incompetence

Traditionally the Board has imposed limitations on practice and other remedial means to address incompetence when the licensee appears cooperative. When a person does not appear to have the skills or the desire to remediate deficiencies, or when the public health and safety is in jeopardy, more severe disciplinary sanctions are necessary. An order imposing remedial steps that does not include limitation on or separation from practice is only appropriate when the practitioner acknowledges the deficiency and there are grounds to believe that the licensee will be able to overcome that deficiency.

In instances where the Board finds that the licensee appears to lack the skill or knowledge necessary to provide services in a practice area, the Board should consider seeking an evaluation of practice skills, and if deficiencies are discovered then it may serve as a basis for remedial steps.

When the Board finds that the licensee lacks the skill or knowledge in a specific practice area so that further evaluation is not needed and that the licensee is otherwise generally competent, separating the licensee from the practice area of deficiency should be imposed until the licensee can demonstrate competency. Some authority to provide services might be appropriate under supervision during the learning process.

A licensee that is found to lack general skill or knowledge should be removed from practice until that skill and knowledge is regained. Some authority to provide services might be appropriate under supervision during the learning process.

If the licensee has the requisite knowledge and skill, but fails to use necessary professional judgment, the Board faces a more difficult task of remediation. Separation from practice, in whole or in part, might become necessary in order to prevent harm to patients.

b. Professional Incompetence of Supervised Persons

Practitioners generally may delegate to others the authority to provide professional services. The person to whom that authority is delegated might be licensed or registered in another health profession, or might have no credential at all. In a civil action for damages, a practitioner who delegates this authority to another person may be liable for damages resulting from the services performed by that other person, even though the practitioner did not personally engage in wrongdoing. In contrast, professional responsibility is not merely based upon vicarious liability. Rather, a licensee is subject to discipline for delegating inappropriately or for the failure to supervise adequately. Generally the disciplinary sanction for failing to delegate or supervise appropriately is punitive rather than remedial.

2. General Misconduct

Sanctioning Grid Categories:

- A. Misconduct - Potentially harmful to patients or other providers, or actually misleads board or is disruptive to board processes
- B. Misconduct - No likelihood for physical or emotional harm to patients but discredits profession or has potential to mislead the board or the public
- C. Misconduct - No likelihood of physical or emotional harm but may cause economic loss to patients
- D. Misconduct - parallel actions by other states or by facilities

Statutes:

- K.S.A. 65-2836(a) (Fraud in application for license)
- K.S.A. 65-2836(b) (Unprofessional, dishonorable, incompetent practice)
- K.S.A. 65-2836(f) (Violation of act, pharmacy or KDHE statutes or regulations)
- K.S.A. 65-2836(g) (Invading branch of healing arts without license)
- K.S.A. 65-2836(h) (Practice under false name)
- K.S.A. 65-2836(j) (Discipline by another state)
- K.S.A. 65-2836(k) (Violation of Board regulation or order)
- K.S.A. 65-2836(l) (Failure to report knowledge of violation)
- K.S.A. 65-2836(n) (Cheated on licensure exam)
- K.S.A. 65-2836(q) (Violated federal controlled substance law)
- K.S.A. 65-2836(r) (Failure to furnish Board information legally requested)
- K.S.A. 65-2836(s) (Sanctions by peer review group)
- K.S.A. 65-2836(t) (Failure to report discipline by other state or peer group)
- K.S.A. 65-2836(u) (Surrender of license or authority in another state or forum)
- K.S.A. 65-2836(v) (Failure to report surrender of license or authority)
- K.S.A. 65-2836(x) (Failure to report adverse judgment)
- K.S.A. 65-2836(aa) (Submitting fraudulent claim, bill or statement)
- K.S.A. 65-2837(b)(3) (Treating without patient consent)

- K.S.A. 65-2837(b)(9) (Wrongful participation in exclusion of licensee from medical staff)
- K.S.A. 65-2837(b)(6) (Betrayal of confidential information)
- K.S.A. 65-2837(b)(10) (Failure to effectuate advanced directive)
- K.S.A. 65-2837(b)(12) (Conduct likely to deceive or harm public)
- K.S.A. 65-2837(b)(15) (Allowing another to use license)
- K.S.A. 65-2837(b)(18) (Obtaining fee by fraud, deceit or misrepresentation)
- K.S.A. 65-2837(b)(21) (Performing tests, exams, services without legitimate purpose)
- K.S.A. 65-2837(b)(27) (Experimental treatments)
- K.S.A. 65-2837(b)(31) (Unlawful abortion of viable fetus)
- K.S.A. 65-2837(b)(32) (Billing for pathology labs not personally performed)

Comments

Misconduct is that which is recognized to be unsafe or improper by the ethical and competent members of the profession. The term also includes general conduct that is dishonorable or unprofessional and that is not addressed in other categories within these guidelines, and includes acts prohibited by policies expressed in legislation. Conduct is deemed misconduct because it fails to conform to the standards that are recognized as necessary for the public's protection. The essence of professionalism is embodied in the human qualities of integrity, respect and compassion. Professionalism includes altruism, accountability, excellence, duty, service, honor, integrity and respect for others. Misconduct which is corrupt, dishonest or unethical is reprehensible. Such misconduct not only potentially causes patient harm, but such misconduct also undermines the public perception of the profession. Discipline for such misconduct is generally punitive in nature.

3. Criminal Conduct

Sanctioning Grid Categories:

- A. Criminal conduct - Felony conviction
- B. Criminal conduct - conviction of Class A misdemeanor relating to professional practice; or crimes of dishonesty, against persons, moral turpitude
- C. Criminal conduct - conviction of Class A misdemeanor not related to professional practice, not against persons, and not a crime of dishonesty or moral turpitude

Statutes:

- K.S.A. 65-2836(c) (Conviction of felony or Class A Misdemeanor)
- K.S.A. 65-2836(cc) (Assisted suicide)
- K.S.A. 65-2837(b)(5) (Performing criminal abortion)

Comments

Conduct which is criminal, or is deemed criminal, may form the basis for imposing discipline against a licensee because such misconduct reflects upon the licensee's fitness and qualifications to practice in the healthcare field and detracts from the trust the public must be able to give healthcare professionals. A licensee who has exhibited dishonesty, poor moral character, a lack of integrity and/or an inability or unwillingness to follow the law has demonstrated an unfitness to practice and may be subject to discipline against his or her professional license. Honesty and

integrity are deeply ingrained in the practice of the various healthcare professions. This category of misconduct should be deemed serious because of its potential for public harm and the ill repute that it brings upon the profession as a whole. This type of conduct should be addressed with discipline that is intended to be punitive.

When a licensee has been convicted of a felony, in addition to the general aggravating and mitigating circumstances that apply to all categories of misconduct the Board must consider K.S.A. 65-2836(c). That section requires the Board to revoke or deny an application "unless a 2/3 majority of the board members present and voting determine by clear and convincing evidence that such licensee will not pose a threat to the public in such person's capacity as a licensee and that such person has been sufficiently rehabilitated to warrant the public trust."

4. Sexual Misconduct

Sanctioning Grid Categories:

- A. Sexual misconduct - abuse or exploitation of a patient or surrogate
- B. Sexual misconduct - impropriety involving patient or surrogate
- C. Sexual misconduct - sexual harassment associated with professional practice

Statute

K.S.A. 65-2836(b)(16) (Sexual abuse, misconduct or exploitation related to practice)

Comments

The Board has a zero-tolerance policy when sexual misconduct involves a minor. In all situations a finding of sexual misconduct involving minors and related to professional practice should result in revocation of a license. These guidelines and comments apply to sexual misconduct with adults.

The professional boundary required between physician and patient is based upon the fiduciary relationship in which the patient entrusts his or her welfare to the physician, reflects the physician's respect for the patient.¹ That boundary, once crossed, severely impacts the patient's wellbeing on an individual basis, and causes distrust to other professional relationships in general. Sexual misconduct is a harmful example of a boundary violation, occurring in multiple contexts and involving a wide range of behaviors. These guidelines cannot foresee all the possible scenarios of misconduct. Sexual misconduct includes sexual impropriety towards a patient, sexual conduct towards patients, sexual harassment in the workplace, facilitating a hostile work environment, sexual conduct between supervisors and subordinates, the commission of sexual assault and other sexual crimes.

Sexual misconduct can occur in circumstances involving two consenting adults. For instance, sexual conduct towards current patients is generally considered misconduct. Sexual conduct towards former patients is misconduct when the licensee exploits knowledge or information obtained from the previous physician-patient relationship. Sexual or romantic relationships between physicians and their patients may exploit the vulnerability of the patient and may

¹ Glen O. Gabbard, M.D. and Carol Nadelson, M.D., *Professional Boundaries in the Physician-Patient Relationship*, Journal of the American Medical Association, May 10, 1995; Vol. 273, No. 18, pg. 1445

obscure the physician's objective judgment concerning the patient's health care. Sexual misconduct between a physician and a patient is never diagnostic or therapeutic. Romantic or intimate relationships may impede the physician's ability to confront the patient about noncompliance with treatment or to bring up unpleasant medical information. Physicians must set aside their own needs or interests in the service of addressing the patient's needs. The physician-patient relationship depends upon the ability of the patient to have absolute confidence and trust in the physician, and a patient has the right to believe that a physician is dedicated solely to the patient's best interests.

Sexual impropriety may include, but not limited to, sexually suggestive behavior, gestures, expressions, statements, and it may include failing to respect a patient's privacy such as in the following examples:

- a.) failing to employ disrobing or draping practices that respect the patient's privacy;
- b.) examination or touching of a patient's genital region without donning gloves;
- c.) inappropriate comments to a patient about the patient's body, sexual orientation, or potential sexual performance during the examination;
- d.) soliciting a date or romantic relationship;
- e.) performing an intimate examination without clinical justification; and
- f.) requesting personal information from the patient not clinically indicated

Sexual conduct may include, but not limited to, physical contact such as:

- a.) genital to genital contact;
- b.) oral to genital contact;
- c.) anal to genital contact;
- d.) kissing;
- e.) touching breasts, genitals, or other body part without clinical justification;
- f.) encouraging patient to masturbate in presence of physician;
- g.) physician masturbation in presence of patient; and
- h.) offering clinical services or prescriptions in exchange for sexual favors.

Sexual harassment, sexual advances, requests for sexual favors and other verbal or physical conduct of a sexual nature is misconduct because of its potential to interfere with the licensee's work and/or creates a hostile work environment. Sexual relationships between supervisors and subordinates are concerning because of the inherent inequalities in the relationship and such relationships that may affect patient care.

This category of misconduct should be deemed serious because in addition to the potential for patient harm, such relationships erode the public's trust and confidence in the health care profession and damages the credibility of the healing arts professions. Upon a finding of sexual misconduct, the Board should take appropriate measures to impose a sanction and/or monitoring requirements that address the severity of the misconduct and the potential risk to patients.

In addition to the general aggravating and mitigating circumstances that apply to all categories of misconduct, the Board may consider the following factors:

- (1) Psychiatric, psychological, neurological or cognitive impairment and the severity of such;
- (2) Whether there were contributory factors (i.e. professional burnout leading to depression);

- (3) The licensee's opportunity and risk of re-offending;
- (4) The licensee's likelihood of successful rehabilitation;
- (5) The presence of compulsive sexual behavior;
- (6) The context in which the misconduct took place;
- (7) Patient consent may be taken into account in determining the appropriate discipline;
- (8) Degree of dependence in the physician-patient relationship;
- (9) Patient age (minor);
- (10) Vulnerability of patient;
- (11) Number of times misconduct occurred;
- (12) Number of patients involved;
- (13) The degree of exploitation;
- (14) Patient harm;
- (15) Duration of the professional relationship;
- (16) Nature of the medical services provided; and
- (17) Lapse of time between termination of physician-patient relationship and sexual involvement; and
- (18) Whether the practitioner had an impairment that was the cause of his actions.

Some examples of limitations that may be imposed upon a licensee's license when suggested by the sanctioning grid are as follows:

- a.) Requiring a supervisory physician;
- b.) Requiring a chaperone to be in attendance during the examination and/or treatment;
- c.) Limitations recommended by an evaluator;
- d.) Monitoring by the appropriate impaired provider program; and
- e.) Continuing education course in boundary issues.

5. Billing / Business Transactions

Sanctioning Grid Categories:

- A. Billing/Business Transactions - involving exploitation of patient or fraud of others
- B. Billing/Business Transactions - otherwise wrongful

Statutes and Regulations:

- K.S.A. 65-2837(b)(19) (Fee splitting)
- K.S.A. 65-2837(b)(22) (Excessive fee)
- K.S.A. 65-2837(b)(29) (Referring patients to entity in which licensee has significant ownership)
- K.A.R. 100-22-3 (Business transactions with patients)

Comments

Billing and business transactions with patients includes misconduct such as charging excessive fees for services, fee-splitting, failing to disclose to the patient a financial interest, and entering into business transactions with patients separate from the practice of the healing arts. Public policy dictates that a practitioner should not charge or collect an excessive fee. Public policy also prohibits fee splitting because the licensee's decision to provide, or not to provide, services may be influenced by the fact that he must split his fees. Such arrangements may also cause

non-licensed professionals to recommend the services of a particular licensee out of self-interest, rather than the actual competence of the licensee. It is believed that the public is best served by recommendations that are uninfluenced by financial considerations.

Additionally, engaging in the sale of non-health related goods by practitioners with their patients erodes the primary obligation of the practitioners to serve the interests of their patients above their own financial interests. The interest of the patient is paramount. Failure to perform these duties regarding patient care has the potential to cause patient harm.

Kansas case law prohibits the corporate practice of medicine. The core of that doctrine is that a general business entity may not engage in a learned profession, such as that of physicians, chiropractors, attorneys and dentists, either through employment of or by contract with one of those licensed professionals. Thus, Licensees are not allowed to form a general corporation (Inc.)(including "S" and "C" corporations) for the purpose of practicing their learned profession.

One exception to the corporate practice of medicine doctrine is when the entity is otherwise permitted by state statute to engage in the profession. For example, a hospital is licensed to provide medical services, and thus may employ physicians. Another exception applies to licensees who form professional associations or professional L.L.C.s which are owned by qualified persons. Qualified persons are those licensed to practice the professional services offered by the business entity.

A business entity organized as an incorporation (Inc.) that engages in the corporate practice of medicine may be found in violation of K.S.A. 65-2867, which prohibits a person other than one who is licensed under the healing arts act from opening and maintaining a location for the practice of the healing arts. The practitioner that is employed or contracts with an incorporation (Inc.) may be disciplined for violation of K.S.A. 65-2837(b)(19), "Directly or indirectly giving or receiving any fee, commission, rebate or other compensation for professional services not actually and personally rendered, other than through the legal functioning of lawful professional partnerships, corporations or associations." As such, a licensee may not split his or her fees for professional services rendered with a general incorporation (Inc.) or any other unlicensed person.

6. Advertising

Sanctioning Grid Category:

A. Advertising -involving false or prohibited statements, exploitation, economic injury, or giving false hope

Statutes and Regulations:

K.S.A. 65-2836(d) (Fraudulent or false advertising)

K.S.A. 65-2837(b)(1) (Fraudulent or false advertising)

K.S.A. 65-2837(b)(2) (Representing permanent cure for incurable disease or injury)

K.S.A. 65-2837(b)(4) (Falsely advertising entitlement to practice branch of healing arts)

K.S.A. 65-2837(b)(7) (Advertising professional superiority)

K.S.A. 65-2837(b)(8) (Advertising guarantee)

K.S.A. 65-2837(b)(13) (Misrepresenting skill of licensee or of treatment)
K.S.A. 65-2837(b)(17) (False, fraudulent or deceptive statement on a document)
K.S.A. 65-2885 (Use of title by licensee)
K.A.R. 100-22-4 (Description of specialty certification)
K.A.R. 100-18-1 (Free offers)

Comments

Advertising is commercial speech protected by the First Amendment. The constitution does not protect false, deceptive or misleading speech, such as representing false credentials, bait and switch advertising, or guarantees of a cure for a manifestly incurable disease. This constitutional protection does extend to puffing, which expresses an opinion that is not made as a representation of fact. When a licensee is found to have advertised using a factual representation that violates the statutes and regulations, the sanction should achieve correction, deterrence from future violations, and a punitive element.

Advertisements that are intended to give the public hope for a cure of an incurable disease; create unreasonable expectations; offer products, devices or services that have no scientific basis; or rely upon science or logic that is not consistent with the education and training of the profession for which the licensee is licensed tend to exploit patients, at a minimum cause financial injury, and potentially lead a person to forego more appropriate care thus leading to harm.

Advertisements that include factual representations that are not likely to lead a patient to physical or economic injury, but which reasonably might lead to confusion on the part of the public are less serious, but must be addressed to protect the public.

Inadvertent mistakes or omissions may be considered as mitigating factors.

7. Impairment / Fitness to Practice

Sanctioning Grid Categories:

- A. Impairment - Non-cooperative, unable to remediate
- B. Impairment - Appears remediable but disciplinary order needed
- C. Impairment - No disciplinary order needed

Statutes

K.S.A. 65-2836(e) (Impaired by alcohol or drugs)
K.S.A. 65-2836(i) (Inability to practice by reason of impairment)
K.S.A. 65-2836(o) (Mentally ill, disabled, not guilty based upon mental disease)

Comments

Impairments include drug abuse, alcohol abuse, and mental or physical conditions that impede the licensee's ability to practice with reasonable skill and safety. In addition to the general aggravating and mitigating circumstances that apply to all categories of misconduct, the Board

may also consider whether the practitioner has insight into the impairment. The Board has traditionally taken the view that a practitioner, who has sought help for impairment and has actively taken steps to adequately address the issue, is less of a concern than an impaired practitioner who refuses to seek help or take steps to address the problem. The goal is to facilitate efforts to rehabilitate those impaired. In the process of rehabilitation, measures including separation from practice are often necessary to protect the public.

In situations where the practitioner is cooperative and seeks rehabilitation, it is the policy of the Board that referral to a facility or organization for evaluation, treatment or monitoring regarding the impairment shall not be considered disciplinary action solely on the basis of a person being impaired. Board action based upon a finding of impairment shall not be considered a limitation constituting disciplinary action solely on the basis of an agreement between the Board and a person if the agreement imposes a condition or completion of some act unless the agreement constitutes a restriction upon the duration, extent, or scope of the full authority to practice the profession that the person would otherwise enjoy. When a licensee is found to be impaired and is not cooperative, or when uninterrupted practice endangers the public, then disciplinary action becomes necessary.

8. Administrative Requirements

Sanctioning Grid Categories:

- A. Administrative Requirements - Intentional or wanton, but not disruptive to regulation of the profession
- B. Administrative Requirements - Negligent failure to adhere

Statutes and Regulations:

- K.S.A. 65-2836(m) (Required disclosures for breast abnormality)
- K.S.A. 65-2836(y) (Failure to maintain liability insurance)
- K.S.A. 65-2836(z) (Failure to pay stabilization fund surcharges)
- K.A.R. 100-22-2 (Disclosure of professional activities for exempt license)
- K.A.R. 100-22-6 (Posting notice at practice location)

Comments

Violations of administrative requirements include conduct such as failure to maintain malpractice insurance and pay premium surcharges, failure to inform a patient in writing of abnormality in breast tissue for which surgery is the recommended treatment, failure to comply with the office based surgery regulations, failure to identify professional activities for exempt licenses and failure to post the prescribed notice to the public in the office. The level of sanctioning should depend upon the licensee's state of mind.

9. Inappropriate Prescribing

Sanctioning Grid Categories:

- A. Inappropriate Prescribing - no legitimate medical purpose
- B. Inappropriate Prescribing - willfully or negligently failed to follow requirements

Statutes and Regulations:

- K.S.A. 65-2836(p) (Controlled substances for other than medically accepted or lawful purpose)
- K.S.A. 65-2837(b)(11) (Amphetamine law)
- K.S.A. 65-2837(b)(23) (Excessive or improper or not in course of regular practice)
- K.S.A. 65-2837(b)(28) (Anabolic steroids or human growth hormone)
- K.S.A. 65-2837a (Amphetamine law)
- K.A.R. 100-22-8a (Lipodissolve)

Comments

Inappropriate Prescribing includes such misconduct as the failure to follow required procedures that have been established to ensure prescriptions are legitimate, prescribing to family or friends who suffer from addiction or misuse, diversion for self use, and criminal trafficking in dangerous drugs. This category of misconduct should be deemed serious because of its potential for public harm and its abuse of the unique privilege to prescribe drugs, including controlled substances. Allegations of inappropriate prescribing practices should be distinguished from proper pain management that follows the Board's pain management guidelines. Also, prescription orders that are believed to not meet the standard of care should be considered as professional incompetence unless there are specific facts that establish unethical or unlawful conduct.

In addition to the general aggravating circumstances that apply to all categories of misconduct, the Board should consider whether the misconduct resulted from the negligent failure to follow required procedures but otherwise occurred within lawful and ethical medical care, or whether the physician willfully failed to do so, or whether the physician prescribed outside of the legitimate physician-patient relationship.

10. Patient Records

Sanctioning Grid Categories:

- A. Patient Records - deceptively altered or intentionally failed to create documentation
- B. Patient Records - poor documentation, negligently failed to meet requirements
- C. Patient Records - fail to maintain confidentiality
- D. Patient Records - fail to disclose as required without just cause

Statutes and Regulations:

- K.S.A. 65-2837(b)(6) (Willful betrayal of confidential information)
- K.S.A. 65-2837(b)(20) (Failure to transfer records to another licensee)
- K.S.A. 65-2837(b)(25) (Failure to keep records)
- K.A.R. 100-22-1 (Failure to release records)

Comments

Failure to adequately maintain patient records includes misconduct such as the failure to adequately document evaluation and/or treatment of the patient, failure to adequately maintain or store the records, and failure to allow the patient or the patient's authorized representative access to the records. The purposes for maintaining patient records include: (1) to furnish documentary evidence of the patient's history, symptoms and treatment; (2) to serve as a basis for review, study and evaluation of the care rendered; (3) to ensure that the records provide meaningful health care information to other practitioners should the patient have his or her care transferred to another provider; and (4) to assist in protecting the legal interests of the patient, and responsible practitioner.

There is also a general policy in favor of allowing patients and/or their authorized representative access to the patient records. The interest of the patient is paramount. Failure to perform these duties regarding patient care has the potential to cause patient harm. In addition to the general aggravating and mitigating circumstances that apply to all categories of misconduct, the Board may also consider the pervasiveness of such misconduct with regard to the licensee's practice in determining the appropriate remedy.

Section III: Aggravating and Mitigating Factors - policy considerations

After it has been established that a violation has occurred, then the Board should consider the facts and circumstances unique to the case to determine whether the presumptive sanction is appropriate in light of any aggravating and/or mitigating factors. Aggravating factors may justify more restrictive or severe discipline. Mitigating factors may justify less severe or restrictive discipline. It is important to note that all factors will not necessarily be given equal weight.

Any of the following factors that the Board considers should be identified in the order, along with a general statement describing how the factor modifies the presumptive sanction:

Factors relevant to the misconduct committed:

- a.) Nature and gravity of the allegations;
- b.) Age or vulnerability of patient;
- c.) Capacity or vulnerability of patient or victim of licensee's misconduct;
- d.) Number/frequency of act;
- e.) Injury caused by misconduct;
- f.) Frequency of commission of acts;
- g.) Potential for injury ensuing from act;
- h.) Consensus about blameworthiness of conduct;
- i.) Abuse of trust;
- j.) Consent of patient;
- k.) Intentional vs. inadvertent;
- l.) Motivation of criminal, immoral, dishonest or personal gain; and
- m.) Length of time that has elapsed since misconduct.

Factors relevant to the licensee:

- a.) Age;
- b.) Experience in practice;
- c.) Past disciplinary record;
- d.) Previous character
- e.) Mental or physical health; and
- f.) Personal circumstances.

Factors relevant to the disciplinary process:

- a.) Admission of key facts;
- b.) Full and free disclosure to the Board;
- c.) Voluntary restitution or other actions taken to remedy the misconduct;
- d.) Bad faith obstruction of disciplinary process or proceedings;
- e.) False evidence, false statements, other deceptive practices during disciplinary process or proceedings;
- f.) Remorse and/or consciousness of wrongfulness of conduct;
- g.) Impact on patient; and
- h.) Public's perception of protection.

General aggravating and mitigating circumstances:

- a.) Licensee's knowledge, intent, degree of negligence;
- b.) Presence of other violations;
- c.) Present moral fitness of the petitioner;
- d.) Potential for successful rehabilitation;
- e.) Petitioner's present competence in medical skills;
- f.) Dishonest / Selfish motives;
- g.) Pattern of misconduct;
- h.) Illegal conduct;
- i.) Heinousness of actions;
- j.) Ill repute upon profession;
- k.) Personal problems (if there is a nexus to violation);
- l.) Emotional problems (if there is a nexus to violation);
- m.) Isolated incident unlikely to reoccur; and
- n.) Public's perception of protection

Section IV: Definitions

For the purposes of these guidelines, the following terms are defined as follows:

"Injury" - harm to a patient, the public, or the profession, which results from a licensee's acts or omissions.

"Potential for Injury" - harm to a patient, the public, or the profession that is reasonably foreseeable at the time of the licensee's acts or omissions, but for some intervening factor or event, would probably have resulted from the licensee's acts or omissions.

"Intent" - the conscious objective or purpose to accomplish a particular result.

"Knowledge" - the conscious awareness of the nature of the conduct, but without the conscious objective or purpose to accomplish a particular result.

"Negligence" - failure to exercise the standard of care that a reasonably prudent licensee would have exercised in a similar situation.

"Ordinary negligence" - the failure to use ordinary care in the licensee's practice.

"Gross negligence" - a conscious, wanton act or omission in reckless disregard for the foreseeable outcome.

"Inadvertence" - an accidental oversight through unintentional neglect.

Section V: Sanctioning Grid

Category of Offense	Description	Sanctioning Goals (In Order of Priority)	Presumed Sanction (Prior to Adjustment for Aggravating / Mitigating factors)	Presumed Sanction for Multiple Instances - Same category of offense * (Prior to Adjustment for Aggravating / Mitigating factors)	Range when Presumed Sanction is Modified by Aggravating / Mitigating Factors (Highest / Lowest)	Presumed Sanction as Modified for Prior Board Actions (Prior to Adjustment for Aggravating / Mitigating factors)
1A	Competency of Practice - Licensee; Lacks skill and judgment; gross negligence	1. Protect public/Remediate if possible; 2. Punish gross neg	30-89 day suspension, limitation, and probation	Revocation	Revocation / Probation	Revocation
1B	Competency of Practice - Licensee; willfully fails to exercise appropriate professional judgment or fails to utilize skill to a degree showing a lack of general competence	1. Protect public 2. Punish 3. Remediate	30-89 day suspension; limitation, and probation; and \$500 - \$2499 fine	Suspension > 90 days; limitation, and probation;	30-89 day suspension / Censure	Revocation
1C	Competency of Practice - Licensee; generally competent but negligently has failed to use skill or judgment	1. Punish 2. Rehabilitation	Probation and \$500 - \$2499 fine	Probation and \$2500-\$5000 fine	Revocation / Probation	Revocation
1D	Competency of Practice - Supervision- incompetent acts of supervised person; supervision is non-existent or is sham relationship; or potential for physical or emotional harm to patients	1. Protect Public 2. Punish	30-89 day suspension, probation or \$2500 - \$5000 fine	Suspension > 90 days, limitation, and probation	Revoke / \$500 - \$2499 Fine	Revocation

Category of Offense	Description	Sanctioning Goals) (In Order of Priority)	Presumed Sanction (Prior to Adjustment for Aggravating / Mitigating factors)	Presumed Sanction for Multiple Instances - Same category of offense * (Prior to Adjustment for Aggravating / Mitigating factors)	Range when Presumed Sanction is Modified by Aggravating / Mitigating Factors (Highest / Lowest)	Presumed Sanction as Modified for Prior Board Actions (Prior to Adjustment for Aggravating / Mitigating factors)
1E	Competency of Practice - Supervision - incompetent acts of supervised person; Fails to meet technical regulatory requirements	1. Protect Public 2. Punish	Censure and \$500 - \$2499 Fine	Suspension < 30 days and probation	Suspension > 90 days / \$500 - \$2499 fine or Censure	30-89 days suspension and probation
2A	Misconduct - Potentially harmful to patients or other providers, or actually misleads board or is disruptive to board processes	1. Protect Public; 2. Punish	30-89 day suspension	Suspension > 90 days; and \$2500 - \$5000 Fine	Revocation / \$500 - \$2499 Fine	Revocation
2B	Misconduct - No likelihood for physical or emotional harm to patients but discredits profession or has potential to mislead the board or the public	Punishment	30-89 day suspension and \$500 - \$2499 Fine	30-89 suspension and \$500 - \$2499 Fine	Suspension > 90 days and \$2500 - \$5000 Fine / Censure and Fine < \$500	Revocation
2C	Misconduct - No likelihood of physical or emotional harm but may cause economic loss to patients	Protect Public	1-29 day suspension; and Fine < \$500	1-29 day suspension; and Fine < \$500	30-89 day suspension and Fine < \$500 for each instance of conduct	Revocation
2D	Misconduct - parallel actions by other states or by facilities	1. Protect Public 2. Rehabilitate 3. Punish	Parallel other state sanction	Parallel other state sanction	Revocation / Fine < \$500	Parallel other state sanction

Category of Offense	Description	Sanctioning Goals) (In Order of Priority)	Presumed Sanction (Prior to Adjustment for Aggravating / Mitigating factors)	Presumed Sanction for Multiple Instances - Same category of offense * (Prior to Adjustment for Aggravating / Mitigating factors)	Range when Presumed Sanction is Modified by Aggravating / Mitigating Factors (Highest / Lowest)	Presumed Sanction as Modified for Prior Board Actions (Prior to Adjustment for Aggravating / Mitigating factors)
3A	Criminal conduct - Felony conviction	1. Protect Public 2. Punish	By statute: revocation	Revocation	Revocation / Censure	Revocation
3B	Criminal conduct - conviction of Class A misdemeanor relating to professional practice, or crimes of dishonesty, against persons, or moral turpitude	1. Protect Public 2. Punish	Suspension < 30 days and \$500 - \$2499 fine	30-89 day suspension; and \$2500 - \$5000 Fine	Revocation / \$500 - \$2499 Fine	Revocation
3C	Criminal conduct - conviction of Class A misdemeanor not related to professional practice, not against persons, and not a crime of dishonesty or moral turpitude	Punishment	\$500 - \$2499 Fine and Censure	30-89 day suspension	Suspension > 90 days / Censure	30-89 day suspension and \$500- \$2499 Fine
4A	Sexual misconduct - abuse or exploitation of a patient	1. Protect Public 2. Punish	Revocation	Revocation	Revocation / 90+ days suspension	Revocation
4B	Sexual misconduct - impropriety involving patient	1. Protect Public 2. Rehabilitate 3. Punish	30- 89 day suspension, limitation, and probation	Revocation	Revocation / Limitation and probation	Revocation
4C	Sexual misconduct - sexual harassment associated with professional practice	1. Protect Public 2. Rehabilitate 3. Punish	30-89 days suspension and probation	30-89 day suspension, probation, and \$2500 - \$5000 fine	Suspension > 90 days, probation, and \$1 - \$499 fine	Suspension > 90 days, probation and \$2500 - \$5000 fine

Category of Offense	Description	Sanctioning Goals) (In Order of Priority)	Presumed Sanction (Prior to Adjustment for Aggravating / Mitigating factors)	Presumed Sanction for Multiple Instances - Same category of offense * (Prior to Adjustment for Aggravating / Mitigating factors)	Range when Presumed Sanction is Modified by Aggravating / Mitigating Factors (Highest / Lowest)	Presumed Sanction as Modified for Prior Board Actions (Prior to Adjustment for Aggravating / Mitigating factors)
5A	Billing/Business Transactions - involving exploitation of patient or fraud of others	1. Protect Public 2. Punish	30 - 89 day suspension, probation, and \$500 - \$2499 fine	30-89 suspension and probation	Revocation / Probation	Suspension > 90 days, probation, and \$2500 - \$5000 fine
5B	Billing/Business Transactions - otherwise wrongful	1. Rehabilitate 2. Punish 3. Protect Public	1-29 day suspension; and \$500 - \$2499 Fine	30-89 day suspension and Fine < \$500 for each instance of conduct	Suspension > 90 days / Probation and Censure	Suspension > 90 days, probation, and \$2500 - \$5000 fine
6	Advertising - involving misleading, false or prohibited statements, exploitation, economic injury, or giving false hope	Protect Public	\$500 - \$5000 Fine and Censure	\$2500 - \$5000 fine for each instance of conduct and Censure	Suspension < 30 days / Censure	Suspension > 90 days and \$2500 - \$5000 Fine for each instance of conduct
7A	Impairment - non cooperative, unable to remediate	Protect Public	Suspension - indefinite and probation	Revoke / Suspension - Indefinite	Revoke / Suspension - Indefinite	Revocation
7B	Impairment - appears remediable but disciplinary order needed	1. Punish 2. Protect Public	Limitation and probation	N/A	Indefinite suspension / limitation, and probation	30-89 day suspension, limitation and probation
8A	Administrative Requirements - Intentional or wanton, potentially disruptive to regulation of the profession	Punishment	\$2500-\$5000 Fine and Censure	Suspension < 30 days and Fine < \$500 for each instance	30-89 day suspension; \$2500 - \$5000 Fine / Censure and Fine < \$500	Suspension > 90 days, limitation and probation

Category of Offense	Description	Sanctioning Goals) (In Order of Priority)	Presumed Sanction (Prior to Adjustment for Aggravating / Mitigating factors)	Presumed Sanction for Multiple Instances - Same category of offense * (Prior to Adjustment for Aggravating / Mitigating factors)	Range when Presumed Sanction is Modified by Aggravating / Mitigating Factors (Highest / Lowest)	Presumed Sanction as Modified for Prior Board Actions (Prior to Adjustment for Aggravating / Mitigating)
8B	Administrative Requirements - negligent failure to adhere	1. Punish 2. Rehabilitate	Fine < \$500 and Censure	\$500 - \$2499 Fine and Censure	Suspension < 30 days / Censure	Suspension < 30 days and Fine < \$500
9A	Inappropriate Prescribing - no legitimate medical purpose	1. Protect Public 2. Punish	Suspension > 90 days and \$2500 - \$5000 Fine	Suspension > 90 days, limitation, probation and \$2500 - \$5000 fine	Revocation / Suspension < 30 days	Revocation
9B	Inappropriate Prescribing - willfully or negligently failed to follow requirements	1. Rehabilitate 2. Protect Public	\$2500 - \$5000 Fine and Censure	\$2500 - \$5000 fine, limitation, and probation	30-89 days suspension; \$2500 - \$5000 Fine / Censure	30-89 day suspension, limitation and probation
10A	Patient Records - deceptively altered or intentionally failed to create documentation	1. Punish 2. Protect Public	30-89 day suspension and \$500 - \$2499 Fine	30-89 day suspension and \$2500 - \$5000 Fine for each instance	Revocation / \$2500 - \$5000 Fine for each instance	Revocation
10B	Patient Records - poor documentation, negligently failed to meet requirements	Rehabilitate	Probation and < \$500 fine	Probation and < \$500 fine for each instance	Suspension < 30 days and probation / Censure	30-89 days suspension and probation
10C	Patient Records - fail to maintain confidentiality	1. Protect Public 2. Punish	\$2500 - \$5000 fine and probation	Suspension < 30 days and probation	Suspension > 90 days and \$2500 - \$5000 Fine / Censure and Fine < \$500	Revocation
10D	Patient Records - fail to disclose as required without just cause	1. Protect Public 2. Punish	\$500 - \$2499	\$500 - \$2499	30-89 day suspension / Censure	30-89 day suspension and \$500- \$2499 Fine for each instance

Section VI: Adoption

Adoption of these Guidelines for the Imposition of Disciplinary Sanctions supersedes the following Policy Statement:

Policy Statement 01-01: Designation of Certain Agency Actions as Non-Disciplinary

The following Policy Statements are not superseded by adoption of these guidelines:

Policy Statement 04-01: "Guidelines for Imposing Fines Relating to Practice on a Cancelled License," as revised April 25, 2008

Policy Statement 05-04: "Guidelines for Imposing Penalties for Deficient Continuing Education Units Following Audit," as revised December 7, 2007

APPROVED by the Kansas State Board of Healing Arts this 26th day of AUGUST, 2008.


John D. Confer
Executive Director

**KANSAS BOARD OF HEALING ARTS
POLICY STATEMENT REGARDING
EXPERIMENTAL TREATMENTS**

I. PREAMBLE

This policy statement is intended to provide guidance to practitioners of the healing arts who provide experimental treatments to patients, the Board and its staff in evaluating complaints regarding experimental treatments, and the public regarding how the Board expects to evaluate complaints regarding experimental treatments. Reference to “treatment” is intended to encompass surgery, drugs, medical devices, diagnostic testing, techniques, procedures, therapies and modalities. Experimental treatments must be offered within guidelines that are designed to protect the public safety and dignity, and with the expectation that patients will be benefitted without undue risk.

It is important for practitioners to use an evidence based approach in providing treatment. Evidence based practices are consistent with the health, safety and welfare of the public. However, clinical research should be encouraged as practices thought of as experimental may subsequently be recognized to be safe and effective and deemed conventional. The Board adopts the following policy statements regarding the use of experimental treatments:

- A. A practitioner of the healing arts has a duty to patients to provide competent, ethical care.
- B. A practitioner of the healing arts must possess and be able to demonstrate a basic understanding of the scientific knowledge connected with any service the practitioner offers or uses in professional practice. A practitioner who does not possess that basic understanding is not professionally competent to offer or use the professional service.
- C. A practitioner is expected to exercise professional judgment resulting from the ethics, method and logic of the profession for which the practitioner is licensed.
- D. A practitioner of the healing arts is expected to offer a plan of care that represents the practitioner’s education, training, continued learning and own clinical experience.
- E. A practitioner may offer experimental treatments to patients if these guidelines are followed. If a practitioner conducts formal clinical trials or research under federal regulations and if those regulations are inconsistent with, or more stringent than these guidelines, those federal regulations must be applied.

II. EXPERIMENTAL TREATMENT GUIDELINES

A. Domain of Licensed Professional

1. Evidence-Based Professional Practice

Evidenced based professional practice is the conscientious and judicious use of current best evidence, integrating clinical proficiency and judgment with external clinical evidence derived from systematic research. Research should be based upon the science of the profession and reported in learned publications (see definition below). The practices and procedures used by licensees should be based on their academic and clinical training received through accredited schools with the use of current diagnostic and therapeutic techniques. A licensee is expected to offer a plan of care that represents the practitioner's education, training, continued learning and own clinical experience.

A licensee should possess and be able to demonstrate a basic understanding of the scientific knowledge connected with any service the licensee offers or uses in professional practice. A practitioner who does not possess that basic understanding may not be professionally competent to offer or use the service.

Off-label use of marketed drugs or devices is not experimental if use is supported by sound evidence and based upon firm scientific rationale and clinical judgment, the practitioner is well informed about the product, and records are maintained about the product's use and effects.

2. Experimental Services

a. If the answer to any of the following questions is yes, then the treatment in question is not experimental¹:

- i. Is it taught as an acceptable method or procedure as part of the core curriculum of an approved professional school? (methods or procedures taught as electives or at sales events and seminars are not necessarily the standard of care)
- ii. Is it taught as an acceptable method or procedure by an academic training institution in an approved post graduate program for the healing arts? (i.e. residency program)
- iii. Is it based upon sufficient learned publications supporting the safety and efficacy?

b. If the treatment is experimental, the Healing Arts Act, K.S.A. 65-2837(b)(27), requires proper informed patient consent, standard criteria or protocols, detailed legible records and periodic analysis of the study and results reviewed by a committee of peers.

- i. **Protocol** - Should contain the research objective or theory based on the scientific principles and thought processes of the particular profession. The protocol usually also includes the types of patients who may participate in the trial; the treatment protocols, research methodologies,

the measures to be used to monitor the safety and efficacy of the treatment, and the length of the study.

- ii. **Review by a Committee or Peers** – An independent review board (“IRB”) or other similarly neutral committee or peers.
- iii. **Informed Consent** – Informed consent requires the patient’s full appreciation and understanding of all of the material facts, including that the treatment is experimental. Should explain the research procedures and objectives, the risks, adverse reactions, benefits, other treatment options that are available, the role of the patient, and how the privacy of the patient’s medical records will be protected.
- iv. **Detailed Documentation** – The licensee must keep detailed documentation regarding the data specified in the research protocol. At a minimum this must include the information required by K.A.R. 100-24-1, it should also include a description of the treatment or a reference to the specific protocol, specific clinical results, adverse events reported, and peer review of the treatment.

B. Public Domain

A practitioner may treat a patient using procedures that are not within the exclusive scope for that profession or using products that may be purchased by patients without an order of a licensed professional. The treatment must be within the scope of the profession. Legitimate professional purpose for the treatment is required. The standard of care for the profession still applies regardless of unlicensed industry practices.

C. Impermissible Practices

Impermissible practices include quackery, treatments not based upon scientific principles, experimental treatments not pursued within these guidelines, and the use of a drug or medical device that cannot be lawfully marketed in the United States without the approval of the Food and Drug Administration when such approval has not been granted.

Some treatments that practitioners have offered to the public are not based upon the education, training, or professional logic and science of the branch of the healing arts for which the practitioners are licensed. Some of those services are experimental, while other practices might be viewed as quackery². The Board has previously disciplined licensees for the use of the treatments listed below because licensees either deviated from the standard of care of the profession, or they did not have sufficient scientific proof of the efficacy of the treatment. The following is not intended to be an inclusive list of experimental treatments, but are just some examples of treatments in past cases:

- Voice Command Medallion
- Colored light therapy
- Sound therapy

- Liver Flushes
- Nambudripad Allergy Elimination Technique (“NAET”)
- Bismacine

IV. DEFINITIONS

“Conventional practices” – those treatments taught in the core curriculum at approved professional schools, in approved post graduate training programs, or generally accepted as the standard of care.

“Evidence based practices” – scientifically proven evidence of the efficacy and safety of a drug, modality, treatment or procedure.

“Experimental treatments” - treatments that embody the scientific principles and thought processes of a particular profession with the expectation that patients will be benefitted without undue risk, but that have not been proven to be safe and effective.

“Learned publications” - published professional reports, articles, journals, treatises or text books meeting the following criteria:

- (1) authored by persons not financially interested by the conclusions of the literature;
- (2) reviewed and approved by the author’s peers;
- (3) based on scientific protocols; and
- (4) which the members of the branch of the healing arts for which the licensee is licensed generally accept as being authoritative.

“Off-label use” - a service provided for a purpose or in a manner not included in a product’s or device’s label or labeling as approved by the Food and Drug Administration or the Secretary of Health and Environment. Off-label use is not deemed experimental if it is (a) taught in an approved school for the branch of the healing arts for which the licensee is licensed, (b) generally accepted by the ethical and prudent members of the branch of the healing arts for which the licensee is licensed as being within the standard of care, or (c) based upon sufficient competent professional literature or other evidence of safety and efficacy.

“Quackery” – includes questionable, deceptive, fraudulent practices, or those based on unproven theories but not complying with these guidelines. Representations that a treatment can prevent, diagnose or cure, even when it is known that such representations are false and/or unproven.

Some statements often used to promote quackery include:

- i. Treatment based on unproven theory.
- ii. Treatment unrealistically promises a cure.
- iii. Discouragement from using conventional treatments.
- iv. The treatment is something only a limited number of people can give.
- v. Promoters of the treatment attack the medical or other established professions.

¹ Exception: the Kansas legislature has allowed patients to elect treatment of the cancer drug laetrile upon only the execution of informed consent which must contain all the information regarding the safety and effectiveness of laetrile. K.S.A. 65-6b02.

² *See, e.g.*, the matter involving John R. Brinkley, the infamous Kansas physician, who sought to restore manly vigor by surgically implanting goat glands. “[The state board of medical examiners alleged] that, being an empiric without moral sense, and having acted according to the ethical standards of an impostor, the licensee has perfected and organized charlatanism until it is capable of preying on human weakness, ignorance and credulity to an extent quite beyond the invention of the humble mountebank who has heretofore practiced his pretensions under the guise of practicing medicine and surgery. *Brinkley v. Hassig*, 130 Kan. 875 (1930).

APPROVED by the Kansas State Board of Healing Arts this 26th day of April, 2008.

Lawrence T. Buening, Jr.
Executive Director

KANSAS STATE BOARD OF HEALING ARTS

POLICY STATEMENT NO. 08-02

Subject: Cancellation of Licenses by Request
Date: February 22, 2008

Each license issued by the Board is valid until the occurrence of an event or time established by statute or until the expiration date established by the rules and regulations of the Board.

It is the policy of the Board that subject matter jurisdiction over each license should be retained for the full time allowed by law, and that a licensee should not be allowed to divest jurisdiction from the Board by early cancellation of a license. It is also the policy of the Board that requests for cancellation of a license by individuals who seek the cancellation for reasons that are legitimate and personal yet undisclosed should not be deemed as derogatory information. In furtherance of these policies, all requests for cancellation of licenses will not be given effect until the date that the license would otherwise be cancelled by operation of law. The license status shall at that time reflect cancellation by request.

This policy does not affect the ability of licensees who meet the requirements of K.S.A. 65-2809(g), to request that their license status be changed from active to inactive status between renewal cycles.

Adopted this 22 day of February 2008.

Kansas Board of Healing Arts



Betty McBride, Public Member
President

KANSAS STATE BOARD OF HEALING ARTS
Policy Statement No. 08-01

Subject: Hearing Officer Panel
Date: February 22, 2008

This policy is adopted to reduce the length time for completing the hearing process in cases which are appropriate for expedited adjudication. In furtherance of that policy, the Board adopts the following procedure:

(a) There is hereby created a standing panel of Board members, identified as the Hearing Officer Panel, who may be appointed as presiding officers in appropriate cases. The Hearing Officer Panel is comprised of no more than five Board members, one from each branch of the healing arts, a doctor of podiatry and a public member. The members of the Hearing Officer Panel serve a one year term beginning in the month of May and ending in April. A Board member may serve consecutive terms on the Hearing Officer Panel. The Board members serving on the Hearing Officer Panel shall not simultaneously serve on the Board's Disciplinary Panel.

(b) Only one member of the Hearing Officer Panel will be appointed as a presiding officer in a case. The Executive Director of the Board may appoint a member of the Hearing Officer Panel to preside over cases involving licensees of their respective profession, and may appoint the public member to preside over the cases involving all other professions.

(c) A member of the Hearing Officer Panel may be appointed in cases where a summary order has been issued and a licensee has requested a hearing. An appointment from the Hearing Officer Panel may also be appropriate in lieu of designating a Board member to approve or monitor the terms of a Consent Order authorized by the Board as a whole. It may be appropriate to appoint a presiding officer from the Hearing Officer Panel in other circumstances where no material facts are disputed.

(d) Appointment to the Hearing Officer Panel alone will not disqualify a Board member from participating in Board action on the matter. A member appointed as a presiding officer in a specific case shall withdraw from participation and shall not be present in discussions or during Board action on the matter, unless objection to his or her participation is waived by the parties.

(e) This policy statement does not prohibit or limit the Board's authority to appoint a presiding officer that is not serving on the Hearing Officer Panel to hear a case, to include the appointment of a presiding officer from the Kansas Department of Administration, Office of Administrative Hearings.

Adopted this 22 Day of February 2008.



Betty McBride, Public Member
President

KANSAS STATE BOARD OF HEALING ARTS

POLICY STATEMENT NO. 05-04

Subject: Guidelines for imposing penalties for deficient continuing education units (CEUs) following audit
Date: October 24, 2005; Revised December 7, 2007.

K.S.A. 65-2863a authorizes the Board to impose administrative fines and limitations for violations of the healing arts act. This policy is intended to address the Board's consideration of imposing disciplinary action against a licensee for reporting on their renewal that they have met their required number of CEUs and are subsequently unable to provide proof of completion when audited by the Board. The Board desires, in most cases, to follow a predictable and consistent pattern of imposing fines and penalties. The Board adopts this policy in an effort to treat all licensees fairly, imposing disciplinary orders that are in proportion to the scope of the violation.

This policy does not have the force and effect of law, and does not suggest any intent to create binding precedent in any case. By adopting this policy statement, the Board does not limit itself to any form of disciplinary order, and may depart from this policy as it desires and without giving notice. The fines suggested in this policy statement are in addition to, and not in lieu of, any other disciplinary order that the Board may impose in its discretion.

Non-healing arts licensees and registrants (PA, PT, PTA, OT, OTA, AT, ND, LRT, RT):

1st Offense: Licensee may be ordered to complete twice the number of deficient CEU hours within 90 days. Licensee may be fined \$250. Licensee's CEUs may be automatically audited for 5 years.

2nd Offense: Licensee may be ordered to complete twice the number of deficient CEU hours within 90 days. Licensee may be fined \$500 per deficient hour.

Healing arts licensees and podiatrists (MD, DO, DC, DPM):

1st Offense: Licensee may be ordered to complete twice the number of deficient CEU hours within 90 days. Licensee may be fined \$500. Licensee's CEUs may be automatically audited for 5 years.

2nd Offense: Licensee may be ordered to complete twice the number of deficient CEU hours within 90 days. Licensee may be fined \$500 per deficient hour.

This policy supercedes and replaces Policy Statement No. 05-04 dated October 24, 2005.

ADOPTED by the Kansas Board of Healing Arts this 7th day of December, 2007.


Betty McBride, Public Member
President

KANSAS STATE BOARD OF HEALING ARTS

POLICY STATEMENT NO. 06-04

Subject: Pain Patient's Quality of Care Act
Date: June 9, 2006

The Kansas Legislature authorizes the State Board of Healing Arts to adopt guidelines for managing pain. The Board has adopted and published those guidelines. The Legislature also authorizes the Board to render an opinion at the request of another regulatory or enforcement agency, or at the request of a licensee, indicating whether the licensee has prescribed, dispensed, administered or distributed controlled substances in accordance with the treatment of pain guidelines adopted by the Board. The following policies shall apply to all requests for opinions authorized by the Pain Patient's Quality of Care Act:

1. The final decision to render an opinion rests with the Board.
2. The Board intends its opinions to be for the purpose of assisting others to understand the Board's guidelines and to apply the guidelines in individual situations rather than for making final determinations that a licensee has violated a provision of law.
3. A request for an opinion shall be made in writing and bear the printed name and signature of the person requesting the opinion. The request shall be addressed to the Board's Executive Director.
4. No information from which a patient reasonably can be identified shall be included in the request.
5. The request must contain a complete statement of the patient's situation, the treatment, and an indication of the concerns or questions regarding the treatment.
6. A request from a licensee shall include a statement disclosing the licensee's knowledge of any investigation by a regulatory or law enforcement agency regarding the licensee's professional practice, or any litigation threatened, pending, or scheduled for determination in a court or regulatory agency. If the licensee has no knowledge of such investigation or litigation, the request shall so state.
7. Opinions of the Board are valid only after approval of the Board or its designee.
8. Requests for opinions and opinions rendered by the Board are deemed to be open public records.

Adopted by the State Board of Healing Arts this 12th Day of June, 2006.


Lawrence T. Buening, Jr.
Executive Director

KANSAS STATE BOARD OF HEALING ARTS

POLICY STATEMENT NO. 06-02

Subject: Continuing Education Credit
Date: April 8, 2006

Whereas, the Board of Healing Arts has adopted regulations requiring the completion of approved continuing education as a requirement for renewal of an active or federal active license to practice chiropractic; and

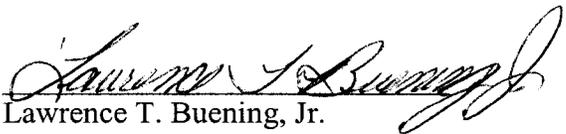
Whereas, the Board finds that the Federation of Chiropractic Licensing Boards (FCLB) recognizes continuing education providers and programs through its Providers of Approved Continuing Education - Chiropractic (PACE) system; and

Whereas, the Board finds that the PACE standards for approval adopted by the FCLB Board of Directors on December 22, 2005 are at least as stringent as the requirements for approval of a program of continuing education established by Board regulations.

NOW, THEREFORE, the Board will recognize a verification of completion of continuing education through PACE as documentation of completion of continuing education required by Board regulations.

APPROVED this 8th day of April, 2006

Kansas Board of Healing Arts



Lawrence T. Buening, Jr.
Executive Director

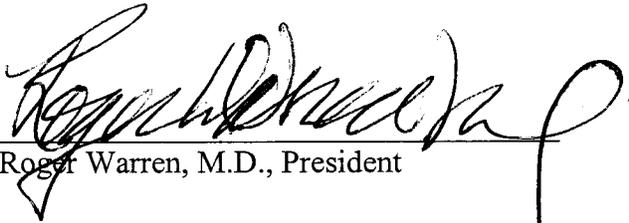
KANSAS STATE BOARD OF HEALING ARTS

POLICY STATEMENT NO. 06-01

Subject: Refund of Fees
Date: February 10, 2006

It is a general rule of the Board that no refund of fees paid for any license, registration, permit, certificate or any renewal thereof will be refunded following receipt of the application for such license, registration, permit, certificate or renewal form. However, if there is an extenuating situation regarding a refund, the Board as a whole will consider the matter.

Adopted by the Kansas Board of Healing Arts this 10th day of February, 2006.


Roger Warren, M.D., President

State of Kansas Workplace Violence Policy

The safety and security of State of Kansas employees and customers are very important. Threats, threatening behavior, acts of violence, or any related conduct which disrupts another's work performance or the organization's ability to execute its mission will not be tolerated.

Any person who makes threats, exhibits threatening behavior, or engages in violent acts on state-owned or leased property may be removed from the premises pending the outcome of an investigation. Threats, threatening behavior, or other acts of violence executed off state-owned or leased property but directed at state employees or members of the public while conducting official state business, is a violation of this policy. Off-site threats include but are not limited to threats made via the telephone, fax, electronic or conventional mail, or any other communication medium.

Violations of this policy will lead to disciplinary action that may include dismissal, arrest, and prosecution. In addition, if the source of such inappropriate behavior is a member of the public, the response may also include barring the person(s) from state-owned or leased premises, termination of business relationships with that individual, and/or prosecution of the person(s) involved.

Employees are responsible for notifying their agency human resource manager of any threats which they have witnessed, received, or have been told that another person has witnessed or received. Employees should also report any behavior they have witnessed which they regard as threatening or violent when that behavior is job related or might be carried out on state-owned or leased property or in connection with state employment.

Each employee who receives a protective or restraining order which lists state-owned or leased premises as a protected area is required to provide their agency human resource manager with a copy of such order.

KANSAS STATE BOARD OF HEALING ARTS

POLICY STATEMENT NO. 05-06

Subject: Election of Officers

Date: October 8, 2005

WHEREAS, the composition of the State Board of Healing Arts is established by statute and includes five members who hold a degree of doctor of medicine, three members who hold a degree of doctor of osteopathy, three members who hold a degree of doctor of chiropractic, one member who is a licensed podiatrist, and three members who are appointed to represent the general public, and

WHEREAS, the Healing Arts Act requires the Board to select a president and vice-president from its membership at the first meeting subsequent to July 1 of each year,

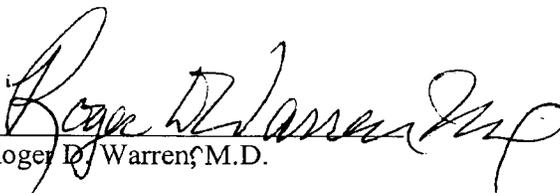
NOW THEREFORE, the Board determines that the election of officers should be guided by the following principles:

Each member of the Board should be considered qualified to hold the offices of president and vice-president;

Each profession and the general public should be considered equal in prominence when selecting officers; and

The Board should elect its officers by establishing a pattern of rotating offices among the three healing arts professions, podiatrists and public members.

The physicians, podiatrists and public members will become eligible to serve as officers after having served on the Board for two consecutive years.


Roger D. Warren, M.D.

KANSAS STATE BOARD OF HEALING ARTS

POLICY STATEMENT NO. 05-03

Subject: Continuing Education Credit

Date: August 13, 2005

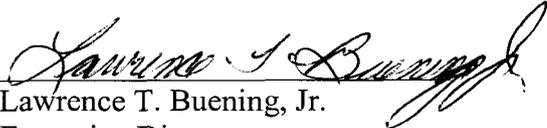
Following adoption of K.A.R. 100-15-4 through 100-15-7, and revocation of K.A.R. 100-15-2, all regulating continuing education as a requirement for renewal of a license to practice the healing arts, the Board of Healing Arts finds as follows:

1. The standards of the AOA, AMA-PRA and AAFP for approval of continuing education programs are at least as stringent as the requirements for approval of a program of continuing education established by Board regulations. As long as the standards of those organizations do not change, the Board will recognize a verification of completion of continuing education from one of those organizations as documentation of continuing education required by Board regulations.

2. Some licensees have previously obtained continuing education for future years. Medical doctors and osteopathic doctors may update their continuing education year for future years no later than upon renewal of a license expiring June 30, 2005 or upon renewal of the license expiring September 30, 2005. Licensees who are identified in Board records as having a continuing education year of 2006, 2007, 2008 or 2009 will not be required to obtain additional continuing education as a condition for renewing a license expiring in that continuing education year.

3. Doctors of chiropractic who, between January 1, 2004 and December 31, 2004, obtained sufficient continuing education credits to carry credits over to the license period ending December 31, 2005 will be allowed those credits.

Adopted by the Board August 13, 2005


Lawrence T. Buening, Jr.
Executive Director

KANSAS STATE BOARD OF HEALING ARTS

POLICY STATEMENT NO. 05-02

Subject: Use of Marijuana
Date: February 12, 2005

WHEREAS, the United States Supreme Court has ruled (May 14, 2001) that the controlled Substances Act may not be violated by the sale of marijuana for medicinal purposes;

WHEREAS, the Supreme Court further opined that there is no medical necessity exception to the Controlled Substances Act's prohibitions on manufacturing and distributing marijuana;

WHEREAS, the recommendation of crude (smoked) marijuana for cancer chemotherapy, glaucoma, wasting in AIDS, depression, menstrual cramps, pain, and miscellaneous ailments (by Grinspoon 1993) are anecdotal and contain no controls, and no independent medical evaluation for efficacy or toxicity; and

WHEREAS, the best evidence of the effects of crude (smoked) marijuana indicate medical dependence, the gateway phenomenon, respiratory problems, spontaneous abortions, congenital mental impairment, reduction of immune response, and impairment of performance in operating aircraft or automobiles.

THEREFORE, BE IT RESOLVED that the Kansas Board of Healing Arts finds that medical uses of marijuana should be those, and only those, approved by the federal Food and Drug Administration; and

BE IT FURTHER RESOLVED that the Kansas Board of Healing Arts forward this resolution to the Federation of State Medical Boards requesting that it formulate model regulations incorporating the Kansas initiative.


Ray N. Conley, D.C.
Board President

KANSAS STATE BOARD OF HEALING ARTS

POLICY STATEMENT NO. 05-01

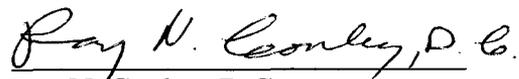
Subject: Paying for Records Subpoenaed from Non-Party Organizations
Date: February 12, 2005

When exercising its subpoena power, the Board frequently exercises the subpoena power established by K.S.A. 65-2839a, requesting documents and other materials from individuals and business entities that are not the subject matter of the investigation to which the subpoena is related. Production of materials by these non-party individuals and organizations imposes a number of costs, including wages for employees and costs of copying materials. Therefore, the Board will pay a reasonable fee when requested for the acquisition of these materials as follows:

1. The Board will pay non-party organizations \$.25 per page for copies produced.
2. The Board will pay the actual costs to copy x-rays and electronic images in an amount not to exceed \$15.00 per image page.
3. The Board will pay actual postage costs.
4. The Board will pay a \$10.00 administrative fee to a non-party organization when other costs exceed \$10.00.

The Executive Director may authorize the payment of costs that deviate from this policy on a case-by-case basis.

The Board does not pay the costs of complying with a subpoena that are incurred by a person who is the subject of the investigation to which the subpoena is related.


Ray N. Conley, D.C.
President

The following items (I, II, and III) were approved by the Board at their regularly scheduled Board Meeting on June 7, 2003:

MEMO

TO: All Board Members

FROM: Lawrence T. Buening, Jr.
Executive Director

DATE: June 6, 2003

RE: **Naturopathic Issues**

The Naturopathic Advisory Council met on Thursday, May 29, 2003. As provided by K.S.A. 65-7214, the Naturopathic Advisory Council is established to advise the Board in carrying out the provisions of the Naturopathic Doctor Registration Act. Recommendations by the Council for which Board action is requested are as follows:

I. Approval of Part I National Board of Chiropractic Examiners (NBCE) as equivalent to Part I of the Naturopathic Physicians Licensing Examination(NPLEX). The Council reviewed K.A.R. 100-72-5. This regulation provides that each applicant for registration as a naturopathic doctor shall pass a nationally administered, standardized examination that is approved by the Board and consists of written questions and practical questions assessing knowledge and proficiency on subject matter from the following content areas pertaining to basic sciences: anatomy, biochemistry, microbiology, pathology and physiology. The Council also reviewed the information provided on Part I of NBCE that provides that examination covers general anatomy, spinal anatomy, physiology, chemistry, pathology, and microbiology and public health. The Council asked that Mr. Stafford make inquiry of the National Association of Boards of Naturopathic Examiners (NABNE) that administers NPLEX to determine if that entity considers Part I of NBCE to be equivalent to Part I of NPLEX. Mr. Stafford has determined that NABNE allows individuals to waive Part I of NPLEX if they have passed either Step 1 of USMLE or Part I of NBCE within the last 10 years and the individual has been granted advanced standing at an accredited naturopathic college. However, we understand that this policy is still be debated and will be further discussed by NABNE at its meeting on August 12. Based upon the response of the NABNE, it is the Council recommendation that the Board approve Part I of NBCE as meeting the basic science requirement of K.A.R. 100-72-5.

II. Approval of Southwest College of Naturopathic Medicine & Health Sciences and the College of Naturopathic Medicine, University of Bridgeport.

The Council recommended that both of these programs meet the criteria for approval of programs in naturopathy established by K.A.R. 100-72-4 and that they be recognized by the Board as providing an approved educational program in naturopathy. As to the University of Bridgeport, the university is accredited by the New England Association of Schools and Colleges and has been so continuously since 1951. The College of Naturopathic Medicine at the University of Bridgeport has candidacy status with the Council on Naturopathic Medical Education since March 31, 2001. By granting candidacy status, CNME determined that Bridgeport is in substantial compliance with all its accreditation standards except the Standard on Research and the Standard on Continuing Education and Certificate Programs.

As to Southwest College, the Council determined that since 1999, many of its financial problems have been resolved. The Higher Learning Commission of the North Central Association of Colleges and Schools granted Southwest candidacy status on December 17, 2001. Fully accreditation of Southwest was granted by CNME in November 1999 and last reaffirmed March 2002.

III. Approval of Continuing Education.

The Council reviewed proposed K.A.R. 100-72-7 that will be submitted to the Board for adoption at a later date. The Council recommended that it be designated to approve and disapprove continuing education that occur in a professionally supervised setting. An appeal could still be taken to the Board as a whole whenever approval of a program has been denied by the Council.

KANSAS STATE BOARD OF HEALING ARTS

POLICY STATEMENT NO. 03-1

Subject: Performance of Manipulation by Doctors of Naturopathy
Date: February 15, 2003

Whereas, in the enactment of the naturopathic doctor registration act, K.S.A. 65-7201, *et seq.* the Kansas Legislature authorizes doctors of naturopathy to perform naturopathic musculoskeletal technique without defining that phrase; and

Whereas, the Kansas Legislature removed proposed language from the naturopathic doctor registration act that would have authorized doctors of naturopathy to perform naturopathic manipulation; and

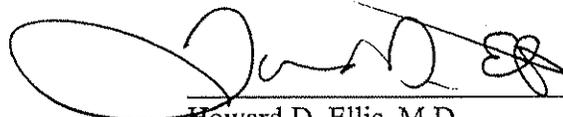
Whereas, questions have been addressed to the Board regarding the authority of doctors of naturopathy to perform manipulation; and

Whereas, individuals whom the Board registers as doctors of naturopathy should be informed of the Board's interpretation of the naturopathic doctor registration act;

Therefore, the Board adopts the following statement regarding the definition of naturopathic physical applications and the performance of manipulation, not as having the force and effect of law, but as indicating the Board's interpretation of the statutes establishing the scope of authority for doctors of naturopathy:

Doctors of naturopathy who are registered by the Board generally may independently perform physical treatments as taught in approved naturopathic schools. However, this general authority is limited to prohibit these registrants from performing manipulation as practiced by licensees of the healing arts. Registered doctors of naturopathy may not represent that the treatments are manipulation or the practice of the healing arts.

Dated this April, 3, 2003
~~day of February, 2003.~~



Howard D. Ellis, M.D.
President

GUIDELINES FOR OPIOID ADDICTION TREATMENT IN THE MEDICAL OFFICE

Section I: Preamble

The Kansas Board of Healing Arts recognizes that the prevalence of addiction to heroin and other opioids has risen sharply in the United States and that the residents of the State of Kansas should have access to modern, appropriate and effective addiction treatment. The appropriate application of up-to-date knowledge and treatment modalities can successfully treat patients who suffer from opioid addiction and reduce the morbidity, mortality and costs associated with opioid addiction, as well as public health problems such as HIV, HBV, HCV and other infectious diseases. The Board encourages all physicians to assess their patients for a history of substance abuse and potential opioid addiction. The Board has developed these guidelines in an effort to balance the need to expand treatment capacity for opioid addicted patients with the need to prevent the inappropriate, unwise, or illegal prescribing of opioids.

Until recently, physicians have been prohibited from prescribing and dispensing opioid medications in the treatment of opioid addiction, except within the confines of federally regulated opioid treatment programs. Because of the increasing number of opioid-addicted individuals and the associated public health problems, as well as the limited availability of addiction treatment programs, federal laws now enable qualified physicians to prescribe Schedule III-V medications approved by the Food and Drug Administration for office-based treatment of opioid addiction¹[1].

Physicians who consider office-based treatment of opioid addiction must be able to recognize the condition of drug or opioid addiction and be knowledgeable about the appropriate use of opioid agonist, antagonist, and partial agonist medications. Physicians must also demonstrate required qualifications as defined under and in accordance with the “Drug Addiction Treatment Act of 2000” (DATA) (Public Law 106-310, Title XXXV, Sections 3501 and 3502) and obtain a waiver from the Substance Abuse and Mental Health Services Administration (SAMHSA), as authorized by the Secretary of HHS. In order to qualify for a waiver, physicians must hold a current license in the State of Kansas and, at a minimum, meet one or more of the following conditions to be considered as qualified to treat opioid addicted patients in an office-based setting in this state:

- Subspecialty board certification in addiction psychiatry from the American Board of Medical Specialties
 - Subspecialty board certification in addiction medicine from the American Osteopathic Association
 - Addiction certification from the American Society of Addiction Medicine
 - Completion of not less than 8 hours of training related to the treatment and management of opioid-dependent patients provided by the American Society of Addiction Medicine, the American Academy of Addiction Psychiatry, the American Medical Association, the American Osteopathic Association, the American Psychiatric Association, or other organization approved by the board.
 - Participation as an investigator in one or more clinical trials leading to the approval of a narcotic drug in Schedule III, IV, or V or a combination of such drugs for treatment of
-

opioid addicted patients (must be evidenced by a statement submitted to the Secretary Health and Human Services by the sponsor of such approved drug).

- Additional qualification criteria may be added through legislative enactment.

In addition to the waiver, physicians must have a valid DEA registration number and a DEA identification number that specifically authorizes such office-based treatment.

The waiver to provide addiction treatment under DATA is granted by the Secretary of HHS, presumably through SAMHSA, no later than 45 days after receipt of the physician's written notification. Upon request from SAMHSA, the Attorney General, presumably through DEA, will automatically assign the physician an identification number that will be used with the physician's DEA registration number. However, if SAMHSA has not acted on the physician's request for a waiver by the end of this 45-day period, DEA will automatically assign the physician an identification number.

Furthermore, if a physician wishes to prescribe or dispense narcotic drugs for maintenance or detoxification treatment on an emergency basis in order to facilitate the treatment of an individual patient before the 45-day waiting period has elapsed, the physician must notify SAMHSA and the DEA of the physician's intent to provide such treatment.

The Board recognizes that new treatment modalities offer an alternative in the treatment of opioid addiction. Based on appropriate patient assessment and evaluation, it may be both feasible and desirable to provide office-based treatment of opioid addicted patients with Schedules III-V opioid medications approved for such use by the FDA and regulated in such use by Center for Substance Abuse Treatment (CSAT)/SAMHSA. Physicians are referred to the Buprenorphine Clinical Practice Guidelines, available at the CSAT/SAMHSA, Office of Pharmacologic and Alternative Therapies, Rockwall II, Room 7-222, 5515 Security Lane, 5600 Fishers Lane, Rockville, MD 20857 (301) 443-7614 or <http://www.samhsa.gov/centers/csat/opat.html>.

The medical recognition and management of opioid addiction should be based upon current knowledge and research and includes the use of both pharmaceutical and non-pharmaceutical modalities. Prior to initiating treatment, physicians should be knowledgeable about addiction treatment and all available pharmacologic treatment agents as well as available ancillary services to support both the physician and patient. In order to undertake treatment of opioid addicted patients, in accordance with these guidelines, physicians must demonstrate a capacity to refer patients for appropriate counseling and other ancillary services.

The Kansas State Board of Healing Arts is obligated under the laws of the State of Kansas to protect the public health and safety. The Board recognizes that inappropriate prescribing of controlled substances, including opioids, may lead to drug diversion and abuse by individuals who seek them for other than legitimate medical use. Physicians must be diligent in preventing the diversion of drugs for illegitimate and nonmedical uses.

Qualified physicians need not fear disciplinary action from the Board or other state regulatory or enforcement agency for appropriate prescribing, dispensing, or administering approved opioid drugs in Schedules III, IV, or V, or combinations thereof, for a legitimate medical purpose in the usual course of opioid addiction treatment. The Board will consider appropriate prescribing, ordering, administering, or dispensing of these medications for opioid addiction to be for a legitimate medical purpose if based on accepted scientific knowledge of the treatment of opioid addiction and in compliance with applicable state and federal law.

The Board will determine the appropriateness of prescribing based on the physician's overall treatment of the patient and on available documentation of treatment plans and outcomes. The goal is to document and treat the patient's addiction while effectively addressing other aspects of the patient's functioning, including physical, psychological, medical, social and work-related factors. The following guidelines are

not intended to define complete or best practice, but rather to communicate what the Board considers to be within the boundaries of accepted professional practice.

Section II: Guidelines

The Board has adopted the following guidelines when evaluating the documentation and treatment of opioid addiction under DATA:

- Compliance with Controlled Substances Laws and Regulations

Generally, to prescribe and dispense Schedules III-V opioid medications for the treatment of opioid addiction under DATA, the physician must be licensed in the state, have a valid DEA controlled substances registration and identification number, comply with federal and state regulations applicable to controlled substances, and have a current waiver issued by SAMHSA. To obtain this waiver, the physician must submit written notification to the Secretary of HHS of their intent to provide this treatment modality, certifying the physician's qualifications and listing his/her DEA registration number. SAMHSA will then notify DEA whether a waiver has been granted. If SAMHSA grants the physician a waiver, DEA will issue the qualifying physician an identification number. In addition to these requirements, the DATA limits the number of patients that a physician or a group practice is permitted to treat to 30. This numerical limitation may be changed by regulation in the future.

Physicians are specifically prohibited from delegating prescribing opioids for detoxification and/or maintenance treatment purposes to non-physicians. Physicians are referred to DEA regulations (21CFR, Part 1300 to end) and the DEA Physician's Manual www.deadiversion.usdoj.gov and (any relevant documents issued by the state medical board) for specific rules governing issuance of controlled substances prescriptions as well as applicable state regulations.

- Evaluation of the Patient

A recent, complete medical history and physical examination must be documented in the medical record. The medical record should document the nature of the patient's addiction(s), evaluate underlying or coexisting diseases or conditions, the effect on physical and psychological function, and history of substance abuse and any treatments therefor. The medical record should also document the suitability of the patient for office-based treatment based upon recognized diagnostic criteria.^{2[2]}

DSM-IV-TR Substance Dependence Criteria³

A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:

- tolerance, as defined by either of the following:
 - a need for markedly increased amounts of the substance to achieve intoxication or desired effect, or
 - markedly diminished effect with continued use of the same amount of the substance

^{2[2]} Buprenorphine Clinical Practice Guidelines, Table 3-1.

³ American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, 4th ed., Text Revision, Washington, D.C.

- withdrawal, as manifested by either of the following:
 - the characteristic withdrawal syndrome for the substance, or
 - the same (or closely related) substance is taken to relieve or avoid withdrawal symptoms
- the substance is often taken in larger amounts or over longer period than was intended
- there is a persistent desire or unsuccessful efforts to cut down or control substance use
- a great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple doctors or driving long distances), use the substance (e.g., chain-smoking), or recover from its effects
- important social, occupational, or recreational activities are given up or reduced because of substance use
- the substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g., current cocaine use despite recognition of cocaine-induced depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption)

- Treatment Plan

The written treatment plan should state objectives that will be used to determine treatment success, such as freedom from intoxication, improved physical function, psychosocial function, and compliance and should indicate if any further diagnostic evaluations are planned, as well as counseling, psychiatric management or other ancillary services. This plan should be reviewed periodically. After treatment begins, the physician should adjust drug therapy to the individual medical needs of each patient. Treatment goals, other treatment modalities or a rehabilitation program should be evaluated and discussed with the patient. If possible, every attempt should be made to involve significant others or immediate family members in the treatment process, with the patient's consent. The treatment plan should also contain contingencies for treatment failure (i.e., due to failure to comply with the treatment plan, abuse of other opioids, or evidence that the Schedules III-V medications are not being taken).

- Informed Consent and Agreement for Treatment

The physician should discuss the risks and benefits of the use of these approved opioid medications with the patient and, with appropriate consent of the patient, significant other(s), family members, or guardian. The patient should receive opioids from only one physician and/or one pharmacy when possible. The physician should employ the use of a written agreement between physician and patient addressing such issues as (1) alternative treatment options (2) regular toxicologic testing for drugs of abuse and therapeutic drug levels (if available and indicated) (3) number and frequency of all prescription refills and (4) reasons for which drug therapy may be discontinued (i.e. violation of agreement).

- Periodic Patient Evaluation

Patients should be seen at reasonable intervals (at least weekly during initial treatment) based upon the individual circumstance of the patient. Periodic assessment is necessary to determine compliance with the dosing regimen, effectiveness of treatment plan, and to assess how the patient is handling the prescribed medication. Once a stable dosage is achieved and urine (or other toxicologic) tests are free of illicit drugs, less frequent office visits may be initiated (monthly may be reasonable for patients on a stable dose of the prescribed medication(s) who are making progress toward treatment objectives). Continuation or modification of opioid therapy should depend on the physician's evaluation of progress toward stated treatment objectives such as (1) absence of toxicity (2) absence of medical or behavioral adverse effects (3)

responsible handling of medications (4) compliance with all elements of the treatment plan (including recovery-oriented activities, psychotherapy and/or other psychosocial modalities) and (5) abstinence from illicit drug use. If reasonable treatment goals are not being achieved, the physician should re-evaluate the appropriateness of continued treatment.

- **Consultation**

The physician should refer the patient as necessary for additional evaluation and treatment in order to achieve treatment objectives. The physician should pursue a team approach to the treatment of opioid addiction, including referral for counseling and other ancillary services. Ongoing communication between the physician and consultants is necessary to ensure appropriate compliance with the treatment plan. This may be included in the formal treatment agreement between the physician and patient. Special attention should be given to those patients who are at risk for misusing their medications and those whose living or work arrangements pose a risk for medication misuse or diversion. The management of addiction in patients with comorbid psychiatric disorders requires extra care, monitoring, documentation and consultation with or referral to a mental health professional.

- **Medical Records**

The prescribing physician should keep accurate and complete records to include (1) the medical history and physical examination; (2) diagnostic, therapeutic and laboratory results; (3) evaluations and consultations; (4) treatment objectives; (5) discussion of risks and benefits; (6) treatments; (7) medications (including date, type, dosage, and quantity prescribed and/or dispensed to each patient); (8) a physical inventory of all Schedules III, IV, and V controlled substances on hand that are dispensed by the physician in the course of maintenance or detoxification treatment of an individual; (9) instructions and agreements; and (10) periodic reviews. Records should remain current and be maintained in an accessible manner and readily available for review. The physician must adhere to the special confidentiality requirements of 42CFR, Part 2, which apply to the treatment of drug and alcohol addiction, including the prohibition against release of records or other information, except pursuant to a proper patient consent or court order in full compliance with 42CFR2, or the Federal or State officials listed in 42CFR2, or in cases of true medical emergency or for the mandatory reporting of child abuse.

Section III: Definitions

For the purposes of these guidelines, the following terms are defined as follows:

Addiction: A primary, chronic, neurobiologic disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include one or more of the following: impaired control over drug use, compulsive use, continued use despite harm and craving.

Agonists: Agonist drugs are substances that bind to the receptor and produce a response that is similar in effect to the natural ligand that would activate it. Full mu opioid agonists activate mu receptors, and increasing doses of full agonists produce increasing effects. Most opioids that are abused, such as morphine and heroin are full mu opioid agonists.

“Approved Schedule III-V Opioids”: Opioids referred to by the DATA, specifically approved by the FDA for treatment of opioid dependence or addiction.

Antagonists: Antagonists bind to but do not activate receptors. They prevent the receptor from being activated by an agonist compound. Examples of opioid antagonists are naltrexone and naloxone.

Maintenance Treatment: Maintenance treatment means the dispensing for a period in excess of 21 days of an opioid medication(s) at stable dosage levels in the treatment of an individual for dependence upon heroin or other morphine-like drugs.

Opioid Dependence: A maladaptive pattern of substance use, leading to clinically significant impairment or distress, manifested by 3 or more of the following, occurring at any time in the same 12-month period:

- A need for markedly increased amounts of the substance to achieve intoxication or desired effect or markedly diminished effect with continued use of the same amount of substance;
- The characteristic withdrawal syndrome for the substance or the same (or closely related) substance is taken to relieve or avoid withdrawal symptoms;
- The substance was taken in larger amounts or over a longer period of time than was intended;
- There is a persistent desire or unsuccessful efforts to cut down or control substance use;
- Significant time is spent on activities to obtain the substance, use the substance, or recover from its effects;
- Important social, occupational, or recreational activities are discontinued or reduced because of substance use;
- Substance use is continued despite knowledge of having a persistent physical or psychological problem that is caused or exacerbated by the substance.

Opioid Drug: Opioid drug means any drug having an addiction-forming or addiction-sustaining liability similar to morphine or being capable of conversion into a drug having such addiction-forming or addiction-sustaining liability. (This is referred to as an opiate in the Controlled Substances Act)

Opioid Treatment Program (OTP) (sometimes referred to as a methadone clinic or narcotic treatment program): Opioid treatment program means a licensed program or practitioner engaged in the treatment of opioid addicted patients with approved Scheduled II opioids (methadone and/or LAAM).

Partial Agonists: Partial agonists occupy and activate receptors. At low doses, like full agonists, increasing doses of the partial agonist produce increasing effects. However, unlike full agonists, the receptor-activation produced by a partial agonist reaches a plateau over which increasing doses do not produce an increasing effect. The plateau may have the effect of limiting the partial agonist's therapeutic activity as well as its toxicity. Buprenorphine is an example of a partial agonist.

Physical Dependence: A state of adaptation that is manifested by a drug class specific withdrawal syndrome that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug, and/or administration of an antagonist.

Qualified Physician: A physician, licensed in the State of Kansas who holds a current waiver issued by SAMHSA (as authorized by the Secretary HHS) and meets one or more of the conditions set forth in Section 1. In addition, a physician must have a valid DEA registration and identification number authorizing the physician to conduct office-based treatment.

Substance Abuse: A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one or more of the following, occurring within a 12-month period:

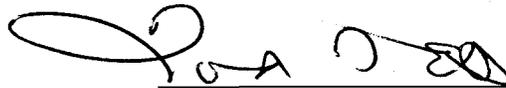
- Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home;
- Recurrent substance use in situations in which it is physically hazardous;
- Recurrent substance-related legal problems;

- Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance.

Tolerance: A state of adaptation in which exposure to a drug induces changes that result in diminution of one or more of the drug's effects over time.

Waiver: A documented authorization from the Secretary of HHS issued by SAMHSA under the DATA that exempts qualified physicians from the rules applied to OTPs. Implementation of the waiver includes possession of a valid DEA certificate with applicable suffix.

APPROVED by the Kansas State Board of Healing Arts this 14th day of December, 2002.

A handwritten signature in black ink, appearing to read "Howard D. Ellis", written over a horizontal line.

Howard D. Ellis, M.D.
President

Joint Policy Statement of the Boards of Healing Arts, Nursing and Pharmacy on the Use of Controlled Substances for the Treatment of Pain

Section I: Preamble

The Kansas Legislature created the Board of Healing Arts, the Board of Nursing, and the Board of Pharmacy to protect the public health, safety and welfare. Protection of the public necessitates reasonable regulation of health care providers who order, administer, or dispense drugs. The boards adopt this statement to help assure health care providers and patients and their families that it is the policy of this state to encourage competent comprehensive care for the treatment of pain. Guidelines by individual boards are appropriate to address issues related to particular professions.

The appropriate application of current knowledge and treatment modalities improves the quality of life for those patients who suffer from pain, and reduces the morbidity and costs associated with pain that is inappropriately treated. All health care providers who treat patients in pain, whether acute or chronic, and whether as a result of terminal illness or non-life-threatening injury or disease, should become knowledgeable about effective methods of pain treatment. The management of pain should include the use of both pharmacologic and non-pharmacologic modalities.

Inappropriate treatment of pain is a serious problem in the United States. Inappropriate treatment of pain includes nontreatment, undertreatment, overtreatment, and ineffective treatment. All persons who are experiencing pain should expect the appropriate assessment and management of pain while retaining the right to refuse treatment. A person's report of pain is the optimal standard upon which all pain management interventions are based. The goal of pain management is to reduce the individual's pain to the lowest level possible, while simultaneously increasing the individual's level of functioning to the greatest extent possible. The exact nature of these goals is determined jointly by the patient and the health care provider.

Prescribing, administering or dispensing controlled substances, including opioid analgesics, to treat pain is considered a legitimate medical purpose if based upon sound clinical grounds. Health care providers authorized by law to prescribe, administer or dispense drugs, including controlled substances, should recognize that tolerance and physical dependence are normal consequences of sustained use of opioid analgesics and are not synonymous with addiction.

A board is under a duty to make an inquiry when it receives information contending that a health care provider treated pain inappropriately. Proper investigation is necessary in order to obtain relevant information. A health care provider should not construe any request for information as a presumption of misconduct. Prior to the filing of any allegations, the results of the investigation will be evaluated by the health care provider's peers who are familiar with this policy statement. Health care providers who competently treat pain should not fear disciplinary action from their licensing board.

The following guidelines are not intended to define complete or best practice, but rather to communicate what the boards consider to be within the boundaries of professional practice. This policy statement is not intended to interfere with any healthcare provider's professional duty to exercise that degree of learning and skill ordinarily possessed by competent members of the healthcare provider's profession.

Section II: Principles

The boards approve the following principles when evaluating the use of controlled substances for pain control:

1. Assessment of the Patient

Pain should be assessed and reassessed as clinically indicated. Interdisciplinary communications regarding a patient's report of pain should include adoption of a standardized scale for assessing pain.

2. Treatment Plan

The written treatment plan should state objectives that will be used to determine treatment success, such as pain relief and improved physical and psychosocial function, and should indicate if any further diagnostic evaluations or other treatments are planned. After treatment begins, the drug therapy plan should be adjusted to the individual medical needs of each patient. The nurse's skill is best utilized when an order for drug administration uses dosage and frequency parameters that allow the nurse to adjust (titrate) medication dosage. Other treatment modalities or a rehabilitation program may be necessary depending on the etiology of the pain and the extent to which the pain is associated with physical and psychosocial impairment. If, in a healthcare provider's sound professional judgement, pain should not be treated as requested by the patient, the healthcare provider should inform the patient of the basis for the treatment decisions and document the substance of this communication.

3. Informed Consent

The physician retains the ultimate responsibility for obtaining informed consent to treatment from the patient. All health care providers share the role of effectively communicating with the patient so that the patient is apprised of the risks and benefits of using controlled substances to treat pain.

4. Agreement for Treatment of High-Risk Patients

If the patient is determined to be at high risk for medication abuse or to have a history of substance abuse, the health care provider should consider requiring a written agreement by the patient outlining patient responsibilities, including:

- Submitting to screening of urine/serum medication levels when requested;
- Limiting prescription refills only to a specified number and frequency;
- Requesting or receiving prescription orders from only one health care provider;
- Using only one pharmacy for filling prescriptions; and
- Acknowledging reasons for which the drug therapy may be discontinued (i.e., violation of agreement).

5. Periodic Review

At reasonable intervals based on the individual circumstances of the patient, the course of treatment and any new information about the etiology of the pain should be evaluated. Communication among health care providers is essential to review of the medical plan of care. The health care providers involved with the management of pain should evaluate progress toward meeting treatment objectives in light of improvement in patient's pain intensity and improved physical or psychosocial function, i.e., ability to work, need of health care resources, activities of daily living and quality of social life. If treatment goals are not being achieved despite medication adjustments, the health care provider's should reevaluate the appropriateness of continued treatment.

6. Consultation

The health care provider should be willing to refer the patient as necessary for additional evaluation and treatment in order to achieve treatment objectives. Special attention should be given to those pain patients who are at risk for misusing their medications and those whose living arrangement poses a risk for medication misuse or diversion. The management of pain in patients with a history of substance abuse or with a co-morbid psychiatric disorder may require extra care, monitoring, documentation and consultation with or referral to an expert in the management of such patients.

7. Medical Records

The medical record should document the nature and intensity of the pain and contain pertinent information concerning the patient's health history, including treatment for pain or other underlying or coexisting conditions. The medical record also should document the presence of one or more recognized medical indications for the use of a controlled substance.

8. Compliance With Controlled Substances Laws and Regulations

To prescribe, dispense or administer controlled substances within this state, the health care provider must be licensed according to the laws of this state and comply with applicable federal and state laws.

Section III: Definitions

For the purposes of these guidelines, the following terms are defined as follows:

Acute pain is the normal, predicted physiological response to an adverse chemical, thermal or mechanical stimulus and is associated with surgery, trauma and acute illness. It is generally time-limited and is responsive to opioid therapy, among other therapies.

Addiction is a neuro-behavioral syndrome with genetic and environmental influences that results in psychological dependence on the use of substances for their psychic effects and is characterized by compulsive use despite harm. Addiction may also be referred to as "psychological dependence." Physical dependence and tolerance are normal physiological consequences of extended opioid therapy for pain and should not be considered addiction. Addiction must be distinguished from pseudoaddiction, which is a pattern of drug-seeking behavior of pain patients who are receiving inadequate pain management that can be mistaken for addiction.

Analgesic tolerance is the need to increase the dose of opioid to achieve the same level of analgesia. Analgesic tolerance may or may not be evident during opioid treatment and does not equate with addiction.

Chronic pain is a pain state which is persistent beyond the usual course of an acute disease or a reasonable time for an injury to heal, or that is associated with a chronic pathologic process that causes continuous pain or pain that recurs at intervals for months or years.

Pain is an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage.

Physical dependence on a controlled substance is a physiologic state of neuro-adaptation which is characterized by the emergence of a withdrawal syndrome if drug use is stopped or decreased abruptly, or if an antagonist is administered. Physical dependence is an expected result of opioid use. Physical dependence, by itself, does not equate with addiction.

Substance abuse is the use of any substance(s) for non-therapeutic purposes or use of medication for purposes other than those for which it is prescribed.

Tolerance is a physiologic state resulting from regular use of a drug in which an increased dosage is needed to produce the same effect, or a reduced effect is observed with a constant dose.

APPROVALS

The foregoing Joint Policy Statement was approved, upon a motion duly made, seconded and adopted by a majority of the Kansas Board of Healing Arts, on the 1st day of June, 2002.

Lance E. Malmstrom, D.C.
President

The foregoing Joint Policy Statement was approved, upon a motion duly made, seconded and adopted by a majority of the Kansas Board of Nursing, on the 17th day of July, 2002.

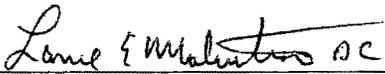
Karen Gilpin, R.N.
President.

The foregoing Joint Policy Statement was approved, upon a motion duly made, seconded and adopted by a majority of the Kansas Board of Pharmacy, on the 10th day of June, 2002.

Max Heidrick, RPh
President

APPROVALS

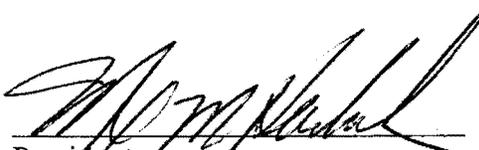
The foregoing Joint Policy Statement was approved, upon a motion duly made, seconded and adopted by a majority of the Kansas Board of Healing Arts, on the 1st day of JUNE, 2002.


President

The foregoing Joint Policy Statement was approved, upon a motion duly made, seconded and adopted by a majority of the Kansas Board of Nursing, on the 17th day of July, 2002.


President.

The foregoing Joint Policy Statement was approved, upon a motion duly made, seconded and adopted by a majority of the Kansas Board of Pharmacy, on the 10 day of June, 2002.


President

KANSAS STATE BOARD OF HEALING ARTS

POLICY STATEMENT NO. 02-1

Subject: Guidelines for Office-Based Surgery and Special Procedures
Date: October 12, 2002

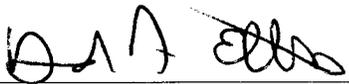
Whereas, there is growing concern nationwide that surgeries in non-hospital settings pose a threat to the safety of patients unless performed by qualified practitioners utilizing proper equipment, facilities, staff and procedures; and

Whereas, the Kansas Medical Society has convened a committee of experts among its membership to study methods of reducing the risk to patients undergoing office-based surgery; and

Whereas, the Kansas Medical Society House of Delegates approved the committee's Guidelines for Office-Based Surgery and Special Procedures; and

Whereas, the Board recognizes that guidelines for practitioners do not have the force and effect of state law, but if utilized by practitioners, guidelines do protect the public health, safety and welfare.

Therefore, the Board commends the work of the committee of the Kansas Medical Society, and approves the Guidelines for Office-Based Surgery and Special Procedures adopted by the House of Delegates May 5, 2002.



Howard D. Ellis, M.D.
President

Kansas Medical Society
Guidelines for Office-Based Surgery and Special Procedures

Approved by KMS House of Delegates May 5, 2002

Statement of Intent and Goals

The following are clinical guidelines for surgical and special procedures performed in physician offices and other clinical locations not otherwise regulated by the Kansas Department of Health and Environment (i.e. hospitals and ambulatory surgical centers licensed pursuant to K.S.A. 65-425). The purpose of these guidelines is to promote patient safety in the non-hospital setting, and to provide guidance to physicians who perform surgery and other special procedures which require anesthesia, analgesia or sedation in such settings. Included are recommendations for qualifications of physicians and staff, equipment, facilities, quality assurance, and policies and procedures for patient assessment and monitoring. These guidelines are not intended to establish a standard of care, and variation from these guidelines does not establish that a required standard of care was not met. Unless otherwise indicated, the terms in these guidelines have the meanings as they are defined in Appendix A.

These guidelines are applicable to any surgical or special procedure involving anesthesia levels which are greater than minimal sedation, local anesthesia in quantities greater than the manufacturer's recommended dose, adjusted for weight, or tumescent local anesthesia exceeding 7 mg/kg of lidocaine. These guidelines are not applicable to minor surgery. Any physician performing office-based surgery, regardless of the level of anesthesia required, should have the necessary equipment and personnel to be able to handle emergencies resulting from the procedure and/or anesthesia.

I. Personnel

- a. All health care personnel should have appropriate licensure or certification and necessary training, skills and supervision to deliver the services provided by the facility.
- b. Appropriate policies and procedures for oversight and supervision of non-physician personnel should be in place.

- c. At least one person should have training in advanced resuscitative techniques (e.g. ACLS or PALS, as appropriate), and should be immediately available to the patient and in the facility at all times until the patient is discharged from anesthesia care.

II. Facility and Safety

- a. Locations at which office-based surgery and special procedures are performed should comply with all applicable federal, state and local laws and regulations pertaining to fire prevention, building construction and occupancy, accommodations for the disabled, occupational safety and health, and disposal of medical waste and hazardous waste.
- b. Policies and procedures should comply with applicable laws and regulations pertaining to controlled drugs supply, storage, security and administration.
- c. Premises should be neat and clean. Sterilization of operating materials should be adequate.

III. Patient and Procedure Selection

- a. Procedures to be undertaken should be within the scope of practice of the health care personnel and within the capabilities of the location.
- b. The procedure should only be of a duration and complexity that can be safely undertaken, and which can reasonably be expected to be completed and the patient discharged during normal operational hours.
- c. The condition of the patient, specific morbidities that complicate operative and anesthetic management, the specific intrinsic risks involved, and the invasiveness of the planned procedure or combination of procedures should be considered in evaluating a patient for office-based surgery.
- d. Nothing relieves the surgeon or physician of the responsibility to make a medical determination of the proper surgical setting or forum, and particular care should be exercised in the evaluation of patients that are considered high risk.

IV. Perioperative Care

- a. Anesthesia services should be provided consistent with the "Essentials for Office-Based Anesthesia" as incorporated herein.
- b. The anesthesia provider should be physically present during the intraoperative period and should be available until the patient has been discharged from anesthesia care.
- c. Patients should be discharged only after meeting clinically appropriate criteria which includes the following factors: stable vital signs, responsiveness and orientation, ability to move voluntarily, reasonably controlled pain, and minimal nausea and vomiting.

V. Monitoring and Equipment

- a. All locations to which these guidelines apply should have a defibrillator, a positive pressure ventilation device, a reliable source of oxygen, suction, resuscitation equipment and emergency drugs; and emergency airway equipment including appropriate sized oral airways, endotracheal tubes, laryngoscopes and masks.
- b. Locations that provide general anesthesia should have medications and equipment available to treat malignant hyperthermia when triggering agents are used. At a minimum, such locations should maintain a supply of dantrolene sodium adequate to treat a patient until the patient's transfer to a hospital or other emergency facility can be effected. All such locations should also maintain tracheostomy and chest tube kits.
- c. There should be sufficient space to accommodate all necessary equipment and personnel and to allow for expeditious access to the patient, anesthesia machine and all monitoring equipment.
- d. All equipment should be maintained, tested and inspected according to the manufacturer's specifications.
- e. An appropriate back up energy source should be in place to ensure patient protection in the event of an emergency.
- f. In any location where anesthesia is administered, there should be appropriate anesthesia apparatus and equipment which allow monitoring in accordance with the criteria set forth in "Essentials for Office-Based Anesthesia" as incorporated herein.

VI. Emergencies and Transfers

- a. At a minimum, the location should have written protocols addressing emergency situations such as medical emergencies and internal and external disasters such as fire or power failures. Personnel should be appropriately trained in and regularly review all emergency protocols.
- b. The location should have written protocols in place for the timely and safe transfer to a pre-specified alternate care facility within a reasonable proximity when extended or emergency services are needed. The location should have a plan for transfer or a transfer agreement with a reasonably convenient hospital, or all physicians performing surgery in the location should have admitting privileges at such a hospital.

VII. Accreditation or licensure

- a. Accreditation by a nationally recognized accrediting agency is encouraged.
- b. Any location at which surgical or other special procedures requiring general anesthesia are performed is strongly encouraged either to be licensed as an ambulatory surgical center under K.S.A. 65-425, or accredited by a nationally recognized accrediting agency.

VIII. Quality Assurance and Peer Review

All locations at which surgical or special procedures subject to these guidelines are performed should establish an internal quality assurance/peer review committee (pursuant to K.S.A. 65-4915) for the purpose of evaluating and improving quality of care. The physician in charge of such location should report to the Kansas Medical Society Office Based Surgery Review Committee, on a quarterly basis, any incidents related to the performance of office-based surgery, special procedures or anesthesia which is a reportable incident or which results in the following quality indicators:

- a. death of the patient during the surgical or special procedure, or within 72 hours thereafter;
- b. transport of the patient to a hospital emergency department;
- c. unscheduled admission of the patient to a hospital within 72 hours of discharge, when such admission is related to the office-based surgery or special procedure;

- d. unplanned extension of the surgery or special procedure more than four (4) hours beyond the planned duration of the procedure being performed;
- e. an unplanned procedure to remove a foreign object remaining in the patient from a prior surgical or special procedure in that location;
- f. performance of wrong surgery, surgery on the wrong site, or surgery on the wrong patient; or
- g. unanticipated loss of function of a body part or sensory organ.

ESSENTIALS FOR OFFICE-BASED ANESTHESIA

Kansas Medical Society Guidelines for Office-Based Surgery and Special Procedures

These criteria and guidelines apply to any administration of anesthesia, including general, spinal, and managed intravenous anesthetics (i.e., local standby, monitored anesthesia or conscious sedation), administered in designated anesthetizing locations and any location where conscious sedation is performed. In emergency circumstances in any situation, appropriate life support measures take precedence and can be started with attention returning to these monitoring criteria as soon as possible and practical. These guidelines are intended to encourage quality patient care, but observing them cannot guarantee any specific patient outcome. In certain circumstances some of these monitoring methods may be clinically impractical, and appropriate use of the described monitoring methods may fail to detect untoward clinical developments. Brief interruptions of continual monitoring may be unavoidable. Under extenuating circumstances the physician may waive these criteria, and in such circumstances it should be so stated (including the reasons) in a note in the patient's medical record. These guidelines are not intended for application to the care of the obstetrical patient in labor or in the conduct of pain management.

1. An orderly preoperative anesthetic risk evaluation should be done by the responsible physician and recorded on the chart in all elective cases, and in urgent emergency cases, the anesthetic evaluations should be recorded as soon as feasible.
2. Every patient receiving general anesthesia, spinal anesthesia, or managed intravenous anesthesia (i.e., local standby, monitored anesthesia or conscious sedation), should have arterial blood pressure and heart rate measured and recorded at least every five minutes where not clinically impractical, in which case the responsible physician may waive this requirement stating the clinical circumstances and reasons in writing in the patient's chart.

3. Every patient should have the electrocardiogram continuously displayed from the induction and during maintenance of general anesthesia. In patients receiving managed intravenous anesthesia, electrocardiographic monitoring should be used in patients with significant cardiovascular disease as well as during procedures where dysrhythmias are anticipated.
4. During all anesthetics, other than local anesthesia and/or minimal sedation (anxiolysis), patient oxygenation should be continuously monitored with a pulse oximeter, and, whenever an endotracheal tube or Laryngeal Mask Airway (LMA) is inserted, correct positioning in the trachea and function should be monitored by end-tidal CO₂ analysis (capnography) throughout the time of placement.
 - a. Additional monitoring for ventilation should include palpation or observation of the reservoir breathing bag, and auscultation of breath sounds.
 - b. Additional monitoring for circulation should include at least one of the following: Palpation of the pulse, auscultation of heart sounds, monitoring of a tracing of intra-arterial pressure, pulse plethysmography, or ultrasound peripheral pulse monitoring.
5. When ventilation is controlled by an automatic mechanical ventilator, there should be in continuous use a device that is capable of detecting disconnection of any component of the breathing system. The device should give an audible signal when its alarm threshold is exceeded.
6. During every administration of anesthesia using an anesthesia machine, the concentration of oxygen in the patient's breathing system should be measured by a functioning oxygen analyzer with low concentration audible limit alarm in use.

7. During every administration of general anesthesia, there should be readily available a means to measure the patient's temperature.

8. Qualified trained personnel dedicated solely to patient monitoring should be available.

APPENDIX A

Kansas Medical Society Guidelines for Office-Based Surgery and Special Procedures and Essentials for Office-Based Anesthesia

Definitions

“**Conscious sedation**” means a minimally depressed level of consciousness that retains the patient’s ability to maintain adequate cardiorespiratory function and the ability to independently and continuously maintain an open airway, a regular breathing pattern, protective reflexes and respond purposefully and rationally to tactile stimulation and verbal command. This does not include oral preoperative medications or nitrous oxide analgesia.

“**General anesthesia**” means the administration of a drug or drugs which results in a controlled state of unconsciousness accompanied by a loss of protective reflexes including loss of ability to independently and continuously maintain patent airway and a regular breathing pattern. There is also an inability to respond purposefully to verbal command and/or tactile stimulation.

“**Local anesthesia**” means the administration of an anesthetic agent into a localized part of the human body by topical application or local infiltration in close proximity to a nerve, which produces a transient and reversible loss of sensation.

“**Minimal sedation (anxiolysis)**” means the administration of oral sedative or oral analgesic drugs in doses appropriate for the unsupervised treatment of insomnia, anxiety or pain.

“**Minor surgery**” means surgery which can be safely and comfortably performed on a patient who has received local or topical anesthesia, without more than minimal sedation and where the likelihood of complications requiring hospitalization is remote.

“**Office-based surgery**” means any surgical or other special procedure requiring anesthesia,

analgesia or sedation which is performed by a physician in a clinical location other than a hospital or ambulatory surgical center licensed by the Kansas Department of Health and Environment, and which results in a patient stay of less than 24 hours.

“Physician” means a person licensed to practice medicine and surgery or osteopathic medicine and surgery in the state of Kansas.

“Reportable incident” means an act by a physician or other health care provider which is or may be below the applicable standard of care and has a reasonable probability of causing injury to a patient, or may be grounds for disciplinary action by the appropriate licensing agency.

“Special procedure” means a patient care service which requires contact with the human body with or without instruments in a potentially painful manner, for a diagnostic or therapeutic procedure requiring anesthesia services (i.e., diagnostic or therapeutic endoscopy; invasive radiologic procedures; manipulation under anesthesia, or endoscopic examination).

“Surgery” means a manual or operative procedure which involves the excision or resection, partial or complete, destruction, incision or other structural alteration of human tissue by any means, including the use of lasers, performed upon the human body for the purpose of preserving health, diagnosing or treating disease, repairing injury, correcting deformity or defects, prolonging life or relieving suffering, or for aesthetic, reconstructive or cosmetic purposes. Surgery includes, but is not limited to incision or curettage of tissue or an organ, suture or other repair of tissue or an organ, a closed or open reduction of a fracture, or extraction of tissue from the uterus, and insertion of natural or artificial implants.

“Topical anesthesia” means an anesthetic agent applied directly or by spray to the skin or mucous membranes, intended to produce a transient and reversible loss of sensation to a circumscribed area.

"Tumescent local anesthesia" means the induction of local anesthesia through the administration of large volumes of highly dilute lidocaine (not to exceed 55mg/kg), epinephrine (not to exceed 1.5 mg/liter), and sodium bicarbonate (not to exceed 10-15 meq/liter) in sterile saline solution by slow infiltration into subcutaneous fat. It does not include the concomitant administration of any sedatives, analgesics and/or hypnotic drugs at dosages that possess a significant risk of impairing the patient's ability to maintain adequate cardiorespiratory function and the ability to independently and continuously maintain an open airway, a regular breathing pattern, protective reflexes and respond purposefully to tactile stimulation and verbal command.

APPENDIX B

Kansas Medical Society Guidelines for Office-Based Surgery and Special Procedures Directory of Resource Organizations

I. Accrediting Organizations for Office-Based Surgery:

American Association for Accreditation of Ambulatory Surgery Facilities, Inc. (AAAASF)

1202 Allanson Rd.
Mundelein, IL 60060
phone: 888.545.5222
fax: 847.566.4580
www.aaaasf.org

Accreditation Association for Ambulatory Health Care, Inc. (AAAHC)

3201 Old Glenview Rd., Suite 300
Wilmette, IL 60091.2992
phone: 847.853.6060
fax: 847.853.9028
info@aaahc.org

American Osteopathic Association Healthcare Facilities Accreditation Program

142 East Ontario St.
Chicago, IL 60611
phone: 800.621.1773
fax: 312.202.8206
www.aoa-net.org

Institute for Medical Quality (IMQ)

221 Main Street, Suite 210
San Francisco, CA 94105
phone: 415.882.5151
fax: 415.882.5149
www.img.org

Joint Commission on Accreditation of Healthcare Organizations (JCAHO)

One Renaissance Blvd.
Oakbrook Terrace, IL 60181
phone: 630.792.5000
fax: 630.792.5005
www.jcaho.org

II. Other Resource Organizations

American Academy of Dermatology

930 N. Meacham Road
Schaumburg, IL 60168
phone 847.330.0230
fax: 847.330.0050
www.aad.org

American Academy of Facial Plastic and Reconstructive Surgery

310 S. Henry Street
Alexandria, VA 22314
phone 703.299.9291
fax 703.299.8898
www.facial-plastic-surgery.org

American Academy of Otolaryngology-Head and Neck Surgery

One Prince St.
Alexandria, VA 22314
phone 703.836.4444
fax 703.683.5100
www.entnet.org

American Association of Nurse Anesthetists

222 South Prospect Ave.
Park Ridge, IL 60068
phone 847.692.7050
fax 847.692.6968
www.aana.com

American College of Surgeons

633 North Saint Clair St.
Chicago, IL 60611
phone 312.202.5000
fax 312.202.5002
www.facs.org

American Society of Anesthesiologists

520 N. Northwest Highway
Park Ridge, IL 60068
phone 847.825.5586
fax 847.825.1692
www.ASAHQ.org

American Society for Aesthetic Plastic Surgery, Inc.

36 West 44th Street, Suite 630

New York, NY 10036

phone 212.921.0500

fax 212.921.0011

www.surgery.org

American Society for Dermatologic Surgery

930 North Meacham Road

Schaumburg, IL 60173

phone: 847.330.9830

fax: 847.330.1135

www.asds-net.org

American Society of Plastic Surgeons

444 East Algonquin Road

Arlington, Heights, IL 60005

phone 847.228.9900

fax 847.228.9432

www.plasticsurgery.org

American Gastroenterological Association

7910 Woodmont Ave., 7th Floor

Bethesda, MD 20814

phone 301.654.2055

fax 301.652.3890

www.gastro.org

Federation of State Medical Boards

400 Fuller Wiser Road, Suite 300

Euless, TX 76039

phone 817.868.4000

fax 817.868.4097

www.fsmb.org

KMS Office-Based Surgery Task Force

Roger Warren, MD, Hanover, (General Surgery), *Chairman*
Larry Anderson, MD, Wellington, (Family Practice)
Gary Baker, MD, Kansas City, (Plastic Surgery)
Howard Ellis, MD, Shawnee Mission, (OBGYN), Kansas State Board of Healing Arts
Thomas Faerber, MD, Shawnee Mission, (Maxillofacial Surgery)
Robert Gibbons, MD, Shawnee Mission, (Anesthesiology)
Jimmie Gleason, MD, Topeka, (OBGYN), KaMMCO
James Hamilton, MD, Topeka, (General Surgery)
David Hendrick, MD, Salina, (Otolaryngology)
Kevin Hoppock, MD, Wichita, (Family Practice)
Michael Hutchison, MD, Kansas City, KUMC, (Anesthesiology)
Frank Koranda, MD, Shawnee Mission, (Otolaryngology)
Alan Kruckemeyer, MD, Salina, (Orthopedic Surgery)
Ron Marek, DO, (Family Practice), Kansas Association of Osteopathic Medicine
Mark McCune, MD, Shawnee Mission, (Dermatology), Kansas State Board of Healing Arts
Christopher Moeller, MD, Wichita, (Dermatology)
Katie Rhoads, MD, Olathe, (General Surgery)
Robert Ricci, MD, Topeka, (Gastroenterology)
David Ross, MD, Arkansas City (Family Practice), KaMMCO
Harl Stump, MD, Hays, (General Surgery)
Kim Templeton, MD, Kansas City, KUMC, (Orthopedic Surgery)

REPORT OF THE SPECIAL COMMITTEE ON OUTPATIENT (OFFICE-BASED) SURGERY

Executive Summary

The Federation of State Medical Boards is a national non-profit organization whose membership includes all medical licensing and disciplinary boards in the United States and its territories. The Federation acts as a collective voice for its 70 member medical boards in promoting high standards for medical licensure and practice. At the Federation's April 2001 Annual Meeting, a resolution was presented by the Arizona Board of Osteopathic Examiners in Medicine and Surgery and approved by the House of Delegates requesting that the Federation establish a committee to evaluate problems associated with outpatient surgery and make recommendations as to the best method of regulating such practices.

In response, a Special Committee was appointed by Federation President George J. Van Komen, MD, in April 2001 and charged to develop recommendations to assist state medical boards in oversight of unregulated office-based surgery and educate licensees as to appropriate standards for office-based surgery. Special Committee members were carefully selected to represent physicians practicing outpatient surgery in regulated and unregulated settings, state medical boards and the public. Robert del Junco, MD, was appointed to chair the committee.

The Committee acknowledged at the outset that outpatient surgery in many settings was already regulated by an array of state agencies and accrediting organizations; however, surgeries performed in office-based settings were increasing and were, in most states, currently unregulated. Proposing guidelines for oversight of office-based surgery (see "Definitions") would involve addressing a multitude of complicated issues beyond basic questions about facilities, equipment and appropriate procedures. In particular, the Committee was divided on whether to exclude specific minor surgery from the guidelines, but opted to leave the issue of what threshold to apply in this regard up to the discretion of individual medical boards.

At its initial meeting in June 2001, the Committee reviewed statistics verifying the growing number of surgical procedures being performed in physicians' offices; surveyed existing state policies, regulations and statutes relating to office-based surgery; reviewed accreditation requirements from recognized accreditation organizations; and examined standards and guidelines relating to outpatient/office-based surgery from several medical professional groups.

Prior to the second meeting of the Committee in August 2001, the Committee reviewed materials from a number of outside entities, including the American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Accreditation Association for Ambulatory Health Care, Inc. (AAAHC), the Institute for Medical Quality (IMQ), the American Society of Anesthesiologists (ASA), the American Association of Nurse Anesthetists (AANA), the American College of Surgeons (ACS), the American Academy of Dermatology (AAD), the American Medical Association (AMA), the American Osteopathic Association (AOA), the Anesthesia Patient Safety Foundation (APSF) and the Health Care Financing Administration (HCFA). The Committee agreed unanimously that input from these and other organizations was critical to successful completion of the committee charge and the ultimate acceptance of its recommendations by policymakers, regulators and practitioners.

At the August meeting, the Special Committee drafted model guidelines and identified three pathways that state medical boards can adopt separately or in combination for oversight of office-based surgery in unregulated settings. The three pathways are:

- Adoption of FSMB Model Guidelines
- Requiring accreditation by a recognized national or state accrediting organization
- Development of individual state standards

A state medical board following the first pathway would adopt the model guidelines recommended in the Special Committee report. These model guidelines are not intended to be all-inclusive, but outline basic policies and procedures that should be in place to ensure public protection in office-based surgery settings. The guidelines are divided into four sections: Administration, Quality of Care, Clinical, and Miscellaneous.

Section	Issues Addressed
---------	------------------

1. Administration	Governance Patients' Rights
2. Quality of Care	Personnel Credentialing Patient Evaluation Informed Consent Medical Records Discharge Emergency & Transfer Protocols Reporting Requirements Peer Review
3. Clinical	Anesthesia Monitoring Surgical Services Ancillary Services Facilities and Equipment
4. Miscellaneous	Liposuction Laser Surgery Advertising

The second pathway provides for accreditation by a nationally recognized accrediting organization in lieu of, or in conjunction with, specific state standards. Under the third pathway, a state could adopt individualized standards.

After a draft of the Special Committee Report was approved by the Federation Board of Directors in October 2001, the report was distributed to member medical boards and other interested parties with provisions for a 45-day comment period. Comments were considered by the Committee during two meetings in January 2002. At that time, the Committee agreed to name the report *The Report of the Special Committee on Outpatient (Office-based) Surgery*. A final draft was approved by the Board of Directors in February 2002 for adoption as Federation policy by the House of Delegates at the Federation Annual Meeting in April 2002.

Introduction and Charge

Before modern advances in anesthesia and medical technology, surgery was almost totally hospital-dependent.¹ As concerns about health care costs mounted during the 1970s, rapid advances in anesthesia, innovations in surgical techniques and technologic advances in equipment made surgery outside the hospital setting, or outpatient surgery, a more viable option for physicians and patients. A 1999 professional journal reported that, "In 1979, less than 10% of all surgeries were done as outpatient procedures. By 1987, almost 40% of 25 million operations done in America were done as outpatient procedures; by 1995, more than 50% were outpatient procedures. Currently, in the United States, more operations are done as outpatient (65%) than as inpatient (35%). It is estimated that, by the turn of the century, almost 70% of the anticipated 36 million operations performed in America will be done as outpatient procedures... It is estimated that 15% to 20% of all outpatient operations are being done as office-based surgeries."²

Ironically, as surgical procedures moved from hospitals to outpatient settings and subsequently to office-based settings, the logical transfer of the oversight function did not follow. While recognized national accrediting organizations accredit a large percentage of outpatient and ambulatory surgical centers today, most office-based surgery remains unregulated. Physician offices typically are not subject to the same state and federal licensing requirements as hospitals and other health care facilities, making it relatively easy to open an office-based surgical practice. In addition, some office-based procedures are not covered by health insurance plans and thus avoid another source of oversight afforded by third-party payers.

In the early 1990s, several untoward medical incidents in office-based surgery settings brought public attention to the lack of oversight and prompted Congressional hearings. Although the hearings highlighted the growing movement of surgical procedures to unregulated settings and exposed the unfortunate consequences of lack of oversight, no significant public policy changes emerged in response to the hearings. Surgery in office-based settings continued to increase through the mid-1990s when state governments began to discuss the need for standards to protect the public from inadequately trained practitioners, ill-equipped facilities, and preventable anesthesia-related incidents. Thus, patient safety emerged as the driving factor in seeking to set standards for office-based surgery.

Under the auspice of the FSMB, the Special Committee ~~1066~~ Outpatient (Office-based) Surgery was formed to develop recommendations to assist medical boards in the oversight of office-based surgery and to educate those physicians as to

appropriate standards of care. The Special Committee agreed that unregulated office-based settings should adhere to professional standards or accepted accrediting organization guidelines.

Pathways for the Oversight of Office-Based Surgery

The Special Committee on Outpatient (Office-based) Surgery has identified and recommends that state medical boards adopt (separately or in combination) the following three pathways for oversight of office-based surgery in currently unregulated settings:

- FSMB Model Guidelines;
- national accrediting organization standards; and/or
- individual state standards.

It is recommended that state medical boards consult with legal counsel prior to adopting guidelines, rules or regulations, national accreditation organization standards, individual states' standards or publishing a position statement. Such counsel is intended to assure that the board's action does not exceed its jurisdictional authority, restrict the practice of health care practitioners in a manner that is inconsistent with state law, or encroach upon the regulatory authority of other state health care regulatory authorities.

Section I. FSMB Model Guidelines

These guidelines are not all-inclusive, but outline the basic policies and procedures which physicians performing office-based surgery should have in place. The decision to mandate these policies is solely the decision of individual states. When adopting guidelines, state medical boards should establish by affirmative statement the threshold at which the guidelines will apply. Such a threshold may relate to the size of the practice, types of procedures performed, the level and type of anesthesia employed, and other practice-related specifications. Outpatient surgery facilities already regulated by a state agency are excluded from the guidelines.

1. Administration

Office-based surgical practices should be administered in a manner to ensure high-quality health services while recognizing basic patient rights.

1A. Governance. All office-based surgical practices should have policies describing organizational structure, including lines of authority, responsibilities, accountability and supervision of personnel. All such practices should have a medical director or governing body that establishes policy and is responsible for the activities of the facility and its staff. In solo practices, the physician may serve in this capacity. Administrative policies should be implemented so as to provide quality health care in a safe environment and ensure that the facility and personnel are adequate and appropriate for the type of procedures performed. Policies and procedures governing the orderly conduct of the facility should be in writing and should be reviewed annually. All applicable state and federal laws and regulations, local laws and codes must be observed.

1B. Patients' Rights. Patients should be treated with respect, consideration and dignity. The patient has the right to privacy and confidentiality. Patients, or a designated person when appropriate, should be provided information concerning the patient's diagnosis, evaluation, treatment options and prognosis. Patients should be given the opportunity to participate in decisions involving their health care when such participation is not contraindicated. Patients have the right to refuse any diagnostic procedure or treatment and be advised of the medical consequences of that refusal. Patients have the right to request information about a physician's professional liability coverage. Patients have a right to obtain a copy of their personal medical records. Facilities must comply with all state and federal statutes and regulations relating to patients' rights.

2. Quality of Care

Office-based surgical practices should develop a system of quality assessment that effectively and efficiently strives for continuous quality improvement.

2A. Personnel. All health care practitioners should have appropriate licensure or certification and the necessary training and skills to deliver the services provided by the facility. All personnel assisting in the provision of health care services must be appropriately trained, qualified and supervised and sufficient in number to provide appropriate care. Functional responsibilities of all health care practitioners and personnel should be defined and delineated. Policies and procedures for oversight of healthcare practitioners and personnel should be in place. Clinical information relevant to patient care should be kept confidential and secure. At least one person with training in advanced resuscitative techniques (e.g., ACLS or PALS) should be immediately available until all patients are discharged. All medical personnel, at a minimum, should maintain training in basic cardiopulmonary resuscitation.

2B. Credentialing. Credentials, including delineation of privileges, of all health care practitioners should be established by written policy, periodically verified and maintained on file.

2C. Patient Evaluation. A history and physical examination should be performed by the surgeon or his/her designee. The history should be current and reassessed by the surgeon on the day of the procedure. Pre-operative evaluation should consist of reviewing the patient history, conducting a physical exam, providing for diagnostic testing and specialist consultation, developing a plan of anesthesia care, acquainting the patient or the responsible adult with the proposed plan, and discussing the risks and benefits of the surgery and alternative methods or treatments. Intra-operative evaluation should include continuous clinical observation and vigilant anesthesia monitoring. At least one person with training in advanced resuscitative techniques (e.g., ACLS or PALS) should be immediately available until all patients are discharged. Careful consideration should be given prior to providing services to infants and children.

The condition of the patient, specific morbidities that complicate operative and anesthetic management, the specific intrinsic risks involved, and the invasiveness of the planned procedure should be considered in evaluating a patient for office-based surgery. Nothing relieves the surgeon of the responsibility to make a medical determination of the proper surgical forum.

2D. Informed Consent. Informed consent for the nature and objectives of the anesthesia planned and surgery to be performed should be in writing and obtained from patients before the procedure is performed. Informed consent should only be obtained after a discussion of the risks, benefits and alternatives and should be documented in the medical record.

2E. Medical Records. A legible, complete, comprehensive and accurate medical record must be maintained for each patient. A record should include a recent history, physical examination and any pertinent progress notes, operative reports, laboratory reports and X-ray reports, as well as communication with other medical personnel. Records should highlight allergies and untoward drug reactions. Specific policies should be established to address retention of active records, retirement of inactive records, timely entry of data in records and release of information contained in records. All information relevant to a patient should be readily available to authorized health care practitioners any time the office facility is open to patients or in the event that a patient is transferred due to surgical complications. Patient information should be treated as confidential and protected from loss, tampering, alteration, destruction and unauthorized or inadvertent disclosure. Records should be organized in a consistent manner that facilitates continuity of care. Discussions with patients concerning the necessity, appropriateness and risks of proposed surgery, as well as discussion of treatment alternatives, should be incorporated into a patient's medical record as well as documentation of executed informed consent.

2F. Discharge. Discharging patients is the responsibility of the surgeon and/or the individual responsible for anesthesia care and should only occur when patients have met specific physician-defined criteria. Such criteria should be in writing and include stable vital signs, responsiveness and orientation, ability to move voluntarily, controlled pain and minimal nausea and vomiting. Written instructions and an emergency phone number should be provided to the patient. If sedation, regional block, or general anesthesia has been used, patients must leave with a responsible adult who has been instructed with regard to the patient's care.

2G. Emergency & Transfer Protocols. Written policies must be in place to ensure necessary personnel, equipment and procedures to handle medical and other emergencies that may arise in connection with services provided. At a minimum, there should be written protocols for handling emergency situations, including medical emergencies and internal and external disasters.

All personnel should be appropriately trained in emergency protocols. Adequate equipment for cardiopulmonary resuscitation should be immediately available.

There should be written protocols in place for the timely and safe transfer of patients to a pre-specified alternate care facility within a reasonable proximity when extended or emergency services are needed. Protocols must include a written transfer agreement with a reasonably convenient hospital(s) or all physicians performing surgery should have admitting privileges at such facility.

2H. Reporting Requirements. Reporting should be structured in a manner to consistently encourage a free flow of information. A state agency should be designated to receive incident reports resulting from office-based surgery. Any incident following surgery or administration of anesthesia in an office-based setting that results in patient death within 30 days, unscheduled transport of patients to a hospital for observation or treatment for a period in excess of 24 hours, or unscheduled hospital admission of patients within 72 hours of discharge after office-based surgery should be required to be reported. Reporting requirements should be consistent with all relevant confidentiality laws and other regulations.

2I. Peer Review. Written procedures for credible peer review to determine the appropriateness of clinical decision-making and the overall quality of care should be established.

3. Clinical

Office-based surgery should be provided by qualified health care professionals in an environment that ensures patient safety.

3A. Anesthesia. The level of anesthesia used should be appropriate for the patient, the surgical procedure, the clinical setting, the education and training of the personnel and the equipment available. The choice of specific anesthesia agents and techniques should focus on providing an anesthetic that will be effective, appropriate and will respond to the specific needs of patients while also ensuring rapid recovery to normal function with maximum efforts to control post-operative pain, nausea or other side affects.

An individual administering anesthesia should be licensed, qualified and working within his/her scope of practice. In those cases in which a non-physician administers the anesthesia, the individual must be under the supervision of an anesthesiologist or the operating physician, unless state law permits otherwise.

All health care practitioners who administer anesthesia or supervise the administration of anesthesia should maintain current training in advanced resuscitation techniques (ACLS or PALS). Medical personnel, at a minimum, should maintain training in basic cardiopulmonary resuscitation.

The anesthesia provider should be physically present during the intra-operative period and be available until the patient has been discharged from anesthesia care. Procedures to be undertaken should be within the scope of practice of the health care practitioners and the capabilities of the facility. The procedure should be of a duration and degree of complexity that will permit patients to recover and be discharged in less than 24 hours or the maximum time allowed by state law, if applicable. Patients who have pre-existing medical or other conditions who may be at particular risk for complications should be referred to a facility appropriate for the procedure and the administration of anesthesia.

Patient care should be individualized according to patient needs and type of surgery performed. The health care practitioner administering the anesthesia, or supervising the administration should: perform a pre-anesthetic examination and evaluation, develop the anesthesia plan, assure that qualified practitioners participate; remain physically present or immediately available for diagnosis, treatment and management of anesthesia-related complications or emergencies; and assure provision of indicated post-anesthesia care. Patient assessment should occur throughout the pre-, peri-, and post-procedure phases. The assessment should address not only physical and functional status, but also physiological and cognitive status and should be documented in the medical record. The surgical procedure and anesthesia should be properly documented in

the medical record.

3B. Monitoring. Monitoring equipment should be appropriate for the type of anesthesia and nature of the facility. There should be sufficient space to accommodate all necessary equipment and personnel and to allow for expeditious access to patients and all monitoring equipment.

Continuous clinical observation and vigilance are the basis of safe anesthesia care. Physiologic monitoring of patients should be appropriate for the type of anesthesia and individual patient needs, including continuous monitoring or assessment of ventilation, oxygenation, cardiovascular status, body temperature, neuromuscular function and status and patient positioning.

At a minimum, provisions should be made for a reliable source of oxygen, suction, resuscitation equipment and emergency drugs. In locations where anesthesia is administered, there should be appropriate anesthesia apparatus and equipment to allow appropriate monitoring of patients. All equipment should be maintained, tested and inspected according to the manufacturer's specifications. Back-up power sufficient to ensure patient protection in the event of an emergency should be available.

When anesthesia services are provided to infants and children, the required equipment, medications and resuscitative capabilities should be appropriately sized for children.

3C. Surgical Services. Surgical procedures should be performed only by appropriate health care practitioners who are licensed in the state in which he/she is practicing. Procedures to be undertaken should be within the scope of practice, training and expertise of the health care practitioners and the capabilities of the facilities. The procedure should be of a duration and degree of complexity that will permit patients to recover and be discharged from the facility in less than 24 hours or the maximum time allowed by state law, if applicable. Patients who have pre-existing medical or other conditions that may be at particular risk for complications should be referred to an appropriate facility for the procedure and administration of anesthesia.

3D. Ancillary Services. Provisions should be made for appropriate ancillary services on site or in another predetermined location. Ancillary services should be provided in a safe and effective manner in accordance with accepted ethical professional practice and statutory requirements. These services include, but are not limited to, pharmacy, laboratory, pathology, radiology, occupational health and other associated services.

3E. Facilities & Equipment. All office-based surgical facilities must comply with applicable federal, state and local laws and codes and regulations. Provisions must be made to accommodate disabled individuals in compliance with the Americans with Disabilities Act of 1990 (42 USC 12101 et. seq.). The facility should be clean and properly maintained and have adequate lighting and ventilation. The space allocated for a particular function or service should be adequate for the activities performed. The facility should be equipped with the appropriate medical equipment, supplies and pharmacological agents which are required in order to provide anesthesia, recovery services, cardiopulmonary resuscitation and other emergency services. All equipment used in patient care, testing or emergency situations should be inspected, maintained and tested on a regular basis and according to manufacturers' specifications. The facility should have appropriate fire-fighting equipment, signage, emergency power capabilities and lighting, and an evacuation plan. The facility should have the necessary personnel, equipment, and procedures to handle medical and other emergencies that may arise in connection with services provided. Appropriate emergency equipment and supplies should be readily accessible to all patient service areas. Hazards that might lead to slipping, falling, electrical shock, burns, poisoning or other trauma should be eliminated.

Procedures should be implemented to minimize the sources and transmission of infections and maintain a sanitary environment. A system should be in place to identify, manage, handle, transport, treat and dispose of hazardous materials and wastes, whether solid, liquid or gas. Smoking is prohibited in surgical areas. The facility must comply with federal and state laws and regulations regarding protection of the health and safety of employees.

4. Miscellaneous

Issues relating to oversight of office-based surgery will evolve as new technologies and procedures affect public demand. Two current issues are liposuction and laser surgery for which national guidelines are currently under discussion. Specific

regulations relating to these issues should be defined by the individual medical boards along with protections from false, misleading, or deceptive information.

4A. Liposuction. Liposuction procedures should be performed by physicians with appropriate training following national professional guidelines. Procedures provided should be within the scope of practice of the health care practitioner and capabilities of the facility. Procedures should be of a duration and degree of complexity that will allow patients to be discharged from the facility within a reasonable time period. States should be advised that national guidelines for liposuction are still in an evolutionary phase. At the time of this report, the American Society for Dermatologic Surgery (ASDS), the American Academy of Dermatology (AAD), the American Society for Aesthetic Plastic Surgery (ASAPS) and the American Academy of Cosmetic Surgery/American Society of Liposuction Surgery have issued formal guidelines.

4B. Laser Surgery. Written policies and procedures should be established, including, but not limited to, laser safety, education and training. In those cases in which a non-physician performs laser surgery, the individual should be under the direct supervision of a licensed physician unless state law permits otherwise. Evidence of safety inspection and preventative maintenance for equipment should be current and available. Policies should ensure a safe environment for laser surgery.

4C. Advertising. No practitioner should disseminate or cause the dissemination of any advertisement or advertising which is in any way false, deceptive or misleading related to office-based surgery. False, deceptive or misleading advertising should be grounds for disciplinary action by the practitioner's regulatory board. The American Medical Association Council on Ethical and Judicial Affairs addressed physician advertising and publicity in their Opinion E-5.02, updated in 1996.

Section II. National Accrediting Organization Models

Accreditation is an evaluation process that examines the quality of services provided in a particular surgical setting or facility compared to nationally established standards assumed to be indicative of quality care. Accreditation is for a specific period of time. Several nationally recognized organizations accredit ambulatory/outpatient surgery facilities; such accreditation certifies that the facility meets the organization's national standards.

In requiring accreditation as a model, the state defers the setting of standards to accreditation organizations, thus avoiding the necessity for development of independent state standards. The accrediting organizations should be responsible to and receive permits for accreditation from the appropriate state agency. Thresholds for requiring accreditation should be established by the state agency. Accreditation organizations apply standards in a variety of ways. How standards are organized and described varies by organization; however, generally they address the same basic list of parameters addressed in other states by rule/regulation and/or statute. These parameters include those outlined in Section 1 (FSMB model).

A state should assess the types of unregulated outpatient surgery performed in their state and the types of surgical facilities being utilized in determining if requiring accreditation is a valid option.

Currently accreditation of outpatient surgery facilities is conducted by a number of recognized national and state accrediting bodies. (See *Directory of Organizations, Section VI)

Section III. Individualized State Regulatory Model

A number of national medical professional organizations, as well as the above-referenced national accrediting bodies, have published standards applicable to office-based surgery. State regulatory agencies may choose to adopt some combination of national medical professional organization standards, recommendations from this report, and national accrediting standards to construct an individualized state regulatory model.

Section IV. Definitions

Accreditation Organization

A public or private organization that is approved to issue certificates of accreditation to outpatient settings. Some nationally recognized accrediting agencies include: American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF), Accreditation Association for Ambulatory Health Care (AAAHC), the American Osteopathic Association

Healthcare Facilities Accreditation Program (HFAP) and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Ambulatory Surgery Center

Used in this report to mean a licensed and accredited freestanding or hospital-based facility with an organized professional staff that provides surgical services to patients who do not require an inpatient bed.

Deep Sedation/Analgesia

A drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients often require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.

General Anesthesia

A drug-induced loss of consciousness during which patients are not arousable even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive-pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.⁴

Health Care Practitioner

A physician, dentist, podiatrist or other licensed health care professional.

Minimal Sedation (Anxiolysis)

A drug-induced state during which a patient responds normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are usually not affected.⁵

Moderate Sedation/Analgesia (Conscious Sedation)

A drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are usually required to maintain a patent airway, and spontaneous ventilation is usually adequate. Cardiovascular function is usually maintained.⁶

Monitoring

The continual clinical observation of patients and the use of instruments to measure, display and record the values of certain physiologic variables such as pulse, oxygen saturation, level of consciousness, blood pressure and respiration.

Office-Based Surgery

Used in this report to describe surgery and other procedures performed in the office of a licensed physician.

Outpatient Surgery

A broad term used in this report to describe surgery performed in any regulated or unregulated free-standing or hospital-based facility, clinic or office that is organized for the purpose of providing care to patients with the expectation that they will not be admitted to the hospital.

Outpatient Surgery Facility

Used in this report to describe any facility, clinic, office, licensed ambulatory surgical center or hospital where outpatient surgery and/or other procedures are performed.

Physician

A doctor holding an MD or DO degree licensed to practice medicine.

Surgery

For the purposes of this report, surgery includes, but is not limited to, the excision or resection, partial or complete, destruction, incision or other structural alteration of human tissue by any means (including through the use of lasers) performed upon the body of a living human for the purpose of preserving health, diagnosing or curing disease, repairing injury, correcting deformity or defects, prolonging life, relieving suffering, or for aesthetic, reconstructive or cosmetic purposes, to include, but not limited to: incision or curettage of tissue or an organ; suture or other repair of tissue or organ, including a closed or an open reduction of a fracture; extraction of tissue, including premature extraction of the products of conception from the uterus; and, insertion of natural or artificial implants.

Section V. Bibliography

1. *Current Issues in Dermatologic Office-Based Surgery*, Joint American Academy of Dermatology/American Society of Dermatologic Surgery Liaison Committee, Journal of the American Academy of Dermatology, October 1999.
2. *Guidelines for Care for Office Surgical Facilities*, American Academy of Dermatology, Part I, 1992, Part II, 1995.
3. *Standards and Checklist for Accreditation of Ambulatory Surgery Facilities*, American Association for Accreditation of Ambulatory Surgical Facilities, 1997.
4. *AAAHC Accreditation Handbook for Ambulatory Health Care*, Accreditation Association for Ambulatory Health Care, 2001.
5. *Standards for Office-Based Anesthesia Practice*, American Association of Nurse Anesthetists, 2001.
6. *Guidelines for Optimal Ambulatory Surgical Care and Office-Based Surgery*, 3rd Edition, May 2000, American College of Surgeons, Board of Governors Committee on Ambulatory Surgical Care.
7. Board of Trustees Report 13-A-01, *Patient Safety in Office-Based Surgical Facilities and Standards of Care*, American Medical Association, Annual Meeting, July 2001.
8. Draft: *Policy Statement: Office-Based Surgery*, American Osteopathic Association, to be presented for AOA Board of Trustees approval, October 2001.
9. *Office-Based Anesthesia: Considerations for Anesthesiologists in Setting Up and Maintaining a Safe Office Anesthesia Environment*, American Society of Anesthesiologists, 2000.
10. *Guidelines for Office-Based Anesthesia*, American Society of Anesthesiologists, October 1999.
11. *Survey Procedures and Interpretive Guidelines for Ambulatory Surgical Services*, Health Care Financing Administration, State Operations Manual, Appendix L, Section Number 416.2, 416.40-416.49.
12. *The Institute for Medical Quality Accreditation Standards for Ambulatory Facilities*, Institute for Medical Quality, 2000 Edition.
13. *Accreditation Manual for Office-Based Surgery Practices*, Joint Commission on Accreditation of Healthcare Organizations, 2001.
14. Jon H. Sutton, Office-Based Surgery Regulation: Improving Patient Safety and Quality Care, *Bulletin of the American College of Surgeons*, Volume 86, Number 2, February 2001, p. 8-12.
15. Thea Graves Pellman, Office-Based Surgery and Public Safety: What are State Medical Boards Doing to Protect the Patient? *Journal of Medical Licensure and Discipline*, Volume 87, Number 2, 2001, p. 47-51.
16. Brett Coldiron, MD, Office-Based Surgery: What Evidence Shows, *Cosmetic Dermatology*, July 2001, p. 29-32.
17. The Data is In: hospital transfers and deaths reported from procedures performed in outpatient settings, Medical Board of California, *Action Report*, July 2001, p. 7.
18. Linda Wasmer Andrews, Office-Based Surgery - The Doctor is In, and More Boards are Watching, *Journal of Medical Licensure and Discipline*, Volume 87, Number 3, 2001, p. 99-103.
19. *Clinical Guidelines for Office-Based Surgery*, Committee on Quality Assurance in Office-Based Surgery, New York State Public Health Council, New York State Department of Health, December 2000.7
20. Sujit K. Pandit, MD, Ambulatory Anesthesia and Surgery in America: A Historical Background and Recent Innovations, *Journal of PeriAnesthesia Nursing*, Volume 14, Number 5, October 1999, p. 270-274.
21. James F. Arens, MD, Anesthesia for Office-Based Surgery: Are We Paying Too High a Price for Access and Convenience? Editorial, *Mayo Clinic Proceedings*, Volume 75, Number 3, March 2000, p. 225-227.
22. Margaret Jean Hall and Linda Lawrence, *Ambulatory Surgery in the United States*, 1996, U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics: Advance Data, Number 300, August 12, 1998.
23. *Guiding Principles for Liposuction*, American Society for Dermatologic Surgery, February 1997.
24. *Guidelines of Care for Liposuction*, American Academy of Dermatology, December 2000.
25. *2000 Liposuction Guidelines*, American Society of Liposuction/American Academy of Cosmetic Surgery, February 2000.
26. *Lipoplasty: Position Statement and Guidelines*, American Society for Aesthetic Plastic Surgery, July 2001.

Section VI. Directory of Organizations

<p>Accreditation Association for Ambulatory Health Care, Inc. * 3201 Old Glenview Road, #300 Wilmette, IL 60091 (847) 853-6060 (Phone) (847) 853-9028 (Fax)</p>	<p>American Academy of Cosmetic Surgery 737 N. Michigan Ave., Suite 820 Chicago, IL 60611 (312) 981-3760 (Phone) (312) 981-6787 (Fax)</p>	<p>American Academy of Cosmetic Surgery P.O. Box 4014 930 N. Meacham Schaumburg, IL 60196 (847) 330-0230 (Phone) (847) 330-0050 (Fax)</p>
---	---	--

e-mail: info@aaahc.org Web site: www.aaahc.org	Web site: www.cosmeticsurgery.org	Web site: www.a
American Academy of Facial Plastic and Reconstructive Surgery 310 S. Henry Street Alexandria, VA 22314 (703) 299-9291 (Phone) (703) 299-8384 (Fax)	American Academy of Ophthalmology 655 Beach Street San Francisco, CA 94109 (415) 561-8500 (Phone) (415) 561-8533 (Fax) Web site: www.aao.org	American Academy of Ophthalmology One Prince Street Alexandria, VA 22304 (703) 836-4444 Web site: www.a
American Association for Accreditation of Ambulatory Surgery Facilities, Inc. * 1202 Allanson Road Mundelein, IL 60060 (847) 949-6958 (Phone) (847) 566-4580 (Fax) e-mail aaaasf@sprynet.com Web site: www.aaaasf.org	American Association of Nurse Anesthetists 222 South Prospect Avenue Park Ridge, IL 60068 (847) 692-7050 (Phone) (847) 692-6968 (Fax) Web site: www.aana.com	American College of Gynecologists 409 12 th Street, S Washington, DC 20004 (202) 638-5577 (Phone) Web site: www.a
American College of Surgeons 633 North Saint Clair Street Chicago, IL 60611-3211 (312) 202-5000 (Phone) (312) 202-5001 (Fax) Web site: http://www.facs.org	American Medical Association 515 North State Street Chicago, IL 60610 (312) 464-5000 (Phone) (312) 464-5600 (Fax) Web site: www.ama-assn.org	American Society of Plastic Surgeons 520 N. Northwest Park Ridge, IL 60068 (847) 825-5586 (Phone) (847) 825-1692 (Fax) e-mail mail@AS.
American Society for Aesthetic Plastic Surgery, Inc. 36 West 44 th Street, Suite 630 New York, NY 10036 (212) 921-0500 (Phone) (212) 921-0011 (Fax) Web site: www.surgery.org	American Society for Dermatologic Surgery 930 N. Meacham Road Schaumburg, IL 60173-6016 (847) 330-9830 (Phone) Web site: www.asds-net.org	American Society of Plastic Surgeons 10 Melrose Avenue Cherry Hill, N.J. 08003 (877) 737-9696 (Phone) (856) 616-9001 (Phone) Web site: www.a
American Society of Plastic Surgeons 444 East Algonquin Road Arlington Heights, IL 60005 (847) 228-9900 (Phone) (847) 228-9432 (Fax) Web site: www.plasticsurgery.org	American Urology Association 1120 North Charles St. Baltimore, MD 21201 (410) 727-1100 (Phone) (410) 223-4370 (Fax) Web site: www.auanet.org	Anesthesia Patient Safety Foundation 4246 Colonial Parkway Pittsburgh, PA 15201 (412) 882-8040 (Phone) (412) 882-8041 (Fax) e-mail: info@ap:; Web site: www.gasnet.org/;
Federated Ambulatory Surgery Association 700 N. Fairfax St., Suite 306 Alexandria, VA 22314 (703) 836-8808 (Phone) (703) 549-0976 (Fax) e-mail: FASA@fasa.org Web site: www.fasa.org	Federation of State Medical Boards 400 Fuller Wisser Road, Suite 300 Euless, TX 7603903855 (817) 868-4000 (Phone) (817) 868-4097 (Fax) Web site: www.fsmb.org	Health Care Financing Administration (Centers for Medicare and Medicaid Services) 7500 Security Boulevard Baltimore, MD 21204 (410) 786-3000 (Phone) Web site: www.h
Institute for Medical Quality * 221 Main Street San Francisco, CA 94105 (415) 882-5151 (Phone) (415) 882-5149 (Fax) Web site: www.imq.org	Joint Commission on Accreditation of Healthcare Organizations (JCAHO) * One Renaissance Blvd. Oak Brook Terrace, IL 60181 (630) 792-5000 (Phone) (630) 792-5005 (Fax) Web site: www.jcaho.org	

Special Committee on Outpatient Surgery

Robert del Junco, MD, Chair

Former President and Member
Medical Board of California

Bernard Alpert, MD
President
Medical Board of California

Lee S. Anderson, MD
President
Texas State Board of Medical Examiners

Paul Benien, DO
President
Oklahoma Board of Osteopathic Examiners

Cynthia Cooper, MD
President
New Hampshire Board of Medicine

Thomas Dilling, JD
Executive Director
State Medical Board of Ohio

Merrill Godfrey, MD
Member
Utah Department of Commerce
Division of Occupational and Professional Licensure

Livingston Parsons, Jr., MD
Member
New Mexico State Board of Medical Examiners

Thea Graves Pellman
Member
New York State Board for Professional Medical Conduct

Daniel Starnes, MD, JD
Former President
Tennessee Board of Medical Examiners

Charles Vacanti, MD
Member, Former Chairman
New York State Board for Professional Medical Conduct

Tanya Williams
Executive Director
Florida Board of Medicine

Ex Officio:

George J. Van Komen, MD
FSMB President

Ronald C. Agresta, MD
FSMB President-elect

Federation Staff:

Dale L. Austin
Interim Chief Executive Officer

Bruce A. Levy, MD, JD
Deputy Executive Vice President

Lisa A. Robin
Assistant Vice President, Leadership and Legislative Services

Jeanne Hoferer
Leadership and Legislative Services

1 Sujit K. Pandit, MD, *Ambulatory Anesthesia and Surgery in America: A Historical Background and Recent Innovations*, *Journal of PeriAnesthesia Nursing*, vol. 14, no. 5, October 1999, p.270.

2 Pandit, p.271-272.

3 American Society of Anesthesiologists, *Considerations for Anesthesiologists in Setting Up and Maintaining a Safe Anesthesia Environment*, 2000, p.16.

4 American Society of Anesthesiologists, p.16.

5 American Society of Anesthesiologists, p.16.

6 American Society of Anesthesiologists, p.16.

7 The New York *Clinical Guidelines for Office-Based Surgery* are in litigation: *New York State Association of Nurse Anesthetists v. Dr. Antonia C. Novello*, New York State Department of Health and the New York State Public Health Council.

Click here

to submit comments about this FSMB policy.

©Copyright 2002 by the Federation of State Medical Boards of the United States, Inc.

KANSAS STATE BOARD OF HEALING ARTS

OPEN RECORDS POLICY Supplement Policy Statement 02-01

Introduction

This policy statement supplements the Open Records Policy adopted April 28, 2001. The purpose of the statement is to comply with the Kansas government records preservation act and the Kansas open records act provisions regarding electronically stored records.

Electronic Mail

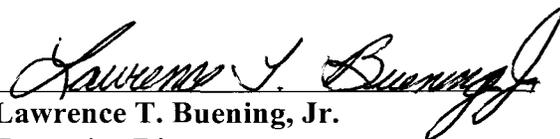
Electronic communications (E-mail) among Board members, among Board staff, and E-mail between Board members or staff and others, including members of the public and staff of other state agencies, constitute public records if created or received in connection with the transaction of official business, activities or functions of the Board. Each staff member and Board member communicating by E-mail, whether the equipment used is the property of the Board or of an individual, shall preserve the E-mail in accordance with record retention and disposition schedules approved by the Kansas State Records Board.

Records of the Board maintained as E-mail are to be disclosed in response to an open-records request in the same manner as other paper records.

Information technology staff are directed to develop a process for managing E-mail electronically in a shared folder. Until such a process is developed, all E-mail constituting public records will be either saved and maintained on the personal computer, or printed and maintained in the same manner as other paper records.

Board staff are directed to prepare procedural instructions for retaining in a proper form all E-mail that constitutes a public record, for disposing of E-mail that does not constitute a public record, and for retaining public records in E-mail form in a manner that allows public access when appropriate under the Kansas open record act.

KANSAS STATE BOARD OF HEALING ARTS


Lawrence T. Buening, Jr.
Executive Director

Apr 6, 2002
Date

APPENDIX II
Records Deemed Confidential¹

Attorney-client communications
Attorney work product
Complaints to the board
Correspondence
Criminal history identification
Records of presiding officer deliberations
Drug and alcohol treatment records
Grades
Investigative reports and information
KDHE data collection
KDHE healthcare data governing board
Medical malpractice claims, payments, closed claims reports
(Includes reports to Board as required by K.S.A. 40-1126 and 40-3421, but does not include copies of civil petitions filed in court and provided to Board as required by K.S.A. 40-3409)
Medical records of patient care
National practitioner data bank reports
Patient names
Peer review reports, findings, conclusions and actions
Physician-patient privilege
Psychiatric hospital records
Reasonable suspicion proceeding records (regarding impairment by drugs, alcohol, psychiatric disability)
Risk management reports, findings, conclusions, and actions
Social security numbers

(Amended 4-6-02)

¹ This list is not intended to identify all confidential records, but is provided as a guide for frequently requested records.

RE: AMENDMENT TO OPEN RECORDS POLICY
Release of Residence Addresses/Home Telephone Numbers

Under **RESTRICTIONS ON ACCESS/When Access Will be Denied**

Add the following paragraph:

If a licensee identifies residential address and home telephone number as the mailing address and main contact number, that information will be made available to the public as other open public records. Otherwise, the release of residence addresses and home telephone numbers is deemed to be a potential unwarranted invasion of personal privacy, and release of this information is at the discretion of the board pursuant to K.S.A. 45-221(a)(30). Release of documents containing this information will be restricted to persons who provide written request for this specific information and who provide consent for release of the information signed by the person identified in the public record.

Any person who, in the opinion of the Executive Director, misuses personal information derived from records obtained from the Board will be denied access to public documents that disclose such information about individuals from that time forward. Misuse of personal information includes offering for sale any product or service except as authorized by Kansas law, or contacting the individual identified in the public record in a harassing or threatening manner.

Adopted by the Board August 13, 2005.

KANSAS STATE BOARD OF HEALING ARTS

235 S.W. Topeka Blvd.
Topeka, KS 66603-3068
(785) 296-7413
FAX (785) 296-0852
e-mail: healer3@ ink.org

Regular Office Hours (except for official state holidays)
Monday through Friday 8:00 a.m. - 4:30 p.m.

OPEN RECORDS POLICY

It is the official policy of the Kansas State Board of Healing Arts that the obligations arising out of the Kansas Open Records Act shall be carried out diligently and in a timely and efficient manner. In furtherance of this policy, and as authorized by K.S.A. 45-220, the Board hereby adopts the following policy for implementing the Kansas Open Records Act.

Notice of Policy to be Posted

A copy of this policy shall be conspicuously posted in the Board office, and a copy or summary of this policy will be made available to any party upon request at no cost.

Brochure to be Available to the Public

A plainly written brochure, containing a basic description of the Board's responsibilities in providing access to public records, explaining the procedures for inspecting or obtaining a copy of public records, and identifying categories of records that are confidential under federal or state law shall be available at the Board office.

Records Custodian

The Executive Director is the official custodian of Board records, and may designate a person to act as official custodian in the Director's absence. The official custodian or designee is authorized to certify records for the Board.

The official custodian or designee shall supervise all inspections and copying of records maintained by the Board. The Executive Director may designate other persons to provide access to or information from public records maintained by the Board. At least one person designated to act on behalf of the records custodian shall be available during regular office hours to carry out the duty of providing access to records.

Freedom of Information Officer

The General Counsel of the Board is the local freedom of information officer and may designate a person to act as local freedom of information officer in the General Counsel's absence.

The freedom of information officer shall provide educational materials to the Board and to the staff to ensure that the intent of both the Kansas Open Records Act and this policy are carried out.

The freedom of information officer shall respond to inquiries and to assist the agency and members of the general public in resolving disputes relating to the open records act.

REQUESTING INFORMATION

A request to inspect or copy records must be made in writing to the records custodian. The request must sufficiently identify the record sought and the name and address of the party requesting access. For purposes of this policy, a request received at the Board office by fax or e-mail is deemed a written request.

If the person requesting the record is not known to the custodian, proof of identity may be required before any name derived from a record will be released. If proof of identity is required, a copy of such proof will be attached to the request.

Any request for records directed to a member of the staff other than the records custodian or designee shall be forwarded to the records custodian or designee. Any staff member who receives a request for access to a public record may release the requested record in accordance with the Kansas Open Record Act and this policy if authorized by the staff member's supervisor.

Removal of original records from the office is not permitted without the records custodian's written permission stating the location where the record will be maintained and the date of return.

Use of names Derived from Public Records

The use of names derived from a public record, whether from a printed roster, other printed record, or electronic record in any form, is limited by K.S.A. 21-3914. If access to a record maintained by the Board reveals an individual's identity, then the person requesting access may be required to submit an *Open Records Request and Certification form* (see Appendix III).

Electronically Stored Records

The Board maintains information in multiple electronic data bases, some of which might not be maintained in printed form (see Appendix I). Much of this information is derived from printed records that are also maintained by the Board as provided in the Board's record retention schedule. When information maintained in electronic form is also available in printed form, the official records custodian may determine the form in which the information will be produced. The Information Resource Specialist is responsible for updating Appendix I at least annually.

Forms

All agency forms required for requesting Board action are open public records.

FEES

Purpose of Charge

Inspection and copying charges are established to compensate the Board for the cost of staff time, copying expenses, and postage. The custodian has discretion to waive payment of costs. No fee will be charged for inspecting or copying a public record when the total calculated cost is less than \$10.00 unless required by the custodian. Advance payment in part or in full may be demanded when the estimated cost exceeds \$100.00.

Calculation of Costs

a. Staff time

The costs of staff time are calculated at the current market hourly rate, calculated to the nearest quarter hour, within the pay range for the job classification of the employee providing access to the record. The relevant job classifications with their assigned pay ranges are as follows:

Administrative Officer: (for providing electronically stored records)	Range 21
Legal Assistant: (for providing all other records)	Range 19

b. Copies

The cost of copies made by the Board is \$.25 per page. If it is necessary to use another facility or business for copying, the actual cost will be charged to the person requesting the copy.

c. Fax

There is no additional charge for providing documents by fax. The decision to provide records by fax is at the discretion of the records custodian or designee. Records in excess of 10 pages will not ordinarily be transmitted by fax.

d. Postage

Costs of postage will be charged.

e. Pre-printed rosters

MD (reprinted after June 30 of each year): \$7.00

DO, DC & DPM (reprinted after September 30 of each year): \$7.00

PA, PT, PTA & AT (reprinted after December 31 of each year): \$3.50

OT, OTA & RT (reprinted after March 31 of each year): \$ 3.50

f. Forms

Any form prescribed by the Board will be provided at no cost.

RESTRICTIONS ON ACCESS

When Access Will be Denied

The records custodian may refuse to provide access to a record if the request places an unreasonable burden on the agency, if there is reason to believe that repeated requests are intended to disrupt functions of the Board and its operations, or if a provision of law prohibits or restricts disclosure of a record. A refusal based upon an unreasonably burdensome request will not be made without first attempting to contact the person who made the request to narrow the scope of the request.

The records custodian may refuse to provide access to a record for any discretionary reason listed in K.S.A. 45-221(a) and amendments thereto. The Board, upon request, may authorize access to such records.

A list of frequently requested records that will not be released because they are confidential under state or federal law is appended to this policy (see Appendix II).

Notice of Denial

If the request for access to records is denied, the records custodian or a designee will provide a detailed written statement notifying the person making the request why access was denied, and where appropriate, will identify the provision of law which prohibits or restricts disclosure.

Hearing and Disciplinary Information

The agency record of any administrative hearing is a public record and is generally available to the public. The agency record consists of pleadings, transcripts, exhibits and any other document considered by the Board and used as a basis for its agency action. Documents in the agency record containing information that is confidential under state or federal law, privileged, or subject to a valid protective order issued by a presiding officer will not be available for inspection or copying, except that such documents will be disclosed if the confidential or privileged information can be deleted, or if a valid and appropriate consent for release of information is given.

If a copy of a transcript made by a certified shorthand reporter is requested, the Board will either (1) forward the request to the reporter; (2) provide sufficient information to the person making the request to allow a copy to be obtained directly from the reporter; or (3) with permission of the reporter, provide a copy of the requested record. The reporter may charge fees for transcripts in accordance with rules of the Kansas Supreme Court.

Licensure Information

The application for initial licensure (by examination, by endorsement, or reinstatement) or registration and all associated documents, and the renewal application and all associated documents are considered public records by the Kansas State Board of Healing Arts. Any portion of the application or renewal application (such as social security number, academic performance records, and confidential disciplinary history) will be deleted from copies of the original record if it discloses information that is confidential or privileged pursuant to federal or state law, or if it discloses the presence or absence of disabilities.

Personnel Records

Release of state employee personnel records is governed by Kansas statute and by rules adopted by the Kansas Secretary of Administration.

This policy supercedes all prior open records policies and customs whether or not adopted in written form.

KANSAS STATE BOARD OF HEALING ARTS



Lawrence T. Buening, Jr.
Executive Director

Date April 28, 2001

APPENDIX I
Register of Records Stored Electronically

A. Licensure Data Base

A profile of each licensee and registrant is maintained in the Board's licensure data base and is a public record. This information includes license status, license number, licensee's name and mailing address, licensee's profession, licensee's specialty (if any), licensee's date of birth, licensee's insurance carrier and policy number, licensee's professional school, licensee's authorization to practice under either endorsement or examination, temporary permit, date temporary permit issued, date temporary permit expires, United States or foreign medical school graduate, continuing education year, license expiration date, renewal extension date, original license date, last renewal date, degree date, last cancellation date, last reinstatement date, and the existence of a disciplinary file.

B. Professional Corporation / Limited Liability Company Data Base

A data base of licensees and registrants who have formed a professional corporation or professional limited liability company is maintained and is a public record. Information contained in the data base includes licensee name and corporate name. This information is obtained from the Kansas Secretary of State, and is continually updated and available through that office.

C. Complaint Data Base

The Board maintains information in electronic form derived from records of complaints and investigations. This information is confidential under state law.

D. Inventory Data Base

The Board maintains a list of property belonging to the agency. This is a public record.

APPENDIX III

OPEN RECORDS REQUEST AND CERTIFICATION

INSTRUCTIONS: Please complete this form for requests of public records maintained by the Kansas State Board of Healing Arts.

Access to public records will be acted upon as soon as possible. The Board has until the third business day following receipt of this signed form to respond to a request.

I hereby certify that the undersigned and/or any person(s) authorized by the undersigned have no intention to and will not use the requested information for any of the following:

(A) Use any list of names or addresses contained in or derived from the records or information for the purpose of selling or offering for sale any property or service to any person listed or to any person who resides at any address listed;

(B) Sell, give or otherwise make available to any person any list of names or addresses contained in or derived from the records or information for the purpose of allowing that person to sell or offer for sale any property or service to any person listed or to any person who resides at any address listed.

The Board is authorized to require this certification pursuant to K.S.A. 45-220. Violation of this provision is a criminal misdemeanor. K.S.A. 21-3914.

DATED THIS _____ DAY OF _____, 20 ____.

Signature

(Print or type name)

(Street Address)

(City, State, Zip)

For Board Use Only:

Date responded/provided

_____ by _____

KANSAS STATE BOARD OF HEALING ARTS
Policy statement no. 00-03

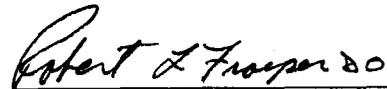
SUBJECT: Review of Initial Orders

DATE: December 9, 2000

WHEREAS, in all matters conducted pursuant to the Kansas administrative procedure act in which the Board has appointed a presiding officer to issue an Initial Order, the Board intends to conduct review and to issue a Final Order; and

WHEREAS, service of Initial Orders does not, in all cases, occur within 15 days prior to a regularly scheduled Board meeting, making it impracticable for the Board to adopt a specific motion in each matter stating its intent to conduct review;

IT IS, THEREFORE, RESOLVED as the policy of the Board that, as a matter of course following service of an Initial Order, the Executive Director or designee shall serve notice in a timely manner stating that the Board will, on its own motion, conduct review. Such notice shall not preclude the parties from filing a timely petition as allowed by law identifying specific issues to be reviewed.



Robert L. Frayser, D.O.
President

KANSAS STATE BOARD OF HEALING ARTS

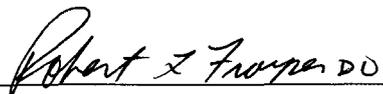
POLICY STATEMENT NO. 00-02

SUBJECT: Designation of local Freedom of Information Officer.

DATE: August 12, 2000

Pursuant to 2000 Senate Substitute for House Bill No.1 2864, the Kansas State Board of Healing Arts designates the individual who holds the position of General Counsel as the Board's local Freedom of Information Officer under the Kansas Open Records Act.

APPROVED by the Kansas Board of Healing Arts this 12th day of August, 2000.



Robert Frayser, D.O.
President

**CANDIDATE REVIEW OF TEST PERFORMANCE
PMLexis**

The Kansas State Board of Healing Arts will support examination review for Podiatrists who have failed the PMLexis examination.

The following protocol will be observed:

- 1. Only failing candidates may review examinations.**
- 2. Only 1 review of a given examination is permitted.**
- 3. The review request by the Board must be filled NOT MORE THAN 30 days after release of the test results.**
- 4. The review must be completed NOT LESS THAN 30 days before the next administration of the PMLexis.**
- 5. The fee for SHL Landy Jacobs to prepare and ship the review materials is \$40. This includes the cost of Federal express shipment to the participating board. The fee is to be collected by the board and should be made payable to SHL Landy Jacobs.**
- 6. The board will be responsible for safeguarding the examination and for conducting and supervising the review.**
- 7. SHL Landy Jacobs will provide for the review the candidate's original test booklets and photocopies of answer sheets. Also provided will be a list of questions omitted from scoring, a diagnostic profile, and a detailed explanation of the process used to insure accuracy in structure/score of the examination.**
- 8. The review time will not exceed one-half the original test time, by section.**
- 9. No copies or notes may be made by the candidate.**
- 10. All materials used in the review will be returned via a traceable courier to the SHL Landy Jacobs in a timely manner.**

APRIL 8, 2000

KANSAS STATE BOARD OF HEALING ARTS

POLICY STATEMENT NO. 00-01

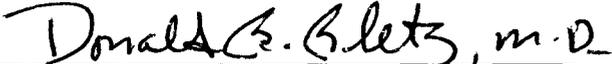
Subject: Delegation of Authority to Executive Director to Rule on Requests for Continuances

Date: April 8, 2000

In matters in which the Board as a whole acts as presiding officer, authority to rule upon requests for continuances is hereby delegated to the Executive Director for the Board as follows:

1. The Executive Director may grant any request for continuance received at least ten calendar days prior to the meeting unless the continuance could result in a threat to the public health, safety or welfare.
2. The Executive Director may grant a written request for continuance received at least five calendar days prior to the meeting only if good cause is shown, including unavailability of a party, counsel or witness.
3. The Executive Director may grant a written request for continuance received at least two calendar days prior to the meeting only if emergent circumstances are shown.
4. Any other request for continuance shall be referred to the President of the Board prior to the meeting or to the Board as a whole at the scheduled hearing.
5. Reasonable efforts shall be made to timely notify the Board members of continuances granted under authority of this policy.

APPROVED by the Kansas State Board of Healing Arts this Eighth Day of April, 2000.



Donald B. Bletz, M.D.
President

KANSAS STATE BOARD OF HEALING ARTS
Amended
POLICY STATEMENT NO 93-03

Subject: *Approved Examinations for license to Practice Medicine and Surgery*

Date: December 11, 1999

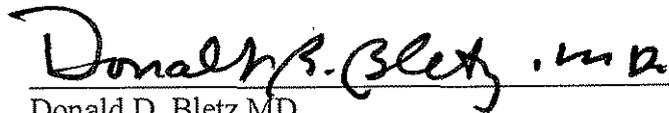
1. Effective January 1, 2000 all applicants for license to practice medicine and surgery will meet the required examination combinations of NBME or NBOME, USMLE or FLEX as indicated on the attached TABLE A pursuant to KSA 65-2873 (a) (1) and (3).

2. To be eligible to sit for Step 3 of USMLE in this state, the individual must have an application for licensure on file that is complete except for the examination required pursuant to KSA 65-2873 (a) (3).

3. After December 11, 1999 no individual who has failed Step 3 of the USMLE on three or more occasions shall be eligible to retake the examination in Kansas without having completed additional educational requirements established by the Board. No further attempts will be allowed after the fourth failure.

4. After January 1, 2000, no person will be granted a license based upon examination without having passed Steps 1, 2, and 3 of USMLE within a 10-year period from passage of the first step.

APPROVED by the Kansas State Board of Healing Arts this 11th day of December 1999.



Donald D. Bletz MD
President

Guidelines for the Use of Controlled Substances for the Treatment of Pain

Section I: Preamble

The Kansas State Board of Healing Arts recognizes that principles of quality medical practice dictate that the people of the State of Kansas have access to appropriate and effective pain relief. The appropriate application of up-to-date knowledge and treatment modalities can serve to improve the quality of life for those patients who suffer from pain as well as reduce the morbidity and costs associated with untreated or inappropriately treated pain. The Board encourages physicians to view effective pain management as a part of quality medical practice for all patients with pain, acute or chronic, and it is especially important for patients who experience pain as a result of terminal illness. All physicians should become knowledgeable about effective methods of pain treatment.

Inadequate pain control may result from physicians' lack of knowledge about pain management or an inadequate understanding of addiction. Fears of investigation or sanction by federal, state and local regulatory agencies may also result in inappropriate or inadequate treatment of chronic pain patients. Accordingly, these guidelines have been developed to clarify the Board's position on pain control, specifically as related to the use of controlled substances, to alleviate physician uncertainty and to encourage better pain management.

The Board recognizes that controlled substances, including opioid analgesics, may be essential in the treatment of acute pain due to trauma or surgery and chronic pain, whether due to cancer or non-cancer origins. The medical management of pain should be based on current knowledge and research and include the use of both pharmacologic and non-pharmacologic modalities. Pain should be assessed and treated promptly, and the quantity and frequency of doses should be adjusted according to the intensity and duration of the pain. Physicians should recognize that tolerance and physical dependence are normal consequences of sustained use of opioid analgesics and are not synonymous with addiction.

The Kansas State Board of Healing Arts is obligated under the laws of the State of Kansas to protect the public health and safety. The Board recognizes that inappropriate prescribing of controlled substances, including opioid analgesics, may lead to drug diversion and abuse by individuals who seek them for other than legitimate medical use. Physicians should be diligent in preventing the diversion of drugs for illegitimate purposes.

Physicians should not fear disciplinary action from the Board for prescribing, dispensing or administering controlled substances, including opioid analgesics, for a legitimate medical purpose and in the usual course of professional practice. The Board will consider prescribing, ordering, administering or dispensing controlled substances for pain to be for a legitimate medical purpose

based on sound clinical grounds. All such prescribing must be based on clear documentation of unrelieved pain and in compliance with these guidelines. If such prescribing meets these criteria, the Board will support physicians whose use of controlled substances has been questioned by another regulatory or enforcement agency.

Allegations of improper prescribing of controlled substances for pain will be evaluated on a case-by-case basis. The board will not take disciplinary action against a physician for failing to adhere strictly to the provisions of these guidelines, if good cause is shown for such deviation. The physician's conduct will be evaluated to a great extent by the treatment outcome, taking into account whether the drug used is medically and/or pharmacologically recognized to be appropriate for the diagnosis, the patient's individual needs—including any improvement in functioning—and recognizing that some types of pain cannot be completely relieved.

The Board will judge the validity of prescribing based on the physician's treatment of the patient and on available documentation, rather than on the quantity and chronicity of prescribing. The goal is to control the patient's pain for its duration while effectively addressing other aspects of the patient's functioning, including physical, psychological, social and work-related factors. The following guidelines are not intended to define complete or best practice, but rather to communicate what the Board considers to be within the boundaries of professional practice.

Section II: Guidelines

The Board has adopted the following guidelines when evaluating the use of controlled substances for pain control:

1. Evaluation of the Patient

The medical record should document the nature and intensity of the pain, current and past treatments for pain, underlying or coexisting diseases or conditions, the effect of the pain on physical and psychological function, and history of substance abuse. The medical record also should document the presence of one or more recognized medical indications for the use of a controlled substance.

2. Treatment Plan

The written treatment plan should state objectives that will be used to determine treatment success, such as pain relief and improved physical and psychosocial function, and should indicate if any further diagnostic evaluations or other treatments are planned. After treatment begins, the physician should adjust drug therapy to the individual medical needs of each patient. Other treatment modalities or a rehabilitation program may be necessary depending on the etiology of the pain and the extent to which the pain is associated with physical and psychosocial impairment.

3. Informed Consent and Agreement for Treatment

The physician should discuss the risks and benefits of the use of controlled substances with the patient, persons designated by the patient or with the patient's surrogate or guardian if the patient is incompetent. The patient should receive prescriptions from one physician and one pharmacy where possible. If the patient is determined to be at high risk for medication abuse or have a history of substance abuse, the physician may employ the use of a written agreement between physician and patient outlining patient responsibilities, including

- urine/serum medication levels screening when requested;
- number and frequency of all prescription refills; and
- reasons for which drug therapy may be discontinued (i.e., violation of agreement).

4. Periodic Review

At reasonable intervals based on the individual circumstances of the patient, the physician should review the course of treatment and any new information about the etiology of the pain. Continuation or modification of therapy should depend on the physician's evaluation of progress toward stated treatment objectives, such as improvement in patient's pain intensity and improved physical and/or psychosocial function, i.e., ability to work, need of health care resources, activities of daily living and quality of social life. If treatment goals are not being achieved, despite medication adjustments, the physician should reevaluate the appropriateness of continued treatment. The physician should monitor patient compliance in medication usage and related treatment plans.

5. Consultation.

The physician should be willing to refer the patient as necessary for additional evaluation and treatment in order to achieve treatment objectives. Special attention should be given to those pain patients who are at risk for misusing their medications and those whose living arrangement pose a risk for medication misuse or diversion. The management of pain in patients with a history of substance abuse or with a co-morbid psychiatric disorder may require extra care, monitoring, documentation and consultation with or referral to an expert in the management of such patients.

6. Medical Records

The physician should comply with and meet the requirements of K.A.R. 100-24-1 in the maintenance of an adequate record for each patient.

7. Compliance With Controlled Substances Laws and Regulations

To prescribe, dispense or administer controlled substances, the physician must be licensed in the state and comply with applicable federal and state regulations.

Section III: Definitions

For the purposes of these guidelines, the following terms are defined as follows:

Acute Pain

Acute pain is the normal, predicted physiological response to an adverse chemical, thermal or mechanical stimulus and is associated with surgery, trauma and acute illness. It is generally time-limited and is responsive to opioid therapy, among other therapies.

Addiction

Addiction is a neuro-behavioral syndrome with genetic and environmental influences that results in psychological dependence on the use of substances for their psychic effects and is characterized by compulsive use despite harm. Addiction may also be referred to by terms such as "drug dependence" and "psychological dependence." Physical dependence and tolerance are normal physiological consequences of extended opioid therapy for pain and should not be considered addiction.

Analgesic Tolerance

Analgesic tolerance is the need to increase the dose of opioid to achieve the same level of analgesia. Analgesic tolerance may or may not be evident during opioid treatment and does not equate with addiction.

Chronic Pain

A pain state which is persistent and in which the cause of the pain cannot be removed or otherwise treated. Chronic pain may be associated with a long-term incurable or intractable medical condition or disease.

Pain

An unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage.

Physical Dependence

Physical dependence on a controlled substance is a physiologic state of neuro-adaptation which is characterized by the emergence of a withdrawal syndrome if drug use is stopped or decreased abruptly, or if an antagonist is administered. Physical dependence is an expected result of opioid use. Physical dependence, by itself, does not equate with addiction.

Pseudoaddiction

Pattern of drug-seeking behavior of pain patients who are receiving inadequate pain management that can be mistaken for addiction.

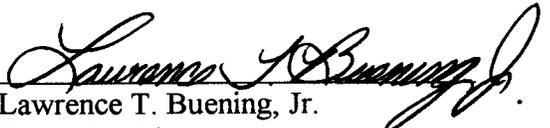
Substance Abuse

Substance abuse is the use of any substance(s) for non-therapeutic purposes or use of medication for purposes other than those for which it is prescribed.

Tolerance

Tolerance is a physiologic state resulting from regular use of a drug in which an increased dosage is needed to produce the same effect, or a reduced effect is observed with a constant dose.

APPROVED by the Kansas State Board of Healing Arts this 17th day of October, 1998.


Lawrence T. Buening, Jr.
Executive Director

August 11, 1998

KANSAS PODIATRIC LICENSURE FOR FOREIGN MEDICAL GRADUATES

The following policy shall be followed for podiatrists graduating outside the United States who have not passed the required examination:

- (a) They have been licensed in another country for at least five years prior to applying.
- (b) They have been continuously and actively engaged in the practice of podiatry from and since their date of original licensure.
- (c) A certificate of endorsement from another state or country shall include grades in subjects required by K.S.A. 65-2004 as certified by a board of examiners of that state or country.
- (d) They have a satisfactory oral interview conducted by the Podiatry Advisory Committee which reflects no grounds such as criminal convictions, addiction, malpractice suits, etc. for which the Board could deny the license.

K.S.A. 65-2004 "each applicant for a license to practice podiatry shall be examined by the board in the following subjects: Anatomy, bacteriology, chemistry, dermatology, histology, pathology, physiology, pharmacology and medicine, diagnosis, therapeutics and clinical podiatry and surgery, limited in their scope to the treatment of the human foot.

RESPIRATORY THERAPIST TRANSCRIPTS - (White/Gravino)

Approve Respiratory Care Council's recommendation regarding programs that are no longer in existence and cannot provide transcripts, that the following is acceptable:

1. Proof in writing from the Joint Review Committee for Respiratory Therapy Education or its successor that the program in question was accredited at the time of the applicant's schooling.
2. Notarized copy of certificate of completion from program from which the applicant graduated.

Carried.

KANSAS STATE BOARD OF HEALING ARTS

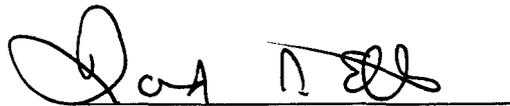
POLICY STATEMENT NO. 96-03

SUBJECT: *Evidence of graduation from an accredited healing arts school*

DATE: *October 19, 1996*

Each applicant for a license to practice the healing arts is required, pursuant to K.S.A. 65-2873(a)(2), to present proof of graduation from an accredited healing arts school. The Board hereby delegates to the Licensing Administrator discretion to accept either a letter from the school of graduation which indicates the date the degree was conferred and which letter has a seal of the school affixed thereto, or a notarized copy of a diploma.

APPROVED by the Kansas State Board of Healing Arts this Nineteenth day of October, 1996.

A handwritten signature in black ink, appearing to read "Howard D. Ellis", written over a horizontal line.

Howard D. Ellis, M.D.
President

KANSAS STATE BOARD OF HEALING ARTS

Policy Statement 93-05

Subject: Laser Surgery by Optometrists

Date: October 9, 1993

At its meeting held October 9, 1993, the Kansas State Board of Healing Arts, through motion and vote, adopted the following position regarding the performance of laser surgery by optometrists:

"Laser surgery is the practice of medicine and surgery. Any practice thereof by individuals not licensed by the Kansas State Board of Healing Arts or under the direct supervision of a licensed medical or osteopathic doctor constitutes the unlicensed practice of medicine and surgery."

Should matters be received by the Board alleging violations of the Healing Arts Act in this regard, such will be investigated and the results of the investigation immediately forwarded to the attention of the District or County Attorney of the county in which proper jurisdiction is established.

APPROVED by the Kansas State Board of Healing Arts this 9th day of October, 1993.


DONALD BLETZ, M.D.
Board President

KANSAS STATE BOARD OF HEALING ARTS

Policy Statement 93-04

Subject: Interpretation of K.S.A. 65-2898a

Date: October 9, 1993

At its meeting held October 9, 1993, the Kansas State Board of Healing Arts, through motion and vote, adopted the following position regarding the Board's interpretation of K.S.A. 65-2898a:

"The Board of Healing Arts is the state agency charged with regulating the practice of the healing arts within the State of Kansas. To carry out these duties, the Board must interpret the statutes comprising the Healing Arts Act. K.S.A. 65-2898a, a statute which addresses the confidentiality of complaints and reports relating thereto, states four exceptions to the confidentiality requirement of said reports. It is the position of the Board that, first, the release of information in accordance with the stated four exceptions, is a discretionary function of the Board and its legal staff, to be exercised in their sole discretion. Second, that in K.S.A. 65-2898a(a)(3), the reference to "the person who is the subject of the information", means the licensee whom the Board is investigating, not the patient, hospital, or any other entity.

The Board specifically delegates its authority to exercise its discretion to release to its legal staff.

APPROVED by the Kansas State Board of Healing Arts this 9th day of October, 1993.


DONALD BLETZ, M.D.
Board President

KANSAS STATE BOARD OF HEALING ARTS
Amended
POLICY STATEMENT NO 93-03

Subject: *Approved Examinations for license to Practice Medicine and Surgery*

Date: December 11, 1999

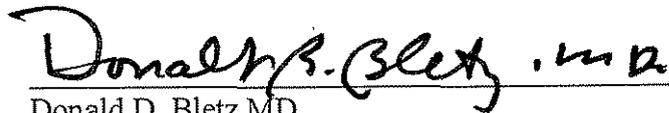
1. Effective January 1, 2000 all applicants for license to practice medicine and surgery will meet the required examination combinations of NBME or NBOME, USMLE or FLEX as indicated on the attached TABLE A pursuant to KSA 65-2873 (a) (1) and (3).

2. To be eligible to sit for Step 3 of USMLE in this state, the individual must have an application for licensure on file that is complete except for the examination required pursuant to KSA 65-2873 (a) (3).

3. After December 11, 1999 no individual who has failed Step 3 of the USMLE on three or more occasions shall be eligible to retake the examination in Kansas without having completed additional educational requirements established by the Board. No further attempts will be allowed after the fourth failure.

4. After January 1, 2000, no person will be granted a license based upon examination without having passed Steps 1, 2, and 3 of USMLE within a 10-year period from passage of the first step.

APPROVED by the Kansas State Board of Healing Arts this 11th day of December 1999.



Donald D. Bletz MD
President

TABLE A

ACCEPTABLE EXAMINATION COMBINATIONS FOR LICENSE
TO PRACTICE MEDICINE AND SURGERY

Examination Sequence	Recommended as Acceptable
Part I plus Part II plus Part III	Part I or Step 1 plus Part II or Step 2 plus Part III or Step 3
FLEX Component 1 plus FLEX Component 2	FLEX Component 1 plus Step 3 or Part I or Step 1 plus Part II or Step 2 plus FLEX Component 2
Step 1 plus Step 2 plus Step 3	

Steps 1, 2, & 3 refer to portions of USMLE examinations
 Parts I, II, & III refer to portions of NBME or NBOME (COMPLEX) examinations

KANSAS STATE BOARD OF HEALING ARTS

POLICY STATEMENT NO. 92-01

SUBJECT: Proposed Fifth Pathway Resolution

DATE: October 31, 1992

A "Fifth Pathway" program consisting of one academic year of supervised clinical education will be considered by the Board as meeting the requirements of K.S.A. 65-2873(d) in lieu of passing an examination (VQE or FMGEM's) given by ECFMG if such was obtained at a LCME accredited medical school and the conditions established by ACGME were met prior to the commencement of the Fifth Pathway program. A Fifth Pathway program will not satisfy post-graduate training which is required for licensure.



REX A. WRIGHT, D.C.
Board President

LTB15/ps.1