

Memo

To: CNM Advisory Council
From: Kelli Stevens, General Counsel
Date: December 1, 2016
Re: Meeting materials and issues to discuss

Attached please find the following documents:

1. **Excerpt from draft of October 14, 2016 Board meeting minutes regarding review of CNM Advisory Council recommendations on regulations.** The Board determined that a TOLAC/VABAC was not within the definition of a normal, uncomplicated pregnancy and delivery and also that the new license should be identified as a "CNM-I" license. These issues may be viewed differently by the Board of Nursing when the draft regulations are presented to them for content approval. However, at this time, these issues do not need further discussion by the Council.
2. **Excerpt from draft transcript of October 14, 2016 Board meeting on same topic** (Note: this document is the real-time transcript and contains many errors. It is being provided for informational purposes since several people left before the Board re-visited this issue later in the meeting).
3. **Revised draft K.A.R. 100-74-1 Definitions.** Added definition of "minor vaginal laceration" per Board member request so as to distinguish from higher degrees of perianal tears. The Council should discuss whether this definition is adequate.
4. **Revised draft K.A.R. 100-74-8 Scope of practice; limitations.** Added episiotomy and repair of minor vaginal laceration; removal of VBAC from scope of license, added prior cesarean delivery to conditions not within scope of license.
5. **Revised draft K.A.R. 100-74-XX Duty to refer or transfer care.** Added "consultation" to referral language.

6. **Revised draft K.A.R. 100-74-XX Assessment of patient for identifiable risks.** Added gestational age as a factor to assess, cleaned up structure of regulation. Removed erroneously duplicated factors previously listed at end of document.
7. **Revised draft K.A.R. 100-74-10 Transfer protocol requirements.** Added in patient choice of hospital document and cleaned up structure. The Council should discuss the feasibility of the requirements in this regulation in a real-world setting.
8. **Draft K.A.R. 100-74-XX Identifiable risks requiring transfer of care of patient.** No changes made.
9. **Revised draft K.A.R. 100-74-XX Identifiable risks requiring transfer of care of newborn.** A Board member suggested that at Apgar score of 7 at 5 minutes was not normal and asked that the Council look at the Apgar score listed in the regulation draft again. However, I did not find any medical literature indicating that a score of 7 at 5 minutes was problematic. I just want to confirm this with the Council members.

Recusals: None

Board Decision: Approve the Consent Order with agreed upon modification.

Elizabeth F. Markowitz, O.T. - Review of Proposed Consent Order. Mr. Behzadi appeared for the Board. Ms. Markowitz appeared in person with counsel, Ms. Carol Ruth Bonebrake.

Recusals: None

Board Decision: Approve the Consent Order as written.

Gurpreet S. Randhawa, M.D. - Review of Proposed Consent Order. Mr. Behzadi appeared for the Board. Dr. Randhawa appeared in person with counsel, Ms. Carol Ruth Bonebrake.

Recusals: None

Board Decision: Approve Consent Order with agreed upon modification.

V. OTHER BUSINESS (cont'd.)

The Board President called the board meeting back to order.

Review of Certified Nurse Midwife Advisory Council Recommendations on Regulations

Draft CNM regulations were presented by Kelli Stevens, General Counsel, for the Board's review and recommendations. The draft regulations will need to go to the Nursing Board for review and content approval. Following questions and comments about the drafts by Board members, the Board heard comments from Dr. Elizabeth Wickstrom, MD, FACOG, a maternal-fetal medicine specialist.

Dr. Wickstrom presented her recommendation that certified nurse-midwives holding the new independent license not be required to use the distinct abbreviation "CNM-I" as it would create difficulties for facility electronic health record systems. She suggested an attestation statement/signature line at the end of treatment notes, etc. which would denote whether a practitioner was practicing under their independent license or their APRN license. She also provided her opinion that a trial of labor after a cesarean birth (referred to as a TOLAC) resulting in a vaginal birth after cesarean (VBAC) should be included in the scope of practice for the independent license in hospitals with immediate surgical availability or in accredited birth centers where there emergency transport availability to such a hospital within minutes. Finally, she discussed how physicians and nurse-midwives collaborate when a patient presents with a potential risk factor to pregnancy and delivery and recommended that the regulations not have strict lists of factors that require referral or transfer, but

instead allow for the independent certified nurse-midwife to use their professional judgment as to when and how to get a physician involved for a patient with risk factors. Board members asked questions of Dr. Wickstrom regarding the amount of time the standard of care would require to be able to do a cesarean delivery when a patient has a TOLAC.

The Board asked Kent Bradley, M.D., FACOG, a physician member of the Certified Nurse Midwife Advisory Council, to provide his differing opinion on whether a TOLAC resulting in a VBAC was within the statutory scope of practice for independent certified nurse-midwives. Dr. Bradley expressed that the lowest risk of uterine rupture is .05 percent, or 1 in 200. He noted that uterine rupture is often life-threatening for mother and baby. Dr. Bradley answered questions from the Board members.

The Board members expressed that in the draft "duty to transfer" regulation, there was language indicating a transfer could be made to a hospital ER. Ms. Stevens indicated that the Council had actually recommended changing that language so that it referral was to a hospital with an obstetrical unit. Board members also requested more clear language regarding the duty to communicate with a physician on transfer and also regarding the independent certified nurse-midwife's ability to provide supervision and delegation of others.

Cara Busenhart, Ph.D., CNM, APRN, a member of the Council, also answered questions from the Board members regarding IV analgesia and sedation. She clarified that CNMs do IV analgesia, but not sedation.

The Board members discussed among themselves whether or not to include VBACs in the scope of practice with a timeframe requirement for availability of a cesarean delivery. The Board members noted that this necessitates balancing the risk with the rights of women who want to have a VBAC.

Dr. Chad Johanning, M.D., a member of the Council, provided his opinion that a prior cesarean birth is an inherently risky condition that excludes it from the limited scope of practice for this license, which is a "normal, uncomplicated pregnancy and delivery." He opined that the timeframe for being able to convert to a cesarean delivery was not the issue, but rather was the condition within the statutory scope of practice. He said that in contrast, the CNM members of the Council viewed a prior cesarean as a condition that was acceptable if reasonably managed, and thus, the Council was unable to resolve the VBAC issue among themselves.

Dr. Wickstrom then stated that the 1 in 200 risk of uterine rupture encompassed all women with a previous uterine scar and referred to any opening of the scar, not necessarily a catastrophic one. She noted that accredited birth centers who do TOLACs have very strict criteria for who they will offer a TOLAC. She noted the American College of Obstetricians and Gynecologists' 2010 Practice

Bulletin recommends that a TOLAC be undertaken where staff can immediately provide an emergency cesarean, but recognizes that those resources are not universally available. It is recommended that patients be made aware of the levels of risk and be informed about available resources and management alternatives. Dr. Wickstrom opined that if TOLACs are not available in hospitals and accredited birth centers under this license, they will happen at home.

The Board then recessed the Board meeting to resume administrative hearings. President Minns indicated if there was time to come back to the issue the Board would do so.

Following the last administrative hearing, the Board resumed discussion of the draft regulations. Ms. Stevens pointed out that if a prior cesarean and a TOLAC inherently were not a “normal, uncomplicated pregnancy and delivery,” the Board could not add it into the scope defined by the Legislature, even in an accredited birthing center or hospital. She noted that practitioners could still do VBACs under their APRN license. Stacy Bond, Assistant General Counsel, clarified that these regulations need to be written for the lowest common denominator and the Board can’t assume these new licensees will still maintain a collaborative agreement to practice under their APRN license.

(Durrett/Varner) Motion that based on the high complication rate of VBACs, they are not “uncomplicated.” Carried.

(Templeton/Webb) Motion to approve the designation of CNM-I for Certified Nurse Midwife-Independent Practice. Carried.

VI. STAFF REPORTS

Licensing Administrator:

Approval of Licensee/Registrant List

(Milfeld/Varner) Approve licensee/registrant list. Carried.

Licensing Report

Mr. Nichols introduced new licensing staff, Paige Miller, Jessica McFarland and Nichole Schlessener, to the Board Members.

Litigation Counsel:

Litigation Report

Mr. Hays reviewed litigation department statistics for this reporting period.

1 seconded. Those in favor going out of closed
 2 session say aye.
 3 ALL: Aye.
 4 PRESIDING OFFICER MINNS: Opposed same
 5 sign? We are in open session. Do I hear a motion?
 6 DOCTOR MILFELD: I'd like to makes a
 7 motion that we terminate the professional
 8 development plan for Doctor Mensch.
 9 DOCTOR GOULD: Second.
 10 PRESIDING OFFICER MINNS: Doctor Milfeld
 11 made the motion, Doctor Gould seconded it. We've
 12 all heard the motion. Will those in favor of the
 13 motion say aye.
 14 ALL: Aye.
 15 PRESIDING OFFICER MINNS: Opposed same
 16 sign? PDP is terminated. Congratulations.
 17 MR. 2: Thank you. You won't see her
 18 again.
 19 PRESIDING OFFICER MINNS: So a little
 20 ahead of schedule but we have a case that's not
 21 here yet that should have been so we'll take a
 22 break a little break here maybe ten minutes and
 23 let the court reporter have a little break too.
 24 (THEREUPON, a recess was taken.)
 25 PRESIDING OFFICER MINNS: If I could have

1 acts in other states or is it just somewhat
 2 unusual in the limitation of scope it provides.
 3 MS. STEVENS: I think it's somewhat
 4 unusual in that pulling this profession and having
 5 it be under the board of healing arts and having
 6 renewal regulatory function of both boards
 7 creating the regulation, the carvout of the very
 8 limited scope of practice is probably a little bit
 9 unusual.
 10 DOCTOR SETTICH: Okay and then I wanted
 11 to ask you obviously you said in here that you
 12 wanted to mimic to the extent you could
 13 regulations from the other states, that match the
 14 statute. Were you able to do is that were you
 15 able to sort of take models from else where to
 16 create our regulations in draft form.
 17 MS. STEVENS: What I think we tried to do
 18 is take primarily clinical language where a
 19 condition has been articulated the council looked
 20 at that where a structure of how referral and
 21 transfer worked, but because so many of the
 22 regulatory schemes that we looked at from other
 23 states involved noncertified nurse- midwife or lay
 24 mid wives or just certified professional mid wives
 25 they aren't apples to apples and we weren't able

1 the board members find their seats I'd like to get
 2 I want to proceed with the licensing administrator
 3 report so I think you need to make so much
 4 introductions before you'd make your report.
 5 (Licensing administrator reports given).
 6 MS. STEVENS: So the materials for
 7 recommendations of the independent certified
 8 nurse-midwife advisory council are on page 2006 of
 9 your eBook and I think that everybody review those
 10 materials in depth we are in a just to let you
 11 know the stage of the process we're at we've had
 12 six advisory council meetings and all of the
 13 minutes, the last set being draft minutes are in
 14 your materials. As you can tell the council has
 15 worked very, very hard and while the minutes
 16 probably only reflect a very high level view of
 17 their the issues they've discussed they got down
 18 -- down in the weeds and have had just great
 19 discussions on the clinical issues, the regulatory
 20 issues involved with this much doctor Settich.
 21 DOCTOR SETTICH: Could I ask a couple
 22 questions first of all the language that was
 23 adopted by the legislature last year for this
 24 independent practice of midwifery is this very
 25 very unusual as compared to the other independent

1 to I mean we could just pull language in and the
 2 could be sill worked very hard at looking where
 3 things were articulated. It wouldn't work
 4 basically.
 5 DOCTOR MINNS: Last question and then
 6 I'll go away for a little bit it seems to me that
 7 one of the stakeholders here is clearly
 8 professional liability carrier for these new
 9 practitioners, right and they were consulted and
 10 (Doctor Settich) the people that write the
 11 coverage for these folks.
 12 MS. STEVENS: Well advanced registered
 13 nurses as a whole now participate in the health
 14 care stabilization fund.
 15 DOCTOR SETTICH: So that's all covered.
 16 MS. STEVENS: Right we didn't have any
 17 issues regarding liability coverage.
 18 DOCTOR SETTICH: Thank you.
 19 MS. STEVENS: So I think the difficult
 20 has struggled with we have a carvout but it is a
 21 narrow scope of practice that in theory sounds
 22 like a very workable arrangement but in practice
 23 pregnant woman don't always remain uncomplicated
 24 or they may be comply capings that is appear to be
 25 significant and are cleared and really don't



1 affect the pregnancy and so the council really has
 2 struggled with how to do risk assessments, how to
 3 define what are prohibited acted and you can see
 4 that reflected in materials. Basically I think
 5 the issues and you're going to hear from Doctor
 6 wick Streptococcus pneumoniae echosa maternal
 7 fetal medicine specialist on specifically some
 8 issues of the use of a separate title certified
 9 nurse-midwife/independent and on having a trial of
 10 labor after cesarean section, those type of
 11 issues, but so we could be very, very restrictive
 12 in language and say this condition is complicated,
 13 automatic referral, transfer, no questions. Or
 14 you can state a nonexclusive list of conditions
 15 that need to be assessed much like the birth
 16 center regulations do, and allow for -- and really
 17 it all allows for it but really rely on the
 18 professionals independent medical judgment in
 19 assessing those risks to determine whether
 20 transfer or referral was necessary.

21 DOCTOR SETTICH: I'm sorry can I
 22 interrupt real quick I promise again are those
 23 actional by us today are these recommended by you
 24 and the other parties as actional by us so they
 25 might go forward in the process or we're not

1 officially adopting or recommending these.
 2 MS. STEVENS: What we're looking at is
 3 we've got some variation on some of the risk
 4 assessment, restrictive you'll see some language
 5 in there. You'll see the draft that was done by
 6 Diane Glenn at the board of nursing on page 2026
 7 which is a broader use your professional judgment,
 8 look at these areas to determine referral and
 9 transfer type language what I want the board to do
 10 today is answer some specific questions but then
 11 knees need to go to the board of nursing for that
 12 I recall approval on content, then at that point
 13 we would move forward with them to in the adoption
 14 process but we are not there yet. You may want to
 15 have the council do some more work, that's really
 16 going to be your prerogative. The primary areas
 17 deal with what's that risk assessment going to
 18 look like, and also the issue of trial of labor
 19 after cesarean section. There was lots of really
 20 good discussion during the council meetings, one
 21 viewpoint being that you need to have immediate
 22 surgical availability and that a prior cesarean
 23 section is inherently a complicated pregnancy
 24 which means that it doesn't fall within the scope
 25 of this license. The other viewpoint being it can

1 be an inherent complication, but if proper
 2 assessment is done, proper safeguards are put in
 3 place, it doesn't necessarily -- you know, it
 4 doesn't mean it's going to result in a complicated
 5 delivery or a repeat cesarean or uterine you
 6 wantture and therefore it is permissible in birth
 7 centers right now and that it should be allowed in
 8 birth centers or in hospitals. Everyone pretty
 9 much agreed that a vaginal birth after cesarean
 10 section was not appropriate for a home birth.

11 DOCTOR TEMPLETON: So if we're going to
 12 move something on to the board of nursing do we
 13 have to vote on something today so that we have a
 14 package to send to the board for their input do we
 15 have to have some sort of finalish draft from us
 16 today.

17 MS. STEVENS: Right and so I certainly
 18 want you to hear from Doctor wick Streptococcus
 19 pneumoniae before we discuss that further. But
 20 the basic differences would be to do there's the
 21 draft regulations in there for that have risks to
 22 patients and risks to newborn that create
 23 automatic transfer, and then you have the draft by
 24 Diane glen from the board of nursing that
 25 basically took some of the risk factors and

1 created more of a use your professional judgment
 2 model but everyone agrees that if a condition
 3 exists that it needs further assessment that might
 4 be a complication of the pregnancy that needs to
 5 be addressed by a physician, certainly a physician
 6 can always clear the patient and return to
 7 treatment by the nurse-midwife. The other issue
 8 is the title, and that really, you know, we all
 9 think about the different titles that our
 10 licensees have and don't really think of it as
 11 being a big issue but here you have people who are
 12 going to be duly licensed as APRNs and this new
 13 independent certified nurse-midwife they could
 14 conceivably and probably will continue to carry
 15 both licenses and maybe even practice under both
 16 licenses and even do that with the same patient
 17 this scope of practice being more narrow patient
 18 presents a complication that doesn't fall within
 19 this scope, I can continue practicing and treating
 20 that patient under my APRN license with with my
 21 collaborative agreement in place and so the
 22 concern from both board staff perspective is one,
 23 how do we know. I mean if we get a case where
 24 the it's alleged someone went outside the scope of
 25 their practice they need to be documenting so we



1 know which license they're practicing under at any
 2 given time but it creates other problems billing
 3 most people use their MPI number it's by provider
 4 not by type of license and are you billing as an
 5 independent certified nurse-midwife are you
 6 billing as abAPRN some pharmacy issues MAR issues
 7 that have arisen but we really do need a separate
 8 designation in medical record so that we know who
 9 is doing what under what license. Yes.

10 DOCTOR VARNER: So if they have a
 11 complication they can change hats and handle the
 12 complication under the ARNP license.

13 MS. STEVENS: There is no prohibition
 14 this license they stand alone separately, so if
 15 you're licensed as an APRN and you have a broader
 16 scope of practice under your collaborative
 17 agreement with a physician there's no certainly in
 18 all of the nurse bid wives on the council stressed
 19 and I think rightly so that you only do what's in
 20 your competency and your skill set, but they may
 21 have a broader scope of practice under their APRN
 22 license and there is no prohibition to practicing
 23 under that license.

24 PRESIDING OFFICER MINNS: Kelly you
 25 mentioned there seems to be two major things you

1 wanted to get discussed today would it be best to
 2 focus on one and then move to the other.

3 MS. STEVENS: Well I'd like you to hear
 4 from Doctor Wick Streptococcus pneumoniae first
 5 but those issues are ken a strict risk assessment
 6 criteria use your professional judgment and
 7 determine those things and then the other being
 8 the trial of labor after cesarean.

9 PRESIDING OFFICER MINNS: I'm just trying
 10 to get a structure to this so would it be best to
 11 hear from our testimony first.

12 A. And then I think talk a little further
 13 but I think we had a few more questions.

14 DOCTOR TEMPLETON: When talk about
 15 transfer the transfers keep they think soing
 16 agreement with the specified hospital but not with
 17 a provider I guess that raises some concerns so if
 18 the woman has issues and you go to a hospital but
 19 there's no indication that there's going to be an
 20 OB or a qualified health care professional that's
 21 going to accept the transfer.

22 MS. STEVENS: I believe in our
 23 discussions with the advisory council it was
 24 referring to not just taking someone to the ER but
 25 someone with an obstetrical unit.

1 DOCTOR TEMPLETON: Okay it doesn't state
 2 that in there it keeps mentioning the hospital not
 3 who's what physician is taking care of them at the
 4 hospital.

5 MS. STEVENS: Yeah.

6 PRESIDING OFFICER MINNS: Mr. Settich.

7 DOCTOR SETTICH: Obviously the character
 8 of my questions are procedural are there member of
 9 the advisory council here today.

10 MS. STEVENS: Yes there are.

11 DOCTOR SETTICH: Okay and I'm assuming
 12 that specially from the medical members of the
 13 board they're discussion is to inform and help our
 14 add ovary vise I committee right.

15 MS. STEVENS: Right we have three
 16 physicians on the advisory council and four
 17 certified nurse mid wives on the council.

18 DOCTOR SETTICH: And also to provide
 19 feedback to the board of nursing and so that's the
 20 reason we're having discussion today.

21 MS. STEVENS: Right.

22 DOCTOR SETTICH: Okay thank you.

23 MS. STEVENS: Do you want to hear from
 24 Doctor Wick storm Liz Liz in Shawnee mission
 25 Kansas and have come up through the ranks working

1 with nurse mid wives literally my entire career
 2 from medical student residency on. I feel like
 3 I'm uniquely qualified to address the interface
 4 between physicians and certified nurse mid wives
 5 having been a medical director for a program and
 6 also having a lot of interaction and collaboration
 7 with nurse bid moves around the city who send
 8 patients to me for the very consultations that
 9 you're talking about.

10 The issues that I wanted to be certain to
 11 raise to you today, one is this idea of changing
 12 the initials after a certified nurse bid move's
 13 name if you say it has to be certified nurse-
 14 midwife- independent that's going to change every
 15 time they log into a hospital electronic medical
 16 record my recommendation instead would be you
 17 leave certified nurse-midwife alone you just leave
 18 it there, but when someone is documenting in the
 19 electronic record that they have evaluated a
 20 patient and have recommended a set of treatments
 21 there can be an at testation they put, a signature
 22 line that you can put that says this interaction
 23 was under my certified nurse-midwife independent
 24 license or if it's someone who's become more
 25 complicated and they're working with them around



Page 177

1 their APRN license with their physician they can
 2 attest such in the electronic medical record the
 3 advantage of that is that it doesn't mean that
 4 there's a whole nother step for them to take with
 5 every hospital and every birth center they work at
 6 every electronic medical record if you have two
 7 Pratt hats you wear and every time you log in you
 8 have to know which hat you're wearing and log in
 9 as such and pay for that separate long in that's
 10 really onerous that's really a burden object
 11 practitioners and a reasonable way to do that is
 12 to call a certified nurse- midwife a certified
 13 nurse-midwife allow them to practice within the
 14 scope that they are trained to do not add another
 15 initial but perhaps require that they have an at
 16 testation so that if you get a case brought before
 17 you and you say which hat did you have on you can
 18 tell by looking at the medical record because they
 19 are attest sod in their documentation so that was
 20 that topic.
 21 Next topic is the idea of trial of labor
 22 after cesarean it's a tricky topic even among
 23 hospitals in Kansas City there are providers that
 24 won't provide trial of labor after cesarean for
 25 their patients because they don't have anyone in

Page 178

1 house 24/. to jump in if there's an issue and
 2 begin an immediate cesarean section so that leaves
 3 a large number of women in Kansas much less in the
 4 not poll tan areas who have no access to trial of
 5 labor after cesarean and nationwide we're trying
 6 to reduce the cesarean section rate we understand
 7 what kind of morbidity that causes in mothers and
 8 baby sos keep cutting people open to have their
 9 babies a very reason way to get those numbers down
 10 would be to say there are circumstances where
 11 trial of labor is appropriate whether that be in a
 12 hospital setting where there's someone immediately
 13 available to jump in and do a C-section or in an
 14 accredited birth center setting where there's a
 15 relationship with their hospital that is minutes
 16 away and with the emergency medical system for
 17 transport minutes away, so those accreditations
 18 are already in place so what I would ask of the
 19 council which it's not you, I get the council is
 20 supposed to be making a recommendation to you what
 21 I would ask the council to do would be to revise
 22 what they've stated and I gave kind of a little
 23 way I would like to see that phrased, because it
 24 involves both hospitals and ago redded birth
 25 centers so as that comes through to you to be

Page 179

1 approved and sent on to the board of nursing I'd
 2 ask you to keep that in mind.
 3 The third issue has to be with how physicians
 4 and nurse mid wives collaborate together. And if
 5 you try to make an exhaust I have list of for
 6 exactly this and this and this situation she just
 7 needs to be cared for by a physician for this and
 8 this and this she can be evaluated by a physician
 9 and then they either send her back or they keep
 10 her for for these things you can pick up the phone
 11 and say hey is this okay for this medicine to use
 12 in pregnancy and I say sure go ahead it's
 13 difficult to form a comprehensive list that's
 14 going to address all of those sits. So instead
 15 what I've presented are definitions of their
 16 various scenarios and then the individual bra
 17 resider the certified nurse-midwife in her scope
 18 of practice can use her judgment based on her
 19 appearance level there may be uncertified nurse-
 20 midwife that's's never taken care of a gestational
 21 diabetic in her life well in my practice a
 22 certified nurse-midwife runs the diabetic program
 23 so each one has their comfort level their
 24 licensing is the same their credibling is the same
 25 but their level of experience may be different so

Page 180

1 for us to try to pinpoint these are the things you
 2 can and can't take care of I think that's a gourd
 3 you know knot and you're just going to do them
 4 forever so my opinion would be based on what I
 5 have heard here today perhaps this take one more
 6 pass back to council to iron out the trial of
 7 cesarean after issue and perhaps enter an at
 8 testation so if you guys ever saw a case from them
 9 you'd know which hat they were wearing and then
 10 bring it back to you for approval and then send it
 11 on to the board of nursing. Questions for me.
 12 PRESIDING OFFICER MINNS: Questions from
 13 the board members Doctor Durrett.
 14 DOCTOR DURRETT: Yes thanks for being
 15 here that clarifies a lot of things in my mind.
 16 So as concerning the three questions to address
 17 your three topics so electronic medical records is
 18 the physician going to come along and sign cosign
 19 those notes where it's not a CNMI and say yes I
 20 approve of that and take over the care or.
 21 THE WITNESS: Exactly so if a nurse-
 22 midwife is work under her APRN hat then when she
 23 writes that note in the electronic medical record
 24 it automatically forwards for signature.
 25 DOCTOR DURRETT: Second you said trial of



1 labor I listened to a couple of the talks that
 2 they had and that seemed to be a hot topic so one
 3 of the things you just said a trial of labor after
 4 cesarean at a birthing center which looking at all
 5 the literature look like that's a reasonable thing
 6 but you just said if we had with availability of
 7 transfer minutes away, so these regulations are
 8 for the entire state of Kansas not just Wichita,
 9 Kansas City Topeka so how does that protect the
 10 public how does that protect patients out in
 11 western Kansas where it's not minutes away.

12 THE WITNESS: I think that's a very
 13 important point. I think that if you are in an
 14 accredited birthing center performing a trial of
 15 labor and I'm calling it trial of labor rather
 16 than V back V back is if you've successfully had a
 17 baby to lack is the hot new thing to say. I
 18 believe that there's a big difference between
 19 women having a trial of labor in hospital and in
 20 an accredited birth center that is close enough to
 21 a hospital that can provide emergency cesarean
 22 birth. I think that's key. I think I don't know
 23 about tell me about are there accredited bit
 24 centers that are out in the boonies all not
 25 currently okay I did.

1 DOCTOR DURRETT: Are there going to be
 2 home deliveries are these rules and regulations
 3 apply.

4 THE WITNESS: So my understanding is that
 5 these rules and regulations are not applicable for
 6 home deliveries that's my understanding the part
 7 about trial of labor after cesarean is not I
 8 believe because the regulation would specifically
 9 say if they phrase it it would specifically say in
 10 a hospital or in an accredited birth center.

11 DOCTOR DURRETT: What's your time frame
 12 when you say transfers immediately available
 13 because most people are going to want to go for
 14 hey we've got a uterine you wanture and impeding
 15 demise that's what I heard from one of the doctors
 16 that testified what's your time frame for a
 17 transfer from birthing center to a hospital and
 18 then into C-section because once you get to the
 19 hospital they've got to be evaluated and then go
 20 what's a safe time frame from the time you say I
 21 want to get this C-section done because this is a
 22 tailed trial of labor not a V back and then go
 23 from there what's that safe time.

24 THE WITNESS: Excellent question so
 25 within hospitals their goal is usually 15 minutes

1 from call to C-section to be in the OR so if
 2 you're an accredited birth center and you're not
 3 in the hospital yet the advantage is having your
 4 hot line phone to labor and delivery to say you
 5 know us you know we're right around the corner
 6 from you open the OR get the surgeons scrubbed get
 7 anesthesia standing there we're coming in now so
 8 that literally can be the same time coming in from
 9 a birthing center as it can be coming in from
 10 another floor.

11 DOCTOR DURRETT: You see the problem with
 12 that though.

13 THE WITNESS: It's a slippery slope.

14 DOCTOR DURRETT: You're calling a surgeon
 15 a technician now we're going right to the OR the
 16 doctor meets the patient it's the standard of care
 17 evaluates the patient I mean we're not technicians
 18 we don't just go and make a decision to pull the
 19 baby out they've got to be reevaluated so I mean
 20 to me, you know, all paperwork that goes on well
 21 you could probably go forgo that in percentage but
 22 isn't that going to be but the question is.

23 DOCTOR TEMPLETON: Let's talk about
 24 transport time getting testimonies there.

25 DOCTOR DURRETT: There's a lot of things

1 involved there and if you're in the hospital if
 2 the nurse-midwife is in the hospital say like a
 3 family practice doctor is doing a V back in the
 4 hospital hey this isn't working I need help quick
 5 and my surgeon on call my family practice doctor
 6 that does C-sections is going to take me in to do
 7 this, I mean I think you need a time in order to
 8 protect the patients of Kansas I think you need to
 9 come up with a time that says this is safe and
 10 when you're saying 15 minutes in the hospital, it
 11 can be half an hour to transport and you could
 12 have fetal demise you could have troubles with mom
 13 you see what I'm saying that's what I'm looking
 14 for what's a safe time.

15 THE WITNESS: And I think that's an
 16 excellent question to bring back to the council
 17 you better.

18 PRESIDING OFFICER MINNS: Any other
 19 questions Doctor Beezley.

20 DOCTOR BEEZLEY: I'm a vascular surgeon
 21 to I'm way removed from OBGYN what is a certified
 22 birthing center and how many of those are say in
 23 Kansas City they're not a hospital right.

24 THE WITNESS: Yeah it's accredited
 25 birthing center four accredited birth centers no



Page 185

1 four birthing centers in the state two of them
 2 immediate accreditation by American association of
 3 birthing centers.
 4 DOCTOR BEEZLEY: So it's a facility
 5 separate from a hospital in afteroffice building.
 6 THE WITNESS: It is a from standing birth
 7 center yes.
 8 DOCTOR BEEZLEY: And other question is
 9 even more stupid you keep referring to midwife
 10 nurses as a she are there any male midwife nurses.
 11 THE WITNESS: I've only met them in hay
 12 tie.
 13 THE WITNESS: There are not in nationwide
 14 there are all the C women so that are very sexist
 15 of me I stand corrected.
 16 PRESIDING OFFICER MINNS: Doctor Beezley
 17 one birthing center I'm aware of in Wichita is
 18 just across the street from Wesley and it's
 19 connected by a tunnel underneath to the OB
 20 department.
 21 MS. STEVENS: It's a hospital birthing
 22 center.
 23 THE WITNESS: Do I get to call on you
 24 Doctor Varner or does he have to call you.
 25 DOCTOR VARNER: I have a little backed in

Page 186

1 this when I first started practice OB for seven
 2 eight years I had fetal monitor and I could tell
 3 you what an uncome complicate pregnancy delivery
 4 was after it was over I couldn't tell you
 5 beforehand so I take think there does need to be
 6 some significant restrictions the second comment
 7 there's two OBGYNs four or five family doctors
 8 that deliver babies and they cannot get insurance
 9 to do V backs or whatever term you used because
 10 the hospital's malpractice insurance wouldn't
 11 cover unless there's 24 hour surgery coverage and
 12 24 hour these coverage is question is do the
 13 birthing centers can they get insurance for all
 14 this.
 15 THE WITNESS: Indeed they are at least
 16 the once that are represented in this room today
 17 and my understanding is that two have to be an
 18 accredited birthing center that that's a
 19 requirement.
 20 PRESIDING OFFICER MINNS: Okay any other
 21 questions? I think we have thank you very much.
 22 THE WITNESS: You're welcome.
 23 PRESIDING OFFICER MINNS: I think we have
 24 two physician members from the council here today
 25 Doctor oh henning and Bradley do either of you

Page 187

1 want to try to clarify any of these issues come on
 2 up to the speaker this is Doctor Bradley who is on
 3 the council Brad Brad yeah I'm happy to answer any
 4 questions I'm happy to expand on the V back
 5 concerns we have. Even the literature on the
 6 nurse-midwife website says the lowest risk chance
 7 of a uterine rupture is .5 percent or one in 200
 8 and so when the law as written specific calls for
 9 normal and uncomplicated in my mind that's a high
 10 enough risk to make it not fit in this category.
 11 I think if every time I was going to get on a
 12 plane one in 200 were going to fall out of the sky
 13 I would view that as not a low risk situation and
 14 I would take extra concern in that manner, so when
 15 there's a rupture there's a view that a practice
 16 obstetrics note it's often a life threatening
 17 emergency situation for mother and baby, so that's
 18 where the concern about that as we were trying to
 19 stratify risks when that came up as a situation in
 20 the council, that's why it raised to this level
 21 and knowing that if there was a problem in the
 22 future the first stop that it would make is back
 23 to the council before it raised to your level if
 24 we couldn't agree at the beginning writing these
 25 regulations that a V back for an independent

Page 188

1 midwife without a collaboration agreement would be
 2 a concern, then that's where the impasse has been
 3 so far.
 4 PRESIDING OFFICER MINNS: Doctor Varner.
 5 DOCTOR VARNER: Do you do V backs after
 6 trial of labor brad brad I practice mainly at
 7 newten medical center in newten Kansas we have
 8 four OBGYNs and we do not do V backs at newten
 9 because we think we need in house anesthesia and
 10 in house surgery team and we don't have that
 11 always available so retransfer any of our patients
 12 at 36 weeks that want to do V back to Wesley where
 13 they can turn a C will have-section in a matter of
 14 minutes and we can't so we don't I'm also vice
 15 chairman of the OB department for KU at Wesley and
 16 obviously Wesley does V backs.
 17 PRESIDING OFFICER MINNS: Mr. Fill fell
 18 you had your hand you will.
 19 DOCTOR MILFELD: Yes Doctor Bradley
 20 thanks for coming and to the rest of your
 21 colleagues on the council also but don't our
 22 plaintiff colleagues have a little say in this and
 23 I'm thinking about time element that is we
 24 discussed and if you say we're in a hospital and
 25 we can get to the OR in ten minutes versus a



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1 birthing center and it took you 30 minutes, that
 2 says it right there. I mean to me and I'm sitting
 3 on a jury and I see this, I mean that's quite
 4 graphic as far as the emergent need for that which
 5 in many instances it seems like as a card thoracic
 6 surgeon you can't anticipate but you've got to
 7 have that availability as quick as you can and
 8 it's going to be a matter of seconds not minutes
 9 brad brad and I don't disagree with you that's why
 10 at newten we've decided not to do V backs but
 11 still offer our patients that option because we
 12 can certain a section in 30 minutes we can turn it
 13 in approximate less than 30 minutes most times but
 14 we can't turn it in five minutes like Wesley can
 15 so.

16 DOCTOR MILFELD: So you've set a high bar
 17 then if identities going to be it's date of birth
 18 brad brad there's standard of practice you all
 19 know that as you said trying to evaluate the
 20 things that you have to at this board but it seems
 21 to me there are certain lines somewhere in there
 22 and, you know, I mean midwives are involved
 23 certified nurse-midwives are involved in trial of
 24 labor and my colleagues from the midwife council
 25 are here and can talk about that if you'd like to,

1 one. Are there others you want to draw to our
 2 attention that are sort of unresolved brad brad I
 3 think Kelly did an excellent job of doing that. I
 4 walked in as she was speaking so I didn't hear her
 5 first remarks but I think my understanding is my
 6 nurse-midwife colleagues are very concerned about
 7 the-I and that is still unresolved and there's a
 8 number of things that I think we're charged with
 9 that we haven't got to yet, ordering tests and
 10 doing some of those things I think we haven't
 11 fully exlo employeed some of those topics because
 12 we haven't got to but I think she her memo and her
 13 presentation did a nice job of.

14 DOCTOR SETTICH: Thank you brad brad I
 15 think it's a difficult job to define what normal
 16 and complicated is going to be and we're just the
 17 first wave you guys are next.

18 PRESIDING OFFICER MINNS: All right thank
 19 you Doctor Bradley brad brad I know I have other
 20 colleagues if you wish to hear from anybody else.

21 PRESIDING OFFICER MINNS: Does the board
 22 have any desire to hear more comments from the
 23 council?

24 DOCTOR DURRETT: I have several more
 25 questions is this the appropriate time.

1 they absolutely do and I think the question in my
 2 mind in this particular situation is the
 3 legislature has carved out an extremely narrow
 4 subset and they have defined that narrow subset
 5 which is different than what is currently
 6 happening in the state so there is currently
 7 certified nurse mid wives that are attending to
 8 trial of labors I believe in the state, but
 9 they've carved out a very narrow focus and they've
 10 put a term on it or normal and uncomplicated and I
 11 think your colleague is correct it's extremely
 12 difficult to define normal and uncomplicated I've
 13 tried to do it for as an expert for the board of
 14 healing arts on cases I've tried to do it and it's
 15 very difficult, you know, in obstetrics normal
 16 uncompliate to holy blank happens in about two
 17 minutes, and so the physician colleagues on this
 18 council were trying to create some sort of lines
 19 somewhere to start.

20 PRESIDING OFFICER MINNS: Mr. Settich you
 21 had a question.

22 DOCTOR SETTICH: Sir in the draft and in
 23 the report we see here there are a couple of areas
 24 which it said the council was unresolved or still
 25 working on a particular area you just discussed

1 MS. STEVENS: Are they clinical questions
 2 are they more directed as the.

3 DOCTOR DURRETT: Okay I've got one for
 4 you it concerns the language in there was one
 5 place where it said that if something happens
 6 something goes wrong the patient can be
 7 transferred to the ER and it will not be
 8 considered patient abandonment to send them to the
 9 ER do you remember that section things go wrong
 10 with mom or baby we're going to send them to the
 11 ER the closest ER.

12 MS. STEVENS: I think and the council
 13 actually expressed that it's not we don't want
 14 patients going to the ERI think that little
 15 provision maybe didn't get completely changed it's
 16 a hospital with an obstetrical unit but we don't
 17 want internal that transfer that's very necessary
 18 to a higher level of care to be construed as
 19 patient abandonment it's kind of a little
 20 liability provision.

21 DOCTOR DURRETT: But it's not from the
 22 imthe will and cobra that's just good care it's
 23 like a clinic where resources are not available so
 24 you're going going to send them to the ER to be
 25 stabilized but my concern about that part was that



1 you can call the hospital and say the patient's
 2 coming in cases of trauma you would call not only
 3 the hospital but you would make a phone call to
 4 the trauma surgeon or the the ER doctor and say
 5 look we've got a case that's out of our
 6 capabilities and I think only one place it
 7 medications the physician I think it's essential
 8 that the provider contact the physician for a
 9 couple of reasons one if baby or mom is not doing
 10 well can you just send it to the you've called the
 11 hospital, hospital knows they're coming and you
 12 haven't made direct contact with the ER physician
 13 or the obstetrician whoever is going to be there
 14 there's vital information that can be given to the
 15 physician which might help take care of the
 16 patient for instance in a trauma case, so you know
 17 that we're going to send all the small hospitals
 18 out west would send their trauma to a level one
 19 trauma center but there's always a phone call made
 20 from whichever physician or provider whether it's
 21 PA nurse practitioner, to the ER doctor, that way
 22 we can get his resources ready so like if mom has
 23 a fourth degree lacerations and is bleeding they
 24 can say call in lab have them get the O negative
 25 blood ready just in case so I think some language

1 that says contact must be made with the physician
 2 also would also help out patients.
 3 MS. STEVENS: And perhaps the draft
 4 regulation doesn't fully articulate and needs to
 5 more but that was absolutely what the certified
 6 nurse mid wives on our council described is you
 7 don't rust just have a list of hospitals that you
 8 go down a list and make phone calls, that you have
 9 a working relationship and that all necessary
 10 information is provided but yeah we might need to.
 11 DOCTOR DURRETT: I didn't see that in
 12 there so that would be very helpful and that's a
 13 good idea. Way to go.
 14 MS. STEVENS: So in the draft regulation
 15 100-74-10 the transfer protocol plan for transport
 16 plan for notification with ongoing communication
 17 about the history and condition and, you know, and
 18 it could be a transfer agreement or certified
 19 nurse-midwife may actually have admitting
 20 privileges at that hospital and.
 21 DOCTOR DURRETT: But then it's
 22 complicated and they're going to consult the
 23 doctor.
 24 MS. STEVENS: What I think was difficult
 25 is again we have on our council we have the very

1 best of the professionals represented but the
 2 regulations have to be for everybody and so we
 3 have best practices being described, that's what
 4 certified nurse mid wives do and they aren't
 5 they're just topnotch as far as best practices,
 6 but that's we can't assume that everyone's going
 7 to use those. And we have no indication that
 8 anyone wouldn't, but we have to set minimum
 9 standards and be very clear what those minimum
 10 standards require and that's a very -- very
 11 difficult thing to do but yes certainly what was
 12 described in the council and what was discussed
 13 was exactly what you're.
 14 DOCTOR DURRETT: So there will be
 15 language that says we'll contact the hospital and
 16 physician or provider because if they're making
 17 that transfer for complications it's complicated
 18 another thing was there was language that said
 19 that the independent practitioner can supervise a
 20 nurse and was this for the delivery or something I
 21 mean that seemed like a big lane from the nurse-
 22 midwife independent doing the delivery to now I'm
 23 going to direct under supervision if she's not in
 24 attendance or something and direct over the phone,
 25 have a nurse do it or something like that was

1 that.
 2 MS. STEVENS: They only supervise the
 3 functions that can be performed by someone else
 4 certainly, you know, ancillary staff we'd want to
 5 make it clear that they can't have ancillary
 6 staff.
 7 DOCTOR DURRETT: This is 100-74-9.
 8 MS. STEVENS: Right.
 9 DOCTOR DURRETT: And so my concern was
 10 that it's the nurse- midwife independent that's
 11 going to be doing the delivery and that made it
 12 sound like they could supervise somebody else
 13 doing the delivery and if that's a nurse-midwife
 14 student that they're training, I mean that may be
 15 appropriate if they're in attendance and it said
 16 some of those things could be done over the
 17 telephone I mean that was a slight concern too so
 18 was it going to be the nurse-midwife independent
 19 doing the delivery or is it going to be, you know,
 20 what I'm saying? Just some better language there,
 21 I think and then I'll have one other major issue
 22 or maybe a couple here so in it'd be nice if one
 23 of the nurse mid wives could help answer this too.
 24 MS. STEVENS: Sure.
 25 DOCTOR DURRETT: One of the things was IV



1 sedation or IV pain medications would that be
2 given during the delivery I mean it says you can
3 prescribe controlled substances which I think is
4 appropriate in any delivery but are you going to
5 be given IV pain medication during delivery? I
6 wasn't clear about that.

7 MS. STEVENS: Yeah and we did discuss we
8 did discuss anesthesia Doctor car a becausen heart
9 I'm the director of the nurse- midwifery program
10 at the only education program.

11 DOCTOR DURRETT: Doctor are you a
12 physician so we talked I believe it was in the
13 definitions about what a normal delivery was and
14 we did include that it could be medications and
15 epidurals for labor because that is not an
16 abnormality.

17 DOCTOR DURRETT: Right.

18 A. Nurse mid wives do not give sedation but
19 they can use IV analgesics.

20 DOCTOR DURRETT: And this is at birthing
21 center this is not a home birthright.

22 A. It's not everyone in a birthing center so
23 at a birthing center they're not giving anesthesia
24 present and they would not give the IV pain
25 medicines in a free standing birth center only in

1 a hospital.

2 DOCTOR DURRETT: This isn't happens at a
3 home birth this is only in a hospital I guess my
4 point is if you're at a birthing center would that
5 woo with the requirement for the office based
6 surgeries where if somebody's sedated you got to
7 set a protocol in your office and do sedation you
8 have to have appropriate equipment.

9 MS. STEVENS: Is scope of practice is
10 limited to the labor and delivery would be in a
11 hospital if the patient required pharmacological
12 induction or augmentation of labor or spinal or
13 epidural anesthesia.

14 DOCTOR DURRETT: Right that's only going
15 to be in a hospital setting.

16 MS. STEVENS: Right.

17 DOCTOR DURRETT: Was that language
18 included in there I just wanted to make sure.

19 MS. STEVENS: That's in the scope of
20 practice 100-74-8.

21 DOCTOR DURRETT: Yeah that's what I was
22 referring to but is that specifically explain for
23 home births that can't be done.

24 MS. STEVENS: It says only shall perform
25 it in a hospital if the patient requires the



1 following interventions.

2 DOCTOR DURRETT: It cede endo you recalls
3 and spinals it didn't say IV sedation for that
4 because if you're going to do that then the office
5 based surgery requirements wouldn't apply I
6 wouldn't believe.

7 MS. STEVENS: So we could add IV
8 medication in that too.

9 DOCTOR DURRETT: I'm just thinking that
10 should be done in the hospital.

11 A. Not all IV medication.

12 MS. STEVENS: So IV sedation yeah.

13 A. We don't do sedation we do analgesic.

14 DOCTOR DURRETT: But could they do
15 sedation in one of those situations.

16 A. Nurse mid wives do not do sedation.

17 DOCTOR DURRETT: But you're a nurse
18 practitioner and you could or not.

19 MS. STEVENS: It's a different type of
20 APRN the yeah.

21 DOCTOR DURRETT: Is there some language
22 it seemed aly vague I was thinking in order to
23 protect patients of course is that if that did
24 happen if there was somebody what they're a nurse
25 practitioner and a nurse bid wife then they could

1 give IV southeast indication than office based
2 surgery things where you had to have appropriate
3 resuscitation.

4 MS. STEVENS: It wouldn't be within their
5 scope of practice to even do that for the nurse-
6 midwife to do it.

7 A. As a nurse practitioner they would have
8 to have the signed collaborative practice
9 agreement in it because they're not included in
10 this.

11 MS. STEVENS: Or CRNA.

12 PRESIDING OFFICER MINNS: Stacy are we
13 making progress in giving you the feedback you
14 need we have ten more minutes.

15 MS. STEVENS: Well good question. We
16 really need I don't know if you want the council
17 worked very hard and basically hit some points of
18 contention. I don't know if we can resolve the
19 trial of labor after cesarean issue. I think we
20 need specific board direction on that issue
21 whether it would and Doctor wick clearly
22 articulated a very good set of criteria that would
23 represent I think is nurse-midwife position on
24 trial of labor and the physician council members
25 very clearly articulated they want immediate

Page 201

1 surgical availability for a trial of ray borrow.
 2 I need board direction.
 3 DOCTOR DURRETT: So I think it goes back
 4 to the time function once again what's the time
 5 and family practitioner they could and if you tell
 6 me your birthing centers are attached to a
 7 hospital and you could wheel them across to the
 8 hospital and be there in the same amount of time I
 9 mean doctor aren't you going to do C sections for
 10 family practice doctors also?
 11 DOCTOR GOULD: Doctor Bradley.
 12 DOCTOR DURRETT: Doctor Bradley so aren't
 13 you doing C sections for family practices doctor
 14 also brad brad yes, sir.
 15 DOCTOR DURRETT: Okay and what's the rule
 16 there I mean if they're going to do a V back and
 17 it's going to take you 15 minutes to do a C-
 18 section I mean I'm still looking for that magical
 19 time and what's the time you want them to be in C
 20 sections because if they could say hey look we
 21 could go from the birthing center to the hospital
 22 and have a C section done is that time 30 minutes
 23 is it 15 minutes? Because if they could come up
 24 and they could meet that time frame we could do it
 25 in 15 or 30 minutes, I mean I think that's the

Page 202

1 hold up here what's the time from hey I'm having
 2 complications and I need C-sections I mean if you
 3 come up with a magical time and they say we can do
 4 that I mean doesn't that fix that problem.
 5 MS. STEVENS: Well, you know, and being
 6 legal person it doesn't matter on the specific
 7 patient because for one patient do you want
 8 immediately availability.
 9 DOCTOR DURRETT: Yes.
 10 MS. STEVENS: Do you want one patient who
 11 has much lower risk factors.
 12 DOCTOR TEMPLETON: When things go wrong
 13 they go wrong for everybody real fast.
 14 DOCTOR VARNER: I think a I think you
 15 have so to assign minutes because if somebody
 16 hopes a birthing center in some rural spot that I
 17 thinkeds go wrong and they get a smart particular
 18 and all you said was minutes an hour is 60 minutes
 19 so I think you have to assign minutes as far as
 20 the availability for transfer.
 21 MS. STEVENS: So if someone gets caught
 22 behind a traffic accident and they don't make it
 23 in time.
 24 DOCTOR VARNER: They're going to be in an
 25 ambulance we would hope.

Page 203

1 MS. STEVENS: You know, I mean something
 2 happens and they can't get there in those minutes.
 3 PRESIDING OFFICER MINNS: Well I think
 4 what we're saying is what level of risk are we
 5 willing to take here and I think you've heard some
 6 say with mother's life and baby's life you're not
 7 going to take risk.
 8 MS. STEVENS: So you're saying define.
 9 PRESIDING OFFICER MINNS: When it happens
 10 you've got to take action.
 11 DOCTOR VARNER: You have to assume if
 12 they're transferring it's a bad deal something's
 13 really serious.
 14 PRESIDING OFFICER MINNS: So what I hear
 15 them saying is they could go along with the trial
 16 of vaginal delivery with a previous cesarean if
 17 theres definitions of how immediate surgical
 18 intervention would be if it didn't work and they
 19 had an ayou want crisis is that what I'm hearing?
 20 So I think that's the feedback that the board's
 21 giving the council is.
 22 MS. STEVENS: Come up with that number.
 23 PRESIDING OFFICER MINNS: 30 minutes from
 24 the hospital, 40 minutes from the hospital.
 25 DOCTOR DURRETT: Doctor Bradley another

Page 204

1 question for you does acock say immediate
 2 availability brad brad if you give me a second I
 3 can tell you.
 4 DOCTOR DURRETT: Because if acrock says
 5 immediate availability and that's our I mean we
 6 looked at evidence based medicine and that's the
 7 evidence that said this is our governing body that
 8 knows the most about it then it's got to be
 9 immediate.
 10 DOCTOR MILFELD: Well they have set a
 11 developmentaled standard at Wesley so you've got
 12 to be able to follow this.
 13 DOCTOR DURRETT:
 14 MR. MACIAS: The laws say reasonable it's
 15 got to be reasonable time.
 16 DOCTOR MILFELD: But if they say they can
 17 do it in ten minutes and it takes us 30 minutes.
 18 MR. MACIAS: There's going to be a
 19 certain level of the public what wants this right
 20 I mean otherwise the professionals can say we're
 21 not doing it at all but the public to some degree
 22 says we still want this so we're doing a balancing
 23 act right here what level are we going to K and
 24 there's studs that show I mean a safety, you know,
 25 that if you're able to have a vaginal birth after



Page 205

1 cesarean that that is safer.
 2 A. High chad so anning family physician in
 3 Lawrence I practice OB and also do C sections
 4 there the timing never came up during our
 5 discussion in terms of risk I think we got hung up
 6 on the original legs that said quote normal
 7 pregnancy and delivery and our big debate with a
 8 patient with a prior C-section would qualify hence
 9 we never got any further along than a discussion
 10 about what would you do in a suchings so that is
 11 where the hang up is with our council right now
 12 the physicians view inherently because obviously
 13 we spent a lot of time on this so obviously it's a
 14 little bit risky that any C-section would give you
 15 inherent risks therefore it would not qualify
 16 underneath the scope because the scope is narrow
 17 wheres a some of our I believe some of our mid
 18 wives I don't want to speak for them they view
 19 that as a still a acceptable case as long as it's
 20 reasonably managed. So that is the that is the
 21 hang up here. I don't believe it has I really I
 22 want to get back on track because I don't think it
 23 has anything to do with timing frankly it has to
 24 do with legislation in the law.
 25 DOCTOR DURRETT: So you think it's not a

Page 206

1 normal uncomplicated pregnancy.
 2 A. That would be my opinion but it would be
 3 the differing opinion.
 4 DOCTOR DURRETT: And a one out of 200
 5 complication rate is not normal.
 6 A. I think that's up for everyone's that's
 7 where we have different opinions.
 8 PRESIDING OFFICER MINNS: I hear what
 9 you're saying but I think some of us are trying to
 10 be flexible here and saying under kern conditions
 11 we would be willing to give on that.
 12 A. I understand but I'm also a firm believer
 13 in the law and the law is written the way it's
 14 written.
 15 MS. STEVENS: And I perhaps maybe the
 16 issues have kind of evolved over time and Doctor
 17 job anning is absolutely correct the V back
 18 provision that was put into the regulation was if
 19 the board would determine that it isn't an
 20 inherent -- it isn't a risk that inherently moves
 21 out of the category of a normal uncomplicated
 22 pregnancy and delivery then do we put in a
 23 provision that immediate surgery, surgical ability
 24 is availability, or do we say it could be allowed
 25 in an accredited birth center with transport

Page 207

1 within a certain amount of time but Doctor job
 2 anning is correct before you get to there, there
 3 is more of the fundamental question.
 4 PRESIDING OFFICER MINNS: So what I hear
 5 the board saying you're not willing to put the
 6 time restrictions and correct me board if I'm
 7 speaking out of turn here that it's not normal an
 8 uncommon.
 9 DOCTOR DURRETT: What I'm hearing them
 10 say is it's not a normal pregnancy we want low
 11 risk because high risk could present a problem and
 12 a one out of 200 complication rate is what I heard
 13 is.
 14 DOCTOR VARNER: Not a low risk.
 15 MS. STEVENS: And there are definitely
 16 differing opinions on how you manage that
 17 pregnancy in lowering that risk and I'm probably
 18 could defer to someone who would much more clearly
 19 articulate that wick wick one thing I want to make
 20 clear is that one in 200 risk is taking all comers
 21 all women with a previous uterine scar the one in
 22 200 risk refers to the opening of a uterine scar
 23 not necessarily a catastrophic one in 200 is a
 24 likelihood that scar would open which can happen
 25 asomematically so that's one thing when the

Page 208

1 accredited birth centers are trying trial of labor
 2 after cesarean they have very strict criteria for
 3 who they can work with and many of the women that
 4 they are working with of the so this is not their
 5 first road quo can toe ago they've done it before
 6 that's a much lower risk group so it's possible
 7 the council will be able to come to sort sort of
 8 an agreement about which of those womens with a
 9 prior cesarean fall into a lower risk but the
 10 reason I came up here was to give you acog so acog
 11 practice bulletin from 2010 it has not been up
 12 dated since then what resources are recommended
 13 for health care providers and facilities offering
 14 a trial of labor after perfect previous cesarean
 15 delivery it says should be undertaken if
 16 facilities capable of emergency deliveries but
 17 they recognize that their previous statement for
 18 immediately available may cause difficult in
 19 providing the required resources in smallers
 20 centers with lower delivery volumes limiting
 21 women's ago same or similar circumstances zests to
 22 trial of lay bar after cesarean this may be
 23 particularly true in rural areas where the option
 24 to travel to laryngoer centers is difficult and so
 25 at the educational background where they talk



1 about these are the things that have a lot of god
 2 science behind them and these are the things that
 3 are wish hi wash she the recommendations based on
 4 consensus and expert opinion, the lowest level of
 5 evidence available they say in their statement
 6 that there is no evidence to say a specific time
 7 they make that very clear a trial of labor after
 8 previous cesarean live I should be undertaken at
 9 facilities capable of emergency deliveries because
 10 of the risks associated with trial of labor and
 11 with uterine rupture and other complications may
 12 be unpredictable the college recommends that this
 13 be undertaken at facilities with staff immediately
 14 available to provide emergency care when resources
 15 for immediate cesarean delivery are not available
 16 so this is everywhere else but your major
 17 metropolitan areas the college recommends to tack
 18 discuss the resources and availability of
 19 obstetric pediatric and operating rooming respect
 20 for patient awe to themy increased levels of risk
 21 thank their carefully and clearly informed and
 22 management alternatives so the other thing I heard
 23 you safe this is something people want and I will
 24 tell you totally unencumbered bid data but I see
 25 it and I know it will happen if you take trial of

1 lay bar after cesarean out of the hands of
 2 certified nurse mid wives in hospital and
 3 accredited birth center settings if you take that
 4 away from them they will happen at home they will
 5 happen no matter what so I would usual you let the
 6 council tell you what they consider try one more
 7 time to some kind of consensusive given you
 8 verbiage that I think is proto.
 9 PRESIDING OFFICER MINNS: Okay thank you
 10 you they asked us to go to C back we're not saying
 11 that you can't come back and come back with more
 12 information our last case is here so I think out
 13 of respect for that case we need to get moving
 14 soon so do you want my any more from us.
 15 MS. STEVENS: Do you want on the we can
 16 work on the designation of CNMI so that we don't
 17 run it afoul of problems so that it's very clear
 18 in you someone represents themselves to patients
 19 so it's very clear in documentation they're going
 20 to have to have a separate designation but we can
 21 work through some of those issues so that it's not
 22 so cumbersome I don't know if we'll reach a
 23 consensus on the trial of labor. If you want the
 24 council to review this again we certainly can, but
 25 I want that direction from the board because we

1 everyone understands time is of the essence on
 2 these but we need good regulations for the
 3 profession we don't want to just cobble something
 4 together.
 5 PRESIDING OFFICER MINNS: Well we gave it
 6 the time that was allotted to take we need to take
 7 our case and if there's time to come back we can I
 8 think they've heard obviously there are different
 9 views okay thank you all for your participation.
 10 Okay our next case Marvin L. McIntosh, MD, docket
 11 16 HA 00095 review of proposed consent order.
 12 Recusals is Kelli Stevens. Would the parties make
 13 their appearances.
 14 MR. 1: I will make my appearances.
 15 PRESIDING OFFICER MINNS: Okay I was told
 16 that they were here.
 17 MR. 1: As soon as opposing counsel comes
 18 in.
 19 MR. HAYS: We got an e-mail that said
 20 they're here but that was half an hour ago.
 21 MR. PEREZ: Yeah. I was waiting for the
 22 room to clear out.
 23 MR. HAYS: They were in a traffic jam.
 24 They're here now.
 25 MR. 1: May it please the board Susan

1 Gering, associate litigation counsel, appears on
 2 behalf of the board.
 3 MR. 2: Atif Abdel-Khaliq appears on
 4 behalf of Dr. Marvin McIntosh who is also present.
 5 PRESIDING OFFICER MINNS: Thank you.
 6 MR. 1: Today there is an offer of
 7 settlement before the board for its consideration.
 8 The current settlement resolves a pending petition
 9 that was filed on April 20th, 2016 alleging
 10 multiple violations of the Kansas healing arts
 11 act. It would be the parties position that the
 12 consent order be accepted as written and drafted
 13 and agreed to by the parties however yesterday Mr.
 14 Khaliq called me and made me aware of two things
 15 that the board should be aware of so I'm going to
 16 turn it over to him so he can provide that
 17 information to the board before we do any kind of
 18 agreement or accept a vote on the consent order.
 19 MR. 2: Thank you very much excuse me let
 20 me set this down. May it please the board there
 21 were two concerns as I went over the consent order
 22 with Doctor McIntosh that I need to bring to the
 23 board and I actually had Doctor McIntosh put it in
 24 a writing so I will read it to you.
 25 Kansas State Board of Healing Arts, regarding



1 prescribing limitations of the consent order
 2 subject: Paragraphs 41, 42 and 43. Board members
 3 the consent states that as of October 31st, 2016 I
 4 will no longer write distribute, etc., C-2 through
 5 C-4 medications. I have the following concerns.
 6 I have several patients that that already have
 7 been seen and I have written prescriptions with
 8 renewals for medications within C-2 through 4
 9 there are several patients who have yet to find a
 10 PCP to accept them. Therefore to give them
 11 continued coverage two prescriptions were written.
 12 As you know this is legal and quite commonly done.
 13 How is this to be handled? These would be on the
 14 K tracks listing in November 2016. I have no
 15 intention of violating the consent order that's
 16 concern number one.
 17 Concern number two there is a prescription
 18 duplication ring operating in the Kansas City area
 19 that has duplicated my prescription blanks. To my
 20 knowledge they have been operating for at least
 21 two years. I have reported this matter to the
 22 Kansas state board of pharmacy and to the Kansas
 23 city police department. One of the perpetrators
 24 has been captured however there are obviously
 25 others as it has continued. The last prescription

1 to my knowledge was written September 13th, 2016.
 2 And then this coincides with number one, the
 3 application requesting a change in my DEA status
 4 ten days after October 31st, 2016, will cause a
 5 federal violation due to the timing of the
 6 renewals being filed. Doctor McIntosh completes
 7 his letter with this: I ask again as I have no
 8 intentions of violating the consent order, how is
 9 this to be handled? What do I -- what do I need
 10 to do to assist. And it was written Marvin
 11 McIntosh.
 12 MR. 1: So I will let the board know that
 13 our disciplinary panel was not able to be
 14 consulted before this information came to the
 15 board. I believe the proper thing would be to
 16 accept this self- report of the prescription pad
 17 being stolen and if there is an investigation that
 18 results from improper scripts being written they
 19 can be handled in that way because the self-report
 20 has been accepted as a complaint into the Board of
 21 Healing Arts system as well as any other
 22 documentation regarding a criminal police report
 23 that was filed or anything along those lines.
 24 The concern I do have is with page nine, 2269
 25 in the eBook pages No. 44, I think what I was

1 understanding is that based on the language that
 2 is currently written, it says licensee shall
 3 within ten days of the board's acceptance of this
 4 consent order surrender his DEA registration and
 5 reapply for a new DEA registration. The problem is
 6 obviously if he were to sign this there would be
 7 renewals that he's already possibly or scripts
 8 that he could possibly write. If he surrenders,
 9 if that is extended to allow for the end of the
 10 month because paragraph 41 allows no later than
 11 October 31st for him to voluntarily desist and be
 12 prohibited from ordering, prescribing, dispensing,
 13 and distributing, you extend that to the last date
 14 that may alleviate some of the current concerns
 15 for some of the current prescribing however if he
 16 is to surrender his DEA license that would be
 17 reported through the DEA they would put a stop on
 18 any prescribing that occurs, so refills would not
 19 be this is my understanding of how the DEA process
 20 works would not be refilled then, so if there were
 21 prescriptions that the board is concerned about
 22 that are still out there those refills would not
 23 be valid unless they are refilled prior to the
 24 date that's documented on the prescription. I
 25 believe you need to consider paragraph 44 as the

1 main issue today based on the information that
 2 we've received because in theory he could possibly
 3 be in violation of that.
 4 PRESIDING OFFICER MINNS: So are you
 5 saying that you feel like we need to alter the
 6 consent order.
 7 MR. 1: I feel it's something it's the
 8 board needs to consider if you do not see that
 9 that could be a possible violation that there are
 10 refills out there and prescriptions.
 11 PRESIDING OFFICER MINNS: Okay so do you
 12 have anything else you want to present.
 13 MR. 1: Other than that, I wanted the
 14 board to be aware that Mr. Khaliq presented his
 15 information. I think maybe for the record a copy
 16 of this should be entered in as an exhibit from
 17 licensee.
 18 MR. 2: I do have it in writing.
 19 PRESIDING OFFICER MINNS: Okay. Is that
 20 acceptable.
 21 MS. BOND: Yes that's fine.
 22 PRESIDING OFFICER MINNS: So Mr. Khaliq,
 23 is there anything else you want to say.
 24 MR. 2: There is nothing else to report.
 25 PRESIDING OFFICER MINNS: Doctor



Page 217

1 McIntosh, if you would like we can swear you in so
 2 you can make any statements to the board or let
 3 the board answer questions so if you would move
 4 towards the mike I will have the court reporter
 5 swear you in. Just a moment got to give her time.
 6 Just a moment she'll swear you in and we'll see if
 7 there's any questions.
 8 MARVIN L. McINTOSH, MD,
 9 Called as a witness on behalf of the Licensee,
 10 having been duly sworn, testified as follows:
 11 PRESIDING OFFICER MINNS: Is there
 12 anything you want to say to the board? It's up to
 13 you.
 14 THE WITNESS: No.
 15 PRESIDING OFFICER MINNS: Does any of the
 16 board members have any questions for Doctor
 17 McIntosh?
 18 MS. BOND: I have one question that might
 19 maybe help solve our dilemma here Doctor McIntosh,
 20 do you know or can you compile a list of patients
 21 for whom you have provided a refill prescription
 22 for a class 2 prescription that would counsel if
 23 we were to get that list and allow him to maintain
 24 his DEA number through the end of November but
 25 restrict that DEA number use to those patients he

Page 218

1 has identified as already having refills would
 2 that potentially cure our problem because if there
 3 are any other names that show up on K tracks then
 4 that would give us maybe a lead as to who has the
 5 prescription pad also and maybe be able to put at
 6 least provide that information to the Kansas City
 7 authorities Doctor McIntosh.
 8 THE WITNESS: The listing I have is of
 9 patients that I have recently written. There are
 10 other patients that I do not have on the list that
 11 also have prescriptions that are within the
 12 confines of C 2 through C 4.
 13 MS. BOND: Okay.
 14 THE WITNESS: And that will probably
 15 extend past the end of November if DEA could those
 16 prescriptions from being written I have no problem
 17 with that as counselor read I have no intentions
 18 on violating the consent order. So if that's where
 19 the shoe drops then that's where the shoe drops.
 20 PRESIDING OFFICER MINNS: Doctor Durrett.
 21 DOCTOR DURRETT: I do have some questions
 22 doctor so you've already given narcotic refills to
 23 patients for the month of November.
 24 THE WITNESS: Yes, I have.
 25 DOCTOR DURRETT: Okay and how have you

Page 219

1 done that you can't put a refill on narcotics is
 2 my understanding have you given them another
 3 prescription and post dated it.
 4 THE WITNESS: No, sir well I don't know
 5 what the term post dating means but it is the
 6 practice of within the pain management area you
 7 can write two prescriptions, one for the month
 8 that you are in and another prescription for the
 9 following month. Both prescriptions have to be
 10 dated the same day, and on the prescription the
 11 instruction to as to when to fill the second
 12 prescription must be on the prescription.
 13 DOCTOR DURRETT: Okay.
 14 PRESIDING OFFICER MINNS: Any other
 15 questions?
 16 MR. 1: Ms. Bond in response to your
 17 question, I believe first off K track does require
 18 an open investigation for us to receive that
 19 information, so a complaint and an investigation
 20 would need to be opened up in order for us to have
 21 that material. I believe the
 22 MS. BOND: Well didn't Doctor McIntosh in
 23 here agree to allowing his K tracks to be
 24 monitored.
 25 MR. 1: But I think statutorily.

Page 220

1 MS. BOND: So that can't be accomplished
 2 even though it's in the consent order.
 3 MR. 1: Unless he violates the consent
 4 order at which time the K tracks could be run and
 5 further violations of the consent order discovered
 6 but paragraph 44 I think would alleviate all of
 7 the concerns because that is the job of the DEA,
 8 those that is how those prescriptions are usually
 9 filled, so if he were to surrender his DEA license
 10 by whatever the board determines on the date, if
 11 they want to have it remain at the ten days then
 12 that would not that would solve a lot of these
 13 problems and we wouldn't have to go through
 14 opening another investigation.
 15 PRESIDING OFFICER MINNS: Doctor Varner.
 16 DOCTOR VARNER: So if he would surrender
 17 his DEA on December 1st that would take care of
 18 the whole problem.
 19 MR. 1: Yes but I would say that the
 20 reason and this is speaking for the disciplinary
 21 panel for why this was originally offered is that
 22 there were concerns with prescribing, so allowing
 23 the prescriptions to continue may ultimately
 24 defeat the purpose of the consent order.
 25 PRESIDING OFFICER MINNS: Any other



Page 221

1 questions? If not we can go into recess. Hearing
 2 no other questions I'm going to recess our hearing
 3 at this point and allow us to go into
 4 deliberations attorney-client discussions and
 5 deliberations.
 6 MR. 2: With whom would I leave this
 7 document?
 8 MS. BOND: I'll take it.
 9 MR. 2: Thank you.
 10 (THEREUPON, a recess was taken.)
 11 PRESIDING OFFICER MINNS: Doctor Varner,
 12 do you want to make a motion?
 13 DOCTOR VARNER: I move we accept the
 14 consent order as written.
 15 DOCTOR TEMPLETON: Second.
 16 PRESIDING OFFICER MINNS: Doctor
 17 Templeton seconded. Any discussion? All those in
 18 favor say aye.
 19 ALL: Aye.
 20 PRESIDING OFFICER MINNS: All those
 21 opposed same sign? Consent order is accepted the
 22 way it was written and thank you for your
 23 presentation.
 24 MR. 2: Thank you very much.
 25 MR. 1: Thank you.

Page 222

1 PRESIDING OFFICER MINNS: Okay Stacy's
 2 going to talk Kelly's going to talk.
 3 MS. STEVENS: On the certified nurse-
 4 midwife issue and I think on what Doctor job
 5 anning referenced is very we put a provision in
 6 the reg for V backs at a hospital accredited birth
 7 center but that's contingent on what the board
 8 opportunitimently believes about the law the law
 9 limits it to a normal uncomplicated pregnancy and
 10 delivery physician member of the council said it's
 11 not un[HA-ERPBT]ly uncomplicated the nurse mid
 12 wives state it is. There is in what you do you
 13 have this very odd situation where we're we would
 14 define it as this is this falls outside of a
 15 normal uncomplicated pregnancy and live I they
 16 would still be able to do it in a birth center or
 17 really under their APRN license we don't have
 18 jurisdiction over that so it's not precluding
 19 total ability to do it, it would be not under this
 20 license given the narrow scope of practice that
 21 the legislature outlined for us Bond Bond when
 22 we've been trying to work on these regulations
 23 what we're trying to keep in mind is that the
 24 APRNs aren't require they're require to maintain
 25 their license but they're not required to maintain

Page 223

1 a collaborative agreement with another physician
 2 so if they only have the CNM-I license then that's
 3 the only way they'll be able to practice so we
 4 really have to write our regs for the lowest
 5 common denominator which is an individual that is
 6 only a CNM-I we can't assume that they're going to
 7 have a collaborative agreement or birthing center
 8 or anything like that because the moment we do
 9 then, you know, we're going to have people who are
 10 down here that are working without license. We
 11 have to think about the lowest common.
 12 DOCTOR DURRETT: So if you're going by
 13 the law and not what the patient wants what
 14 additional risks the patient's willing to accept
 15 Bond Bond is patient's wants are not consequence
 16 usual to law.
 17 DOCTOR DURRETT: One in 200 complication
 18 rate and even their representative said one in 200
 19 complication rate is not normal so V backs cannot
 20 be done Bond Bond but that's what the group wants
 21 to that's where the struggle comes in is that we
 22 understand that I have an APRN license and can do
 23 lots of things under that license but what we have
 24 to work with is this little bitty portion that the
 25 legislature gave us to work with and we have to

Page 224

1 treat it as that's the only license they're
 2 working under.
 3 MS. STEVENS: We can't assume they're
 4 going to maintain a collaborative agreement
 5 Bondoned or in a birth center or anything like
 6 that.
 7 DOCTOR DURRETT: So per Doctor Bailey and
 8 per their pediatrician who testified acog says one
 9 in 200 is not uncomplicated I mean it's a high
 10 rate of complication so if we're going by the
 11 strict letter of the law that's not a normal
 12 pregnancy and they can't do V backs.
 13 MS. STEVENS: Right.
 14 DOCTOR DURRETT: Okay.
 15 MS. STEVENS: So I would like a vote.
 16 DOCTOR DURRETT: Okay so you would want
 17 the motion that V backs are not uncomplicated Bond
 18 Bond that we are complicated.
 19 DOCTOR DURRETT: Sorry that they are
 20 complicated with 1 in 200 complication rate and
 21 that explains that's why we're doing.
 22 DOCTOR TEMPLETON: And to include to
 23 electric and whatever other kind of definition
 24 they want to call it.
 25 MS. STEVENS: And I will tell you that



Page 225

1 the nursing board is most likely going to disagree
 2 they will want the board to follow the national
 3 standards for certified nurse mid wives which
 4 would just permit a trial of labor.
 5 DOCTOR DURRETT: But you can point out
 6 the law says uncomplicated and we have sided oh
 7 our experts and their experts that one in 200 is
 8 not uncomplicated that's a high complication rate
 9 and that's what we've based our decision on is
 10 what the legislature said and what acog say.
 11 MR. MACIAS: But it sounds like the
 12 legislature is leaving it up to us to define what
 13 that is right.
 14 DOCTOR DURRETT: Right and we've got to
 15 go with evidence based medicine and once begun
 16 their representative is a pediatrician and the
 17 doctor's representative OBGYN and family practice
 18 said one in 200 is high it's complicated.
 19 MR. MACIAS: Well that's fine one in 200
 20 if that's the way a license were flying K and
 21 Doctor wick that's across the board people with
 22 the transverse scar and everything that number
 23 probably does go lower when you.
 24 DOCTOR DURRETT: Do a low transverse
 25 versus classical.

Page 226

1 DOCTOR VARNER: If you read the medical
 2 legislature nobody openly embraces trial of labor
 3 after a previous C-section I mean they dong the
 4 issue nobody says it's a good thing most people
 5 shy away from it. It is not a simple
 6 uncomplicated delivery period.
 7 MS. STEVENS: In medicine and here's the
 8 thing the new act holds the independent certified
 9 nurse-midwife under this license to the medical
 10 standard of care.
 11 PRESIDING OFFICER MINNS: So I have a
 12 motion on the floor.
 13 DOCTOR VARNER: I'll second.
 14 PRESIDING OFFICER MINNS: Second.
 15 DOCTOR TEMPLETON: I'll third.
 16 PRESIDING OFFICER MINNS: Any further
 17 discussion of the motion.
 18 DOCTOR LAHA: This is the only thing
 19 we're going to discuss about this is this one
 20 issue I just have another issue.
 21 MS. STEVENS: Everyone left when we said
 22 we're going to take it back to the council.
 23 PRESIDING OFFICER MINNS: Let's deal with
 24 the motion.
 25 MS. STEVENS: So I feel kind of bad we're

Page 227

1 discussing it again.
 2 PRESIDING OFFICER MINNS: There's no
 3 further discussion. All in favor of the motion say
 4 aye?
 5 ALL: Aye.
 6 PRESIDING OFFICER MINNS: Opposed say
 7 aye.
 8 MR. MACIAS: Aye.
 9 PRESIDING OFFICER MINNS: So the motion
 10 passes so we can tell them the board voted.
 11 MS. STEVENS: And I think the risk
 12 assessment and those things can be worked out.
 13 PRESIDING OFFICER MINNS: Okay. Thank
 14 you.
 15 DOCTOR TEMPLETON: We need to also vote
 16 on the designation of the CNMI so we can take that
 17 back to the board of nursing.
 18 DOCTOR DURRETT: I don't even understand
 19 what that's about.
 20 DOCTOR VARNER: I don't either.
 21 MS. STEVENS: I think we have to have
 22 some form of a different.
 23 DOCTOR TEMPLETON: So I would move that
 24 we adopt the designation of CNMI whatever the
 25 issues are with that.

Page 228

1 DOCTOR WEBB: I'd second that.
 2 PRESIDING OFFICER MINNS: Further
 3 discussion on the motion? Can always tell when
 4 it's getting close to quitting time. All in favor
 5 of the motion say aye.
 6 ALL: Aye.
 7 PRESIDING OFFICER MINNS: Opposed?
 8 DOCTOR DURRETT: Nay. Well I don't
 9 understand it.
 10 DOCTOR LAHA: I just have a general
 11 question about nurse midwives I mean the new law
 12 says they can do episiotomies. Doesn't that
 13 constitute surgery.
 14 DOCTOR DURRETT: It says they cannot do
 15 complicated repairs you're right.
 16 DOCTOR LAHA: Doesn't that mean that I
 17 take that as a surgical procedure.
 18 MS. STEVENS: They excepted it out of the
 19 definition of medicine and surgery I mean
 20 basically a layperson wouldn't do an episiotomy
 21 repair.
 22 DOCTOR VARNER: Can they do repairs like
 23 third degree repair.
 24 MS. STEVENS: It's a limited in the
 25 degree of laceration.



Page 229

1 PRESIDING OFFICER MINNS: Okay doctor
 2 Durrett do you want to say something.
 3 DOCTOR DURRETT: Okay that made my list
 4 too but there's a lot going on for now they can do
 5 an episiotomy so it's so what defines that there's
 6 four grate grades and if you have to do an
 7 episiotomy that becomes complicated and they can't
 8 repair it so they can create a problem but they
 9 can't fix it.
 10 DOCTOR VARNER: Well you know what's
 11 going to happen it didn't exist.
 12 DOCTOR DURRETT: I'm sorry.
 13 DOCTOR VARNER: It didn't exist it was
 14 just an episiotomy.
 15 DOCTOR DURRETT: They've got to do and
 16 it's a huge difference.
 17 DOCTOR TEMPLETON: Or is this another
 18 indication to transfer which would seem to be
 19 inappropriate.
 20 DOCTOR DURRETT: That is an indication to
 21 transfer.
 22 DOCTOR TEMPLETON: But they would have to
 23 have an appropriate repair.
 24 DOCTOR DURRETT: Yes because it's done
 25 under anesthesia.

Page 230

1 PRESIDING OFFICER MINNS: Kelli do you
 2 have enough.
 3 MS. STEVENS: Does that cover everything.
 4 PRESIDING OFFICER MINNS: This is enough
 5 feedback for them to go back to the council.
 6 MS. STEVENS: It is I think we'll have to
 7 have some discussions because when we left things
 8 off when everybody was here it was we'll let the
 9 council discuss this more and now that we have
 10 some specific direction we'll do that.
 11 PRESIDING OFFICER MINNS: Do you want to
 12 give your report now.
 13 MS. STEVENS: Sure.
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100-74-1. Definitions. As used in this article, each of the following terms shall have the meaning specified in this regulation:

- (a) "Abortion" has the meaning specified in K.S.A. 65-6701, and amendments thereto.
- (b) "Antepartum" means the stage of care that commences when a pregnant woman presents herself for care during pregnancy and ends at the onset of labor.
- () "Birthing center" means a facility which provides delivery services for normal, uncomplicated pregnancies but does not include a medical care facility as defined by K.S.A. 65-425, and amendments thereto.
- () "Family planning services" means the provision of contraceptive methods, preconception health services, and sexually transmitted infection screening and treatment to patients.
- () "Home birth" means an attended birth in a private residence or a location other than a birth center or hospital.
- () "Hospital" has the meaning specified in K.S.A. 65-425, and amendments thereto.
- () "Identifiable risks" mean conditions which may affect the course of pregnancy, labor, delivery or the health of the patient or newborn.
- () "Initial care of a normal newborn" means clinical services provided to a normal newborn during the first 28 days of life.
- () "Intrapartum" means the stage of care commencing with the onset of labor and ending after the delivery of the placenta.
- () "Licensee" means a certified nurse-midwife licensed by the Board to engage in the independent practice of midwifery as defined in **Sec. 89(c)**.

() "Minor vaginal laceration" means a laceration of the superficial perineal skin or vaginal mucosa that does involve the perineal muscle, anal sphincter, or the rectum.

Commented [RH1]: While this definition could have simply stopped after "superficial perineal skin or vaginal mucosa", the real concern is that a CNM-I would repair a muscle. This definition prevents any subjective definition that might justify a repair extending into a muscle.

() "Newborn" means a newborn infant during the first 28 days of life after birth.

() "Normal newborn" means a newborn infant that has been clinically determined to have no complications or be at low risk of developing complications.

() "Normal, uncomplicated delivery" means delivery of a singleton cephalic vaginal birth that has been clinically determined to be at low risk for complications.

() "Normal, uncomplicated pregnancy" means a pregnancy that is initially determined to be at a low risk for a poor pregnancy outcome and that remains at a low risk throughout the pregnancy.

() "Patient" means a woman for which an independent certified nurse-midwife provides clinical services.

() "Poor pregnancy outcome" means any outcome other than a live, healthy patient and newborn.

() "Postpartum" means the stage of care commencing with the delivery of the placenta and ending six weeks after birth.

(Authorized by K.S.A. _____; implementing K.S.A.; effective, T-_____,
_____; effective P-_____.)

100-74-8. Scope of practice; limitations. (a) A licensee may perform clinical services within the scope of practice set forth in Sec. 89(c), and amendments thereto, including:

- (1) ordering and interpreting laboratory and diagnostic tests;
- (2) prescribing and administering prescription-only medications, including controlled substances;
- (3) distributing manufacturers' samples of prescription-only medications;
- (4) prescribing the use of medical devices;
- (5) ordering ancillary professional services;
- (6) performing a clinically indicated episiotomy;
- (7) repair of a minor vaginal laceration;
- (8) performing an uncomplicated circumcision on a male, normal newborn; and
- (9) insertion and placement of contraceptive devices.

(b) A licensee shall perform clinical services involving labor and delivery in a hospital if the patient requires any of the following interventions:

- (1) pharmacologic induction or augmentation of labor; or
- (2) spinal or epidural anesthesia.

(c) A licensee shall not provide clinical services to a patient with any of the following conditions:

- (1) Multiple gestation pregnancy;
- (2) Noncephalic presentation of the fetus at the onset of labor or rupture of membranes;

or

(3) Prior cesarean section delivery. (Authorized by K.S.A. _____; implementing
K.S.A.; effective, T-_____, _____; effective P-_____.)

100-74-XX. Duty to refer or transfer care. (a) A licensee shall immediately refer for consultation or transfer care of a patient to a person licensed to practice medicine and surgery, or transfer the patient to a hospital if at any time the patient's medical history or condition presents identifiable risks to the course of pregnancy, labor, delivery, or health of the patient or newborn.

(b) The licensee may resume providing clinical services to the patient if a person licensed to practice medicine and surgery has determined that the patient's medical history or condition has been resolved or that any risk factors presented by the patient's medical history or condition are not likely to affect the course of pregnancy, labor, delivery, or health of the patient or newborn.

(c) A licensee shall immediately refer for consultation or transfer care of a newborn to a person licensed to practice medicine and surgery or transfer the newborn to a hospital if at any time the newborn's condition presents identifiable risks to the health of the newborn.

(d) The licensee may resume providing clinical services to the newborn if a person licensed to practice medicine and surgery has determined that the newborn's condition has been resolved or that any risk factors presented by the newborn's condition are not likely to affect the health of the newborn. (Authorized by K.S.A. _____; implementing K.S.A.; effective, T-_____, _____; effective P-_____.)

100-74-XX. Assessment of patient for identifiable risks. Each licensee shall perform and document an initial and ongoing assessment of any identifiable risks to the course of labor, delivery or health of the patient or newborn to determine whether the pregnancy is a normal, uncomplicated pregnancy, including the following:

(a) Age of the patient;

(b) Gestational age;

(c) major medical problems including any of the following:

(1) Chronic hypertension, heart disease, or pulmonary embolus;

(2) any congenital heart defect assessed as pathological by a cardiologist that places the patient or fetus at risk;

(3) a renal disease;

(4) a drug addiction or required use of anticonvulsant drugs;

(5) diabetes mellitus;

(6) thyroid disease; or

(7) a bleeding disorder or hemolytic disease;

(d) previous history of a significant obstetrical complication or medical condition, including any of the following:

(1) RH sensitization;

(2) a previous uterine wall surgery, including cesarean section;

(3) seven or more term pregnancies;

(4) a previous placental abruption; or

(5) a previous preterm birth.

(e) medical indication of any of the following:

(1) pregnancy-induced hypertension;

- (2) polyhydramnios or oligohydramnios;
- (3) placental abruption;
- (4) chorioamnionitis;
- (5) known fetal anomaly;
- (6) multiple gestations;
- (7) intrauterine growth restriction;
- (8) fetal distress;
- (9) alcoholism or drug addiction;
- (10) thrombophlebitis; or
- (11) pyelonephritis.

(Authorized by K.S.A. _____; implementing K.S.A.; effective, T- _____,
_____ ; effective P- _____.)

100-74-10. Transfer protocol requirements.

(a) A licensee shall have a written protocol in place for each patient and newborn for the timely and safe transfer to a prespecified hospital and physician or medical group within a reasonable proximity of the location of labor and delivery if extended or advanced medical services or emergency services. Each written protocol shall include:

(1) A plan for transporting the patient or newborn by an emergency medical services entity;

(2) a plan for notification of the specified hospital and physician or medical group;

(3) a plan for communication about the patient's or newborn's medical history and present condition;

(4) an available form document which may be completed by the patient to indicate choice of hospital for transfer; and

(5) at least one of the following:

(A) A plan for patient transfer to the specified hospital and physician or medical group;

(B) evidence of a transfer agreement with the specified hospital and physician or medical group to be utilized when no patient choice has been identified or transfer to the patient's choice is not medically prudent; or

(C) evidence that the licensee has admitting privileges at the specified hospital.

(b) Each licensee shall ensure that all staff attending the patient's labor and delivery have immediate access to a working telephone or another communication device and all necessary information for transferring a patient or a newborn in case of an emergency. (Authorized by

K.S.A. _____; implementing K.S.A.; effective, T-_____, _____;
effective P-_____.

100-74-XX. Identifiable Risks Requiring Transfer of Care of Patient.

(a) A licensee shall immediately transfer the care of a patient to a hospital or other appropriate level of care if the patient has any of the following conditions:

- (1) Maternal fever in labor of more than 100.4 degrees Fahrenheit, in the absence of environmental factors;
- (2) Suggestion of fetal jeopardy, such as frank bleeding before delivery, any abnormal bleeding, with or without abdominal pain, evidence of placental abruption, or detection of abnormal fetal heart tones;
- (3) Current spontaneous premature labor;
- (4) Current pre-term premature rupture of membranes;
- (5) Current pre-eclampsia;
- (6) Current hypertensive disease of pregnancy;
- (7) Continuous uncontrolled bleeding;
- (8) Postpartum bleeding that does not subside with the administration of oxytocin or other anti-hemorrhagic agent;
- (9) Delivery injuries to the bladder or bowel;
- (10) Grand mal seizure;
- (11) Uncontrolled vomiting;
- (12) Coughing or vomiting blood;
- (13) Severe chest pain; or
- (14) Sudden onset of shortness of breath and associated labored breathing.

(b) A licensee who deems it necessary to transfer or terminate care of a patient pursuant to the rules and regulations of the Board, shall not be regarded as having abandoned care or wrongfully terminated services. Before non-emergent discontinuation of services, the licensee shall notify the patient in writing, provide the patient with names of licensed physicians and contact information for the nearest hospital emergency room and offer to provide copies of medical records regardless of whether copying costs have been paid by the patient.

(Authorized by K.S.A. _____; implementing K.S.A. _____, effective, T- _____; effective P- _____.)

100-74-XX. Identifiable Risks Requiring Transfer Care of Newborn.

(a) A licensee shall immediately transfer the care of a newborn to a hospital for emergency care or to a pediatric physician if the newborn has any of the following conditions:

- (1) Respiratory distress defined as respiratory rate greater than 80 or grunting, flaring, or retracting for more than one hour;
- (2) Any respiratory distress following delivery with meconium stained fluid;
- (3) Central cyanosis or pallor for more than ten (10) minutes;
- (4) Apgar score of six or less at five minutes of age;
- (5) Abnormal bleeding;
- (6) Any condition requiring more than eight hours of continuous postpartum evaluation;
- (7) Any vesicular skin lesions;
- (8) Seizure-like activity;
- (9) Any green emesis;
- (10) Poor feeding effort due to lethargy or disinterest for more than two hours immediately following birth;
- (11) Temperature instability, defined as a temperature less than 96.8 degrees Fahrenheit or greater than 100.4 Fahrenheit documented two times more than fifteen minutes apart;
- (12) Murmur lasting more than 24 hours immediately following birth;
- (13) Cardiac arrhythmia;
- (14) Congenital anomalies;

- (15) Birth injury;
- (16) Clinical evidence of prematurity, including but not limited to, low birth weight of less than two thousand five hundred (2,500) grams, smooth soles of feet, or immature genitalia;
- (17) Any jaundice in the first twenty-four (24) hours after birth or significant jaundice at any time;
- (18) No stool for more than twenty-four (24) hours immediately following birth;
- (19) No urine output for more than twenty-four (24) hours; or
- (20) Development of persistent poor feeding effort at any time.

(b) A licensee who deems it necessary to transfer or terminate care of a newborn pursuant to the rules and regulations of the Board, shall not be regarded as having abandoned care or wrongfully terminated services. Before non-emergent discontinuation of services, the licensee shall notify the patient in writing, provide the client with names of licensed pediatric physicians and contact information for the nearest hospital emergency room and offer to provide copies of medical records regardless of whether copying costs have been paid by the patient. (Authorized by K.S.A. _____; implementing K.S.A. _____, effective, T- _____; effective P- _____.)