Approved: 3/28/11
Date

MINUTES OF THE HOUSE FEDERAL AND STATE AFFAIRS COMMITTEE

The meeting was called to order by Chairman Steven Brunk at 1:30 p.m. on March 09, 2011, in Room 346-S of the Capitol.

All members were present except:
Representative Fund – excused
Representative Huebert - excused
Representative Kiegerl - excused
Representative Seiwert – excused
Representative Peterson - excused

Committee staff present:
Mike Heim, Office of the Revisor of Statutes
Doug Taylor, Office of the Revisor of Statutes
Julian Efird, Kansas Legislative Research Department
Dennis Hodgins, Kansas Legislative Research Department
Stephen Bainum, Committee Assistant

Conferees appearing before the Committee:
Kathy Ostrowski, Legislative Director, Kansans for Life
Herbert Hodes, M.D. Center for W omen's Health

Others attending:
See attached list.

The Chairman opened the hearing on **HB 2337 Licensing of abortion clinics by department of health and environment.**

Mike Heim reviewed the thirteen sections in the bill.

Representative Brunk asked for a definition of "culpable mental state" in Section 8 on page 5. Mike said it is not considering the mental state when a crime is committed because that is no excuse for the crime. Representative Loganbill asked Mike if he was aware of any other statute that goes into this amount of detail for any other medical condition. Mike said he was not the best one to answer that question. Representative Knox asked if doctors offices, hospital and surgical centers were licensed now by KDHE? Mike said there was a license procedure but again, he is not the best one to ask. He also asked if the fee structure was similar to the fees in this bill. Representative Brunk said that a revised fiscal note was coming.

Kari Bruffett, Assistant Secretary, Policy & External Affairs, Kansas Department of Health and Environment said that a new fiscal note was being worked on and would be made available soon. Representative Knox asked if the inspections and licensure were fee funded? Charles Moore, KDHE answered the question in relation to hospitals. State licensing is all state funds. Once a hospital is medicaid, medicare certified, then there is a combination of Federal and state money.

Kathy Ostrowski, Legislative Director of Kansans for Life presented testimony as a proponent of **HB 2337** (Attachment 1). She said that abortion clinic licensure is on firm constitutional ground. **HB 2337** is based on the abortion industry's own professional standards, and for the most part, is identical to the bills that were passed and vetoed in 2003 and 2005. The attachments mentioned in her testimony are available from Kansans for Life.

Representative Brunk called attention to the fact that two other legislative bodies had passed very similar bills in 2003 and 2005. Representative Rubin asked what the status of Krishna Rajanna's license was. Kathy said that it was eventually revoked.

Herbert Hodes, M.D., Center for W omen's Health, presented testimony as an opponent of **HB 2337** (Attachment 2). He said that the authors of **HB 2337** ignored the May 2002 Guidelines for Office-Based Surgery passed by the Kansas Board of Healing Arts.

Representative Gatewood asked for an explanation of the RU486 portion of the bill. Dr. Hodes said that

he did not prescribe RU486 because he was not comfortable with some of its issues. The main thing is where does the patient live and how willing is she to come back. He said that that portion of the bill was perfect. Representative Wolfe Moore stated that this bill was about asking to legislate guidelines for a procedures, and in affect, overruling the physicians and surgeons who set out these guidelines. Representative Knox asked if disclaimers of liability were standard procedure? Dr. Hodes said that you cannot give away your privileges. Patients sign the disclaimer because they want the surgery. The reason for the disclaimer is to get the patient to return to us for a follow up exam.

Representative Patton said that you mentioned that there had been many deaths over the last few years from abortions with unintended outcomes, how many? Dr. Hodes denied that he said many deaths. He said there had been a few in Kansas, maybe 5 maternal deaths in the last 5 years or 10 years.

The Chairman said that he would keep this hearing open for a later date.

The next meeting is scheduled for March 10, 2011.

The meeting was adjourned at 3:15 p.m.

HOUSE FEDERAL AND STATE AFFAIRS COMMITTEE

3/9/11

ROOM 346-S

NAME	REPRESENTING
Johnathan Reeves	Rep. Davis
H. C. Hodes, MD	CITIZEN
Andrea Hodes	
Sarah Gillooly	PPKM
TED HENRY	CS.
Karl Bruffett	KDHE
[illegible]	KDHE
[illegible]	KDHE
Edward Larson	KS Catholic Conference

Kansans for Life
www.kfl.org

State Office
2501 East Central
Wichita, KS 67214
(800) 928-LIFE (5433)
Fax (316) 687-0303
kfl@kfl.org

Legislative Office
929-A S. Kansas Ave.
Topeka, KS 66612
(785) 234-2998
Fax (785) 234-2939
topeka@kfl.org

K.C. Regional Office
7808 Foster
Overland Park, KS 66204
(913) 642-LIFE (5433)
Fax 642-7061
kansansforlife@aol.com

PROPONENT, HB 2337

March 9, 2011

Chairman Brunk and Committee,

I am Kathy Ostrowski, Legislative Director of Kansans for Life, testifying in support of HB 2337.

Abortion clinic licensure is on firm constitutional ground, following the 1992 U.S. Supreme Court *Casey* decision. Abortion clinic regulations from South Carolina were upheld by the U.S. 4th Circuit Court of Appeals' 2000 decision, which read:

1. The regulations serve a valid state interest and are little more than a codification of national medical and abortion association recommendations designed to ensure the health and appropriate care of women seeking abortion.

2. The regulations do not strike at the abortion right itself.

3. The increased costs of abortion caused by implementation of the regulations, while speculative, are modest & have not been shown to burden the ability of a woman to make the decision to have an abortion.

4. Abortion clinics may rationally be regulated as a class while other clinics or medical practices are not.

South Carolina provisions that were upheld are similar to, and arguably more stringent, than HB 2337. (see blue attachment.)

HB 2337 is based on the abortion industry's own professional standards, and for the most part, is identical to the bills that were passed and vetoed in 2003 and 2005.

In 2003, the Kansas legislature passed a clinic inspection, licensure & regulation bill, based on testimony concerning more than 50 cases of Kansas-licensed abortionists' malpractice, including 3 patient deaths by the Planned Parenthood physician. Gov. Sebelius vetoed the bill as 'unneeded.' Thus, when the Wyandotte County D.A. called the Healing Arts Board to take care of a nasty KCK clinic police had discovered on a routine call, he was told, "no law is being broken."

In 2004, despite photographs taken by a whistle-blower, and a plea from the Attorney General, the Healing Arts Board stalled disciplinary action against the Krishna Rajanna clinic. It is instructive to match up the abuses of the Rajanna business with that of Kermit Gosnell (newly indicted Philadelphia abortionist- see second blue attachment), as both flourished under a pro-abortion administration, and both:

- **re-used unsterilized instruments;**
- **stored fetal remains with food in a staff refrigerator;**

House Fed & State Affairs
Date: 3.9.11

- **hired cheap, uneducated and incompetent staffers;**
- **broke state, federal and professional protocols on handling and injecting drugs;**
- **lacked required resuscitative equipment;**
- **had blocked emergency exits;**
- **targeted low-income, minority women who traditionally do not seek legal redress for malpractice or seek out governmental redress for medical abuse.**

In 2005, in the wake of a cover-up of an abortion clinic death (Christin Gilbert), and even more legislative testimony of abortion hospitalizations, the House & Senate re-passed the same clinic inspection, licensure & regulation bill. Gov. Sebelius again vetoed it.

Meanwhile, Kansans for Life had exposed the role of the Healing Arts Board executive Director, Larry Buening, in protecting dangerous abortionists from the examination and discipline of the Board he was supposed to be serving. When the Board discovered what had been done under their nose, they instigated a subcommittee to draw up rules that would toughen Kansas Medical Society recommendations.

The subcommittee's rules resulted in the first-ever inspection of every abortion clinic that was a doctor office (as reported to the Board on license renewals), and directly led to the shuttering of one abortion business in Wichita.

These rules represented a minor victory because they essentially require the presence of a physician AND a licensed health professional with training in advanced resuscitation during every surgical procedure, so that one practitioner can solely monitor the woman under anesthesia.

But they also included such subjective mandates as, "*Each office-based surgery and special procedure shall be within the scope of practice of the physician;*" which allowed an elderly pulmonary-trained physician with a long disciplinary record with the Board to stay in the abortion business.

In Dec. 2006, these "office-based-surgery rules" began to apply to Kansas' doctor-office surgical abortion clinics (numbering 6 in 2005, now 2) but do not cover the Comprehensive Health/ Planned Parenthood business in Overland Park, licensed as an ambulatory surgical center (ASC) under the state health department.

The FATAL FLAW is that these agency rules-- beyond not covering ASCs-- are not state statutes, and assurance that they are being followed depends on the willingness of the agency to be diligent in the face of political pressure, and our state Board has been outrageously political.

Additionally, the rules do not authorize spot inspections, nor can they close a deficient facility to protect women from abortion profiteering.

Aborted women and their families are resistant to protesting shoddy treatment and unhygienic facilities-- for fear of exposing the abortion. As shown in the green attachments, women and girls have been erroneously warned that they have signed away their legal rights.

Thus it is welcome to read in the U.S. Supreme Court 2007 *Gonzales* decision that state oversight of abortion businesses is well-justified. The Court included these declarations:

- the government [has an] interest in protecting the integrity and ethics of the medical profession;
- the law need not give abortion doctors unfettered choice in the course of their medical practice, nor should it elevate their status above other physicians in the medical community; and
- the State may use its regulatory power to bar certain procedures and substitute others, all in furtherance of its legitimate interests in regulating the medical profession in order to promote respect for life, including life of the unborn.

Importantly, HB 2337 **changes Kansas law to require that all abortions**, not just those after 22 weeks gestation, **be performed by a state-licensed physician**, and adds the requirement that the physician have clinical **privileges at a hospital located within 30 miles of the facility**, as is law in Missouri.

HB 2337 specifies that abortions after 22 weeks gestation take place in ASCs or hospitals.

And HB 2337 **requires the physical presence of the physician onsite during the delivery of abortion by pills,** using language that Oklahoma adopted last year. This is will prevent the delivery of dangerous abortion drugs via "webcam," a targeted "growth industry" that phone-conferee Abby Johnson, former Planned Parenthood clinic director has confirmed.

We strongly believe the high fiscal note misjudges the willingness of 67 hospitals to begin offering abortions and absurdly anticipates requiring the services of a birthing expert. The note does correctly report only 3 locations in Kansas provide abortions.

KDHE already has a staff for ASC inspections that can certainly appropriate KSBHA protocols and the inspection reports of South Carolina and other states to manage to inspect 3 abortion locations at a reasonable price. Alternatively, the price for licensing could be raised to accommodate the cost of inspection.

Kansans for Life urges the committee pass HB 2337 favorably out of committee, thank you.

Attachments:

Sample South Carolina approved abortion clinic regs (blue)
How abortionist Gosnell caused women's death (blue)
Planned Parenthood (Overland Park) inspection deficiencies
Malpractice filings v PP past abortionist Robt.Crist
Abortionists' bad practices same in 1992, 2002
Krishna Rajanna clinic photos
What police saw inside horrendous KCK clinic
Malpractice filings vs current abortionist Herb Hodes
3 samples of unsupportable threats in informed consent (green)
KSBHA 2006 Office-based surgery regs (yellow)
KMS 2002 recommended office standards (yellow)

CENTER FOR
WOMEN'S HEALTH
HODES NAUSER

Herbert Hodes, M.D. FACOG
Center for Women's Health
4840 College Boulevard
Overland Park, Kansas 66211

March 9, 2011

Members of the House Committee on Federal & State Affairs:

Thank you for the opportunity to speak to you in opposition to HB 2337. My name is Herbert Hodes, MD. I have been an abortion provider in Kansas for over 30 years. I am a board-certified Ob-Gyn; and, according to the Code of Ethics of the American College of Obstetricians and Gynecologists, I am qualified to speak about this bill. The American College of Obstetricians and Gynecologists is the accrediting organization of 45,000 specialists in women's health care across the country.

The authors of HB 2337 – lay people, have once again chosen to ignore the May 2002 Guidelines for Office-Based Surgery passed by the Kansas Board of Healing Arts. A committee of over twenty physicians and surgeons, not politicians and lay-people, drew up these guidelines. These medical practitioners knew what was appropriate for ***all*** physicians who perform office-based surgery – those who provide abortions as well as those who perform the dozens of other office-based surgeries offered in Kansas. These guidelines apply to ***all*** physicians, dentists, and oral surgeons.

The authors of HB 2337 have assumed that abortion providers need additional rules to govern their practices. We already operate under the supervision of many medical organizations:

Kansas Board of Healing Arts
Kansas Medical Society
City/County Health Departments
Kansas Department of Health & Environment
OSHA
Nat'l Abortion Federation
Abortion Care Network
Insurance Companies (Payees)
County Medical Societies
Professional Liability Carriers
ACOG
HIPAA
CLIA
AMA

I urge this committee to vote against HB 2337, and support the universal guidelines for all physicians and dentists as approved by the Kansas Board of Healing Arts in May 2002.

I welcome any questions.

Sincerely,

Herbert C. Hodes, MD, FACOG

House Fed & State Affairs
Date: 3.9.11
Attachment 2

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, (Ob-Gyn), KS Board of Healing Arts
Thomas Faerber, MD	Shawnee Mission, (Maxillofacial Surgery)
Robert Gibbons, MD	Shawnee Mission, (Anesthesiology)
Jimmie Gleason, MD	Topeka, (Ob-Gyn), KaMMCO
James Hamilton, MD	Topeka, (General Surgery)
David Hedrick, MD	Salina, (Otolaryngology)
Kevin Hoppock, MD	Wichita, (Family Practice)
Michael Hutchinson, MD	Kansas City, KUMC, (Anesthesiology)
Frank Koranda, MD	Shawnee Mission, (Otolaryngology)
Alan Kruckemeyer, MD	Salina, (Orthopedic Surgery)
Ron Marek, DO	Family Practice, KS Assoc. of Osteopathic Medicine
Mark McCune, MD	Shawnee Mission, (Dermatology), KS 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
Hari Strump, MD	Hays, (General Surgery)
Kim Templeton, MD	Kansas City, KUMC, (Orthopedic Surgery)

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 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 O2, suction, resuscitation equipment, emergency drugs; and emergency air-way 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. Such locations should 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 specs.
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.

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

(Approved by KMS House of Delegates May 5, 2002)

ESSENTIALS FOR OFFICE-BASED ANESTHESIA

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 CO_2 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 plethsymography, or ultrasound peripheral pulse monitoring.

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.

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

(Approved by KMS House of Delegates May 5, 2002)

APPENDIX A

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 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

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
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
info@aaahc.org

American Osteopathic Association Healthcare Facilities Accreditation Program
142 East Ontario St.
Chicago, IL 60611
Phone: 800.621.1773
www.aoa-net.org

Institute for Medical Quality (IMQ)
221 Main Street, Suite 210
San Francisco, CA 94105
Phone: 415.882.5151
www.img.org

Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
One Renaissance Blvd.
Oakbrook Terrace, IL 60181
Phone: 630.792.5000
www.jcaho.org

II. Other Resource Organizations

American Academy of Dermatology
930 N. Meacham Road
Schaumberg, IL 60168
Phone 847.330.0230
www.aad.org

American Academy of Facial Plastic and Reconstructive Surgery
310 S. Henry Street
Alexandria, VA 22314
Phone 703.299.9291
www.facial-plastic-surgery.org

American Academy of Otolaryngology-Head and Neck Surgery
One Prince St.
Alexandria, VA 32314
Phone 703.836.4444
www.entnet.org

American Association of Nurse Anesthetists
222 South Prospect Ave.
Park Ridge, IL 60068
Phone 847.692.7050
www.aana.com

American College of Surgeons
633 North Saint Clair St.
Chicago, IL 60611
Phone 312.202.5000
www.facs.org

American Society of Anesthesiologists
520 N. Northwest Highway
Park Ridge, IL 60068
Phone 847.825.5586
www.ASAHQ.org

American Soc./Aesthetic Plastic Surgery, Inc.
36 West 44th Street, Suite 630
New York, NY 10036
Phone 212.921.0500
www.surgery.org

American Society for Dermatologic Surgery
930 North Meacham Road
Schaumburg, IL 60173
Phone: 847.330.9830
www.asds-net.org

American Society of Plastic Surgeons
444 East Algonquin Road
Arlington, Heights, IL 60005
Phone 847.228.9900
www.plasticsurgery.org

American Gastroenterological Association
7910 Woodmont Ave., 7th Floor
Bethesda, MD 20814
Phone 301.654.2055
www.gastro.org

Federation of State Medical Boards
400 Fuller Wiser Road, Suite 300
Euless, TX 76039
Phone 817.868.4000
www.fsmb.org