Approved 3-5-91
Date

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Carol H. Sader
Chairperson at

1:30 ~~x~~a.m./p.m. on February 27, 1991 in room 423-S of the Capitol.

All members were present except:

Committee staff present:
Emalene Correll, Research
Bill Wolff, Research
Norman Furse, Revisor
Sue Hill, Committee Secretary

Conferees appearing before the committee:

Representative Joan Wagnon
Chip Wheelen, Kansas Psychiatric Society/Kansas Medical Society
Pat Johnson, Kansas State Board of Nursing
Dick Morrissey, Deputy Director/Division of Health/Dept. Health/Environment
Cheryl DeBrot, Registered Therapist with National Board of Respiratory Care
Representative Henry Helgerson
Dr. Charles Konigsberg, Director/Div. of Health/Dept. Health/Environment
David Pomery, Kansans for Non-Smokers Rights

Chair called meeting to order, noting agenda today has scheduled briefings and hearings on **HB 2253** and **HB 2336.**

Chair recognized Rep. Amos in regard to **SB 1.**

Rep. Amos reviewed the favorable passage of **SB 1** at meeting yesterday, February 25th. Rep. Amos noted as he was on the prevailing side of that motion, he would like to reconsider the bill this date. Rep. Amos made a motion to reconsider **SB 1,** to strike the amendment voted on yesterday, and to add, after "virus or tests", "to evaluate biological specimens". Rep. Amos explained rationale. Motion seconded by Rep. Flower. Motion carried.

On SB 1 as a whole, Rep. Amos moved to advance **SB 1** favorably as amended, motion seconded by Rep. Wiard. Motion carried.

Chair requested staff to give a briefing on **HB 2253.**

HEARINGS BEGAN ON HB 2253.

Rep. Wagnon offered hand-out (Attachment No. 1). She stated both she and Rep. Sebelius together had introduced **HB 2253.** This proposal will add language to the various practice acts of mental health service providers that will allow for disciplinary action for sexual exploitation of patients or former patients. The idea for the bill came from Dr. Stuart Twemlow, from his practice and his book, "Sexual Exploitation in Professional Relationships". She called attention to Dr. Twemlow's position on **HB 2253** attached to her hand-out. She urged support.

Rep. Wagnon noted Dr. Twemlow discusses fiduciary trust, and to break that trust with a client who may have an unconscious dependency on the care giver can be very harmful. Rep. Wagnon cited some specific cases. This problem is widespread and HB 2253 will be a tool for setting out mandatory reporting, and to set up standards saying to the professionals, "This is not good behavior." She answered questions.

Chip Wheelen, Kansas Psychological Society and Ks. Medical Society offered hand-out (Attachment No. 2). He suggested that health care providers should not be the only class of professionals subject to punitive laws in regard to sexual exploitation of patients/clients. In 1987 the Kansas Supreme Court said health care providers should not be singled out and given unique treatment under the equal protection laws. He noted the Ks. Medical Society and Ks. Psychological Society could both be far more supportive of legislation that would apply to all professional groups. He noted neither support or opposition to suggested amendments to the various licensure acts in the bill. He asked members to consider that psychiatrists are not the only physicians who are called upon to provide diagnosis and treatment of the mentally ill, or to counsel patients suffering emotional distress. However, it is the purpose of the Legislature to reduce incidences of sexual exploitation. Any incidences of rape or crimes of this magnitude are unacceptable under any circumstances. He answered numerous questions.

Pat Johnson, Ks. Board of Nursing offered hand-dout (Attachment No. 3), noting the Board supports the protection of patients or former patients from acts of sexual abuse, misconduct, or exploitation from all mental health service providers, including nurses and mental health technicians. She discussed specific cases in which the Board was unable to conduct full proceedings because of gray areas in the regulations. Because of this, she suggested several amendments, i.e., to combine sections (4) and (5); add new language, "to be unable to practice with reasonable skill and safety due to physical or mental disabilities, including deterioration through the aging process, loss of motor skills or abuse of drugs or alcohol; to add to the authority of the Board to limit license to practice as mental health technicians; to combine sections (2) and (3) and to omit section (a)(7) and to replace in lieu thereof "to have been guilty of a felony if the board determines, after investigation, that such a persons has not been sufficiently rehabilitated to warrant the public trust. She urged support for these recommended changes to **HB 2253.** She answered numerous questions.

Dick Morrissey, Department of Health/Environment offered hand-out (Attachment No. 4) and noted it is appropriate to require reporting of sexual abuse or exploitation upon consent of the patient. Few victims choose to file complaints on their own to regulatory boards. Mandatory reporting with patient consent should assist in stimulating additional complaints. He cited specifics of licensed male professionals reported to having committed sexual misconduct with patients during treatment stages. He stated the issue of determining emotional dependence will be complicated and difficult, even with the statutory definition of "emotional dependency." He cited concerns with **HB 2253**, i.e., there are no provisions for reporting of an act by a nonregulated practitioner. He drew attention to a summary of four initiatives that Minnesota and other states have initiated. Mr. Morrissey highlighted this summary, then answered questions.

CONTINUATION SHEET

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE,

room 423-S Statehouse, at 1:30 /a.m./p.m. on February 27, 19 91

HEARINGS CONTINUED ON HB 2253.

Dr. William Albott, Ks. Psychiatric Society offered hand-out (Attachment No. 5). He stated support for **HB 2253**, however, there are a number of problems the bill does not address or language is too vague. Experience has taught him that investigation and litigation of cases involving sexual misconduct are time consuming and very expensive. He outlined a number of items not addressed in the bill, i.e., no penalty for false reporting; no provision for hearings to be held in camera, (to protect both client/patient from exposure in the media, and to also protect the practitioner if falsely accused). He suggested the appointment of a special committee made up of persons from the Boards of Health Professionals, and members of the Legislature and that this committee be charged with drafting a bill for the 1992 legislature that would address all areas of concern. He answered questions.

HEARINGS CLOSED ON HB 2253.

HEARINGS BEGAN ON HB 2336.

Cheryl DeBrot, Registered Respiratory Therapist offered hand-out (Attachment No. 6). She stated, in the majority of patients she has worked with, active and/or passive smoking is the major contributing factor in the development of their lung disease. There is no cure today for chronic lung disease. Smoking in the State Capitol hallways, rotounda, and other public areas is damaging the health of not only those who smoke, but those who are subjected to passive smoke. Both smokers and non-smokers are affected. The capitol is intended to be used by all Kansans, and the health of all those who visit the Capitol will be better protected with the passage of **HB 2336.** She answered questions.

Representative Henry Helgerson offered an informational packet. (Attachment No. 7, statistics on subject of Blue Cross Annual Report comparing smoker versus non-smoker for Ks. State Health Plan. (Attachment No. 8), recorded as his testimony. He noted there are four reasons why he strongly supports **HB 2336.** 1) Smoking in the state capitol sets a bad example for the young children, state employees and general citizens, since smoking is prohibited in many schools and most city and county offices. 2) The capitol is a treasure and smoking increases the damage done to murals and increases costs of maintenance. 3) Limiting and discouraging smoking can reduce additional health care costs. 4) Studies indicate that indirect smoke, or second-hand smoke causes the same effects on non-smokers as smoking does to smokers, only to a lesser degree. It is his right to breathe clean air, therefore would like to see smoking restricted in the capitol. He answered questions.

Dr. Charles Konigsberg, Director of Health/Department of Health/Environment offered hand-out (Attachment No. 9), noted the position of the Department is fairly obvious. Smoking has proven to have negative effects on public health and safety and is the number one preventable cause of death. He noted provisions in **HB 2336** that designate small enclosed office spaces as allowable smoking areas still pose an increased risk for those persons working within an enclosed smoke-filled space. He asked that committee give consideration to the clear intent of the bill and take steps necessary for its implementation.

David Pomeroy, Kansans for Non-Smoker's Rights, offered hand-out (Attachment No. 10). He noted their organization is small with no lobby group. He spoke in support of **HB 2336.** Two of the most volunerable groups of people visit the capitol regularly, the young and the elderly. The passive smoke is harmful to them, as well as all others who visit and work in this building. He quoted statistics regarding illness and deaths because of smoking and effects of passive smoke. It is his belief that persons who come to visit the capitol should be able to do so without putting their health at risk.

HEARINGS CLOSED ON HB 2336.

Meeting adjourned.

JEST REGISTER

HOUSE PUBLIC HEALTH AND WELFARE COMMITTEE

DATE Feb. 27, 1991

NAME	ORGANIZATION	ADDRESS
Betra Chang	Board of Nursing	Topeka
Pat Johnson	Board of Nursing	Topeka
Tom Barber	Topeka State Hospital	Topeka

STATE OF KANSAS

JOAN WAGNON
REPRESENTATIVE, FIFTY-FIFTH DISTRICT
1606 BOSWELL
TOPEKA, KANSAS 66604
(913) 235-5881
OFFICE:
STATE CAPITOL, 272-W
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TOPEKA

HOUSE OF
REPRESENTATIVES

COMMITTEE ASSIGNMENTS
CHAIR: TAXATION
MEMBER: ECONOMIC DEVELOPMENT
FEDERAL & STATE AFFAIRS
LEGISLATIVE POST AUDIT

February 27, 1991

To: Public Health and Welfare Committee
Re: HB 2253

This proposal adds language to the various practice acts of mental health service providers that allows for disciplinary action for sexual exploitation of patients or former patients.

A similar bill was introduced in the 1990 session which was heard by the Judiciary Committee rather late in the session. Their recommendations were incorporated into the language used this session.

The idea for the bill came from Dr. Stuart Twemlow from his practice and a book, Sexual Exploitation in Professional Relationships. Since he is not able to be present today, I have attached his previous testimony which describes in detail the problems professionals experience and remedies which have been in use in other states.

I would urge your favorable consideration.

PHHW
2-27-91
Attm #1

TO: Judiciary Committee

FROM: Stuart W. Twemlow, M.D.

RE: House Bill #2837

I am a board certified psychiatrist who has been in practice in Kansas for the past 19 years. A brief biographical sketch summarizing my clinical and professional background is attached. I am appearing in support of this bill based on my clinical and research activities with people who have been victims of sexual exploitation by professionals. In addition, I have had numerous occasion to treat the exploiting professional, who has sought my help either stimulated by peer group and/or legal threats or by virtue of his own realization of the pathological nature of his relationship with the patient/client.

In the edited collection entitled Sexual Exploitation in Professsional Relationships(1), published by the American Psychiatric Association in 1989, I authored a chapter entitled "The Lovesick Therapist" together with the editor of the volume, Dr. Glen O. Gabbard, who has already presented his views to committees concerned with penalties for such exploitation. That chapter addresses the psychodynamic pathology behind the abusing therapists.

Bill 2837 should be taken as an expression of the current increased concern with exploitation in relationships where there exists an element of emotional dependency between the client or patient and the professional individual. The legal term, "fiduciary relationship", has

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2-27-91
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been used for this phenomenon. Although this term is a legal one, it is more widely known and understood than most psychoanalytic ideas and thus is useful because of widespread acceptance. In Black's Law Dictionary, such a relationship is defined as one; "Where there is a special confidence reposed in one who in equity and good conscience is bound to act in good faith and with due regard to interests of one reposing the confidence." (P. 753-754). All of the professional groups named in this bill are fiduciaries within that definition by virtue of their licensure and/or practice. This bill does not address other fiduciary relationships such as school teachers, attorneys, etc. It is apparent that such fiduciary trust occurs in these groups as well and that similar exploitation is likely as frequent as in the groups named in this bill. I am pleased to see that the bill addresses not only psychiatrists, but the physician group as a whole. Non-psychiatric physicians are much less aware of the problems associated with emotional dependency and more in need of such training. Our research into the nature of physician-caused (iatrogenic(2 & 3)) illness has indicated that frequently in relationships between doctors and patients, an unconscious dependency exists in which the patient relates to the doctor in a child-like way, expecting the same care, attention and consideration as they would from a parent. The vast majority of clinicians respect that unconscious trust. A small percentage of the various professions do not. At least this was the view until recently. A number of surveys

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have been performed by anonymous questionnaire and reported in the book, providing us with a much more worrying picture. It appears that in most groups surveyed, the prevalence of sexual contact with patients or clients exceeds the rare event one might have hoped for. A variety of estimates have been given, ranging from 6% to 12%, but one must remember that anonymous questionnaires probably only tap the tip of the iceberg. It is conceivable that perhaps even 12-20% of patients are the victims of a variety of forms of inappropriate sexual contact representing a manipulation of the fiduciary relationship with the professional concerned. From a common sense point of view, one would expect that the exploiting professional would be an extremely disturbed individual. From time to time, patients who have been the victims of perverse and bizarre sexual abuse will publish autobiographical sketches. The physicians or professionals represented in these types of books in general fall into either severely disturbed criminal elements (anti-social personality) or psychotic professionals. One recent publication in that regard is the book Therapist(4). Unfortunately, the experience of ethical committees of the American Psychiatric Association and professionals such as myself indicate that such dramatically disturbed medical professionals are only a very small percentage of the exploiting group, a majority of which never actually come to the attention of the law courts nor do the patients or physicians report the relationship. They come in the typical context of my practice, which is in the strictly

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2-27-91

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confidential pyschoanalytic one-on-one contact. In our chapter, we summarize the pathology of this neurotic group who are not severely disturbed and who probably represent at least 90% of the abusing professionals. We have found that such professionals tend to be middle-aged men who abuse women on the average of 16 years younger than they are in the context of an unhappy marriage and family relationship and unsatisfying professional life.

With regard to the prevention of this tragic situation; I quote here from page 85 of our chapter entitled "Prevention".

> Prevention of lovesickness in therapists and the countertransference acting out that accompanies it is a formidable task. Clearly, a personal treatment experience for the therapist is not a fool-proof method of prevention. The Chapter 1 survey by Gartrell et al. found that offenders were more likely than nonoffenders to have undergone therapy or analysis. Profiles of susceptible therapists, such as those by Brodsky in Chapter 2 and by Pope and Bouhoutsos (1986), provide some guidelines for detecting which therapists might be at risk. The middle-aged male therapist, who is in the midst of a divorce or other problems in his intimate relationships should be alert to any tendencies toward overinvolvement with his patients. Does he inappropriately disclose aspects of his personal life to his patients? Does he think about a particular patient when she is not in the office with him? Does she enter his dreams? Does he begin to think that what his patient needs is love to make up for the lack of love she received in childhood? Finally, does he begin to think that he sees aspects of himself in his patients?
>
> The primary difficulty with preventing therapist-patient sexual intimacy is that all of these questions must be asked by the therapist

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himself. M[illegible] them are simply standard questions th[illegible]ry well-trained ther[illegible] uses to monitor his countertransferenc[illegible] continual basis. However, the fact remains that no one can monitor these internal states other than the therapist himself. If the therapist does not seek out help at the first sign of these warning signals, he will rapidly descend into the chasm of lovesickness and no longer be amenable to help. Moreover, we are aware of some therapists who developed lovesickness while they were in regular supervision and simply withheld the information about the developing sexual relationship from their supervisors. These therapists felt that the relationship was so special that no supervisor could truly understand it. They concealed the information from supervision precisely because they did not want to stop the sexual relationship.

One prophylactic measure—one that therapists must enforce for themselves—is the avoidance of nonsexual dual roles with patients. A therapist-patient relationship should be a strictly professional one that is not contaminated with financial deals (other than fee arrangements) or various forms of socializing outside the therapy hour. An extensive questionnaire survey of 4,800 psychiatrists, psychologists, and social workers (Borys and Pope, in press) revealed that therapists involved in nonsexual boundary violations during psychotherapy are at an increased risk of becoming sexually involved with their patients.

While education about ethical problems in the practice of psychotherapy is important, if not essential, in training programs and continuing education workshops, the surveys reported in this book indicate that inadequate training is not the main problem. The narcissistic disturbance in the lovesick therapist is so pervasive among psychotherapists in general (see Buie 1982-83; Finell 1985; Miller 1981) that we would be hard pressed to delineate some point on the continuum at which a therapist's wish to receive certain affirming responses from his patient becomes so extreme that it places him at risk for falling in love with the patient and acting out his sexual wishes with her. Psychotherapists would do far better to assume that everyone is at risk and to engage in a continual intrapsychic monitoring process as part of their professional practice.

The data in Chapter 1 by Gartrell et al. indicate that only 41 percent of offenders sought out consultation because of their sexual involvement. Obviously, we have no data on the number of therapists who seek out consultation before getting involved as a way of preventing it. The therapist who wishes to seek help may be faced with a dilemma. As Pope (1987) points out, neither consultation nor supervision provide the extensive privilege under some state laws that the therapist-patient relationship provides. The therapist may wish to enter psychotherapy rather than pay for supervision or consultation simply to assure himself that whatever he says will be held in strict confidence. This situation may change in the near future, however, as many states are currently considering whether to allow either mandatory or discretionary reporting of therapist-patient sex even when therapist-patient privilege applies, similar to the current situation in most states regarding child abuse. For those who do seek out therapy, Pope (1987) has provided a useful model of intervention.

Finally, nothing can be more important than attention to one's private life. Far too many therapists put more energy into treatment relationships than into their marriages, where one can rightfully expect to seek personal gratification. The best prophylaxis is a satisfying personal life.

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2-27-91
1-6.

In commentary on this excerpt; clearly for the abusing professional psychotherapist there is comprehensive supervisory and peer review, including impaired physician groups available for detection of sexually exploiting medical psychotherapists and for their treatment. I am not implying that training is the only solution to the problem, but it's certainly a very important one. The other authors in this book strongly support the need for training in the ethics and problems associated with intense emotional feelings for patients. For professional counselors including sex therapists and ministers, the rules, regulations and monitoring and licensing bodies are far less formally structured and monitored, largely because of the less clearly defined nature of the professional boundaries in such groups. Such counselors are also often trained in ways which are more technique-oriented and much less attuned to subtle nuances of the relationship which can lead to unconscious emotional dependency.

The bill might well be criticized by some groups who would perhaps correctly imply that their professional licensing and monitoring authorities already contain sufficient safeguards against this type of behavior (e.g. psychiatrists), yet still in my opinion, it would be useful to specify this relationship as a unique case for this broad range of professional groups. The reasons for this include the following:

1. The problem is more widespread than had been thought.

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2-27-91
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2. The effect on patients or clients of sexually exploitative relationships is incredibly destructive. Clinical opinion of most therapists concur that at least 90% of patients are very severely damaged by such contact, including a very high suicide rate. This has also been my clinical experience. Patients who have been exploited in such a way are not psychologically dissimilar to veterans who have been severely traumatized in war. Both groups often show signs of a Post Traumatic Stress Disorder, and significant psychological disorganization, often out of proportion to any preexisting psychopathology in the patient.

3. There is a natural enough tendency in all professional groups to avoid facing issues that are distasteful to the image of the profession. No professional group is immune to this particular problem. By specifying the uniqueness of this problem, the licensing authorities and professional therapists are forced to deal directly with something that often is unconsciously swept under the carpet. To imply that such abuse occurs only rarely and in very disturbed professionals is not supported by the facts.

In summary, this bill provides a specific category for sexual exploitation, and a specific protection for those who report such offences. I strongly support this bill.

PNoW
2-27-91
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Footnotes:

1. Twemlow, S., Gabbard, G.O.: The Lovesick Therapist in Sexual Exploitation in Professional Relationships. Edited by Gabbard, G.O. Washington, DC, American Psychiatric Press, 1989; 71-87.

2. Twemlow, S., Gabbard, G.O: Iatrogenic Disease or Doctor-Patient Collusion? American Family Physician, 24:3; 129-134. September 1981.

3. Twemlow, S., Gabbard, G.O.: Iatrogenic Disease or Folie a Deux? in The Iatrogenics Handbook. Edited by Morgan, R. Toronto, Ontario, IPI Publishing, 1983; 109-119.

4. Plasil, E. Therapist. New York, St. Martins, 1985.

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Brief Biographical Sketch Revised January, 1990

Stuart W. Twemlow, M.D., married with five children, was born in New Zealand and has traveled widely. He graduated from medical school in New Zealand and entered General Practice in New Zealand and Australia emphasizing Surgery, Obstetrics and Trauma Medicine until 1970. He then traveled to the U.S.A. to study psychiatry and became a Fellow in The Menninger School of Psychiatry, Topeka, Kansas. He is Board Certified in General Psychiatry, a Fellow of the American Psychiatric Association, and is certified in Adult Psychoanalysis by the Topeka Institute for Psychoanalysis, Menninger Foundation.

He started writing with an educational book and since has published over 75 articles and book reviews in various areas such as health care delivery systems, the doctor-patient relationship, psychotherapy, drug abuse and alcoholism, psychiatric hospital treatment, biofeedback, altered states of consciousness, guided affective imagery, intensive meditation and neuropathology. His newest book with Dr. Glen Gabbard is entitled "With the Eyes of the Mind: An Empirical Analysis of Out-of-Body States" published by Praeger Special Studies, New York, 1984.

His current professional writing includes articles on clinical aspects of Out of Body Experiences, a Psychoanalytic study of the sexually abusing psychotherapist and incest. He has a Veterans Administration funded research study of the Doctor-Patient relationships derived from his clinical research into iatrogenic disease. This questionnaire and interview study investigates unconscious factors distorting communication between doctor and patient. The study will also follow-up subsequent health and practice patterns of physicians who graduated from a medical school which placed special emphasis on doctor-patient relationships. He has begun a tentative excursion into writing on psychological topics for the general public. His first book, now under contract, is entitled "Stopping Violence: A Survival Guide for the 21st Century". This book explores the pyschology of the victim and attacker with techniques to avoid bodily harm.

Formerly he was Chief of Research Service, Topeka Veterans Administration Medical Center and a faculty member of the Menninger School of Psychiatry. Currently he is in the private practice of Psychiatry in Topeka, Kansas, and is an instructor in the Topeka Psychoanalytic Institute. He is also Associate Clinical Professor of Psychiatry in two Kansas University Medical Schools; Kansas City and Wichita, Kansas. He is a member of a number of professional and Scientific Societies including the Sigma Xi Scientific Research Society, the Shawnee County Medical Society, and the American Psychoanalytic Association.

His main (even consuming) extraprofessional interests are the Martial and Meditative Arts. With his children he studies Karate and is ranked Advanced Black Belt in three systems including the Okinawa Kobudo (weapons) system. He is a Member of the Board of Directors and Head of Certification for the United States Kempo Federation and is listed in Who's Who in American Martial Arts. He is also studying and practicing the Zen Meditative approach to Mind-Body integration and teaches these techniques to students in his Topeka School of the Martial & Meditative Arts.

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KANSAS MEDICAL SOCIETY
1300 Topeka Avenue • Topeka, Kansas 66612 • (913) 235-2383
Kansas WATS 800-332-0156 FAX 913-235-5114

February 27, 1991

TO: House Public Health and Welfare Committee

FROM: Kansas Medical Society and Kansas Psychiatric Society

SUBJECT: House Bill 2253; Sexual Exploitation of Clients of Health Care Providers

Thank you for this opportunity to provide testimony on the subject of HB 2253. We neither support nor do we oppose the suggested amendments to the various licensure acts contained in this bill. This statement is collaborated because while HB 2253 is directed at psychiatrists and other providers of mental health services, the amendment to the Healing Arts Act affects all physicians in the same manner as it affects psychiatrists. Please keep in mind also that psychiatrists are not the only physicians who are called upon to provide diagnosis and treatment of mentally ill persons or to counsel patients suffering emotional distress.

You will note that the amendment to the Healing Arts Act contained at lines 26-28 on page 5, constitutes very little change in current law. In fact, this amendment would do little more than repeat ethical standards of the medical profession. The psychiatrists and other physicians of Kansas agree that exploitation of a patient or a former patient is unacceptable under any circumstances. This would appear to be grounds for discipline by the State Board of Healing Arts under the existing language of current law and would surely be interpreted as such by the State Board of Healing Arts. Fortunately, the Healing Arts Act assures the due process rights of a licensee if he or she is accused of sexual exploitation of a patient or former patient.

On the other hand, we believe that there are important questions that should be answered before enacting any new legislation, including HB 2426 as well as HB 2253. First, is it the purpose of the Legislature to reduce the incidence of sexual exploitation or instead to simply punish those who may be guilty of transgressions; and second, are providers of health care services the only ones who exploit others during a time when the victim is particularly vulnerable?

We wish to point out that in addition to the existing grounds for disciplinary action by respective licensing agencies (including suspension or revocation of a license) there are after all, criminal laws under which one may be prosecuted for commission of a sex crime. All these forms of redress are available under current laws.

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Attm # 2

We would also respectfully suggest to you that health care providers should not be the only class of professionals subject to special punitive laws for dealing with sexual exploitation of patients or clients. In 1987 we were told by the Kansas Supreme Court that health care providers should not be singled out and given unique treatment under the laws (equal protection). We could be far more supportive of legislation that applies to all professionals in a uniform manner.

Thank you for considering our comments and suggestions. We trust that you will exercise sound judgement in this matter.

/cb

PH&W
2-27-91
Attm. # 2-2

Kansas State Board of Nursing

Landon State Office Building
900 S.W. Jackson, Rm. 551
Topeka, Kansas 66612-1256
913-296-4929

Patsy L. Johnson, R.N., M.N.
Executive Administrator
913-296-3068

TO: The Honorable Representative Carol Sader, Chairperson and Members of the Public Health & Welfare Committee

FROM: Patsy L. Johnson, R.N., M.N.
Executive Administrator

DATE: February 25, 1991

RE: HB 2253

Thank you Madam Chairman for allowing me to testify to HB 2253. The Kansas State Board of Nursing supports the protection of patients or former patients from acts of sexual abuse, misconduct or exploitation from all mental health service providers. This would include nurses and mental health technicians.

In the past, the Board has investigated sexual abuse, misconduct or exploitation under regulation on unprofessional conduct; K.A.R. 60-3-110 for R.N.'s and L.P.N.'s, and K.A.R. 60-7-106 for L.M.H.T.'s. In the last two years, we have had four cases investigated involving sexual misconduct or exploitation. Three cases involve registered nurses and one involved a mental health technician. In three of the four cases, we were unable to proceed due to gray areas of the regulation. In the fourth case, a stipulation agreement was reached and the nurse is in another type of nursing.

With the introduction of changes to K.S.A. 65-1120 and K.S.A. 65-4209, the Board of Nursing would like you to consider some additional proposals which would clean up present language.

Revisions for consideration:

K.S.A. 1990 Supp. 65-1120

To combine sections (4) & (5)

PH&W
2-27-91
Attm #3

Janette Pucci, R.N., M.S.N.
Education Specialist
296-3782

Belva J. Chang, R.N., M.N., J.D.
Practice Specialist
296-3783

Patricia McKillip, R.N., M.N.
Education Specialist
296-3782

(a) Grounds for disciplinary actions.

(4) to be habitually intemperate in the use of alcohol or addicted to the use of habit-forming drugs;

(5) to be mentally incompetent;

New language

to be unable to practice with reasonable skill and safety due to physical or mental disabilities, including deterioration through the aging process, loss of motor skill or abuse of drugs or alcohol;

New language is parallel to that from K.S.A. 65-4924, risk management.

K.S.A. 1990 Supp. 65-4209

(a) The board shall have the power, after notice and an opportunity for hearing, to withhold, deny, revoke, **limit** or suspend any license to practice as a mental health technician issued or applied for in accordance with the provisions of this act or otherwise to discipline a licensee upon proof that the licensee:

Addition of limit to parallel language in nursing statute K.S.A. 1990 Supp. 65-1120.

To combine sections (2) & (3)

(2) is habitually intemperate or is addicted to the use of habit forming drugs;

(3) is mentally incompetent:

New language

to be unable to practice with reasonable skill and safety due to physical or mental disabilities, including deterioration through the aging process, loss of motor skills or abuse of drugs or alcohol;

Omit section (a)(7)

(7) has been convicted of a felony or of any misdemeanor involving moral turpitude, in which

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2-27-91
Attm 3-2

event the record of the conviction shall be conclusive evidence of such conviction. The board may inquire into the circumstances surrounding the commission of any criminal conviction to determine if such conviction is of a felony or misdemeanor involving moral turpitude.

and replace with

to have been guilty of a felony if the board determines, after investigation, that such person has not been sufficiently rehabilitated to warrant the public trust.

Again, this language is parallel to nursing statute K.S.A. 1990 Supp. 65-1120.

The Board of Nursing agrees there is a need to strengthen the ability to take action against a nurse's license for sexual abuse, misconduct or exploitation of patients or former patients. They also support such action with regard to other disciplines who deal with patients who become emotionally dependent. The Board of Nursing supports HB 2253. We ask you also to consider the other changes listed.

Thank you. I would be glad to answer any questions.

PLJ:bph

P&HW
2-27-91
Attm. # 3-3

State of Kansas
[redacted]
Joan Finney, Governor
Department of Health and Environment
Division of Health
Landon State Office Bldg., Topeka, KS 66612-1290

Acting
Stanley C. Grant, Ph.D., Secretary

Reply to: _____
FAX (913) 296-6231

Testimony

TESTIMONY PRESENTED TO THE

HOUSE PUBLIC HEALTH AND WELFARE COMMITTEE

BY

THE KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

House Bill 2253

House Bill 2253 requires any mental health services provider to report to the state licensure/registration board another mental health services provider who has sexually abused or exploited a patient or former patient. "Mental health services provider" means a physician, psychologist, nurse, professional counselor, social worker, alcohol or drug counselor, member of the clergy, or any other person, whether or not licensed or registered by the state, who provides mental health services for remuneration.

It is indeed appropriate to require such reporting upon consent of the patient. Compared to the projected number of incidents of sexual exploitation, very few victims choose to file complaints on their own to regulatory boards. However, mandatory reporting upon consent of the patient should assist in stimulating additional complaints, particularly since the therapist who made the report is to appear in person at the investigation/hearing to provide information.

In addition, this bill amends the licensing/registration acts for nurses, mental health technicians, professional counselors, social workers, and master's level psychologists. The amendments allow disciplinary action to be taken if the practitioner has committed an act of sexual abuse, misconduct, or exploitation of a patient or former patient who is emotionally dependent on the practitioner.

The bill's provisions concerning disciplinary action that may be taken against nurses, social workers, psychologists, and professional counselors who sexually abuse or sexually exploit patients is appropriate. However, physicians and psychiatrists already can be disciplined for sexual abuse or exploitation of a patient and the threat of revoking one's license has not been an effective system of control. As you are aware, national surveys show that approximately five to seven percent of licensed male

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psychiatrists, PhD psychologists, and physicians reported having had sexual intercourse with patients during treatment stages. Once a therapist becomes sexually involved with one patient, there is repetition of the behavior in 75 to 80 percent of the cases. In addition, the bill allows for disciplinary actions to be taken against mental health services providers who sexually abuse or exploit former patients who are emotionally dependent on the mental health services provider. The issue of determining emotional dependence will be complicated and difficult even with the statutory definition of "emotional dependency."

This proposal is also limited in that it only applies to disciplinary actions that can be taken against professionals who are regulated by the state. The bill does not allow for the reporting of an act by a nonregulated practitioner. There is a problem with nonregulated practitioners. For example, the Kansas Attorney General's office concluded that there were 25 to 35 complaints filed in 1985 against nonregulated mental health service providers. The most common complaint made against these individuals was that the practitioners made sexual advances or actually engaged in sexual conduct with clients. In addition, no action could be taken on the complaints received about the nonregulated therapists unless the therapists misrepresented themselves as licensed or registered professionals.

The department endorses the bill as a welcome effort in attempting to address a serious problem that has not received proper attention. However, as noted above, this measure alone is not adequate to address the issue of sexual exploitation of patients by mental health service providers. Several states have taken a comprehensive approach to the problem of sexual exploitation. (A summary of four initiatives that Minnesota and other states have initiated is attached.)

One of the initiatives taken by several other states is an amendment to the criminal code which adds sexual exploitation by mental health services providers as an unlawful sexual act. The department recommends serious consideration and passage of House Bill 2253 and the bill introduced by this committee at the request of Representative David Heinemann which changes the criminal code to make it illegal for a mental health services provider to sexually exploit a patient.

Presented by: Richard Morrissey, Deputy Director
Division of Health
Kansas Department of Health and Environment
February 27, 1991

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2-27-91
Attm H-2

House Bill 2253 Attachment I

SEXUAL EXPLOITATION

Summary of Initiatives

Criminal Law

This proposal amends the criminal code by adding sexual exploitation and aggravated sexual exploitation to the list of unlawful sexual acts. The bill makes it unlawful for health care providers who are rendering mental health services for remuneration to be sexually intimate with clients under certain circumstances. The circumstances being "during the therapy session, or if the client is emotionally dependent upon the therapist, or if the actions occurred by therapeutic deception." In addition, this proposal removes the consent plea as a defense in any sexual exploitation case.

Sexual exploitation refers to "sexual contact" under the circumstances described in the above paragraph and is a Class D felony. Sexual contact is defined as lewd fondling or touching to arouse or satisfy sexual desires. Aggravated sexual exploitation refers to sexual intercourse or sodomy under the circumstances described above and is a Class E felony.

This proposal is designed to apply to the most apparent situations in which the inherent nature of the therapeutic relationship may lend itself to sexual exploitation. This being the health care providers who are rendering mental health services.

Educating the Client (patient)

This initiative creates a new statutory requirement that all mental health service providers distribute to a client prior to treatment a disclosure of information statement. The bill requires that the disclosure include 16 informative items. Twelve of these items are one sentence statements that describe ethical practice standards (e.g., in a professional relationship, sexual intimacy is never appropriate). The information required should consist of one or two pages of information. A state designed form can be developed to eliminate any perceived problem of excessive qualification narratives.

No penalties for violations of the proposed law or any provision contained in the disclosure statements have been included since the state boards would determine the appropriate disciplinary actions against licensed or registered personnel. In the case of unlicensed and unregistered groups, the disciplinary authority and possible disciplinary options for violators of this bill are created in the second proposal.

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Attm. 4-3

Regulating Unlicensed and Unregistered Mental Health Providers

This initiative requires all unlicensed and unregistered mental health providers to file certain information on a state designed form with the Board of Behavioral Sciences in order to practice. Violation of this requirement is a Class A misdemeanor. The bill allows consumers to file complaints with the board and gives the board authority to reject a filing or application or impose adverse action under the conditions described in the bill. Sixteen conditions are listed and a majority of the conditions deal with violating ethical practice standards which includes sexual exploitation. Disciplinary actions, including the revoking the right to practice, are also delineated in this bill. This proposal does not establish educational requirements for the practice of the various unregulated occupations, nor does it imply or certify in any way that a particular practitioner has met any educational training standards or criteria, nor does it protect or define a scope of practice for the various occupational groups not required to be licensed or registered by the state.

Civil Law

This bill creates a new statutory cause of action for clients who have been sexually exploited by a health care provider rendering mental health services. This proposal allows the victim to sue the abusing health care provider and/or the provider's employer for damages under certain circumstances. As with the criminal code proposal, the act of consent is not a defense. The health care provider is liable if the sexual contact occurred: (1) during the period the client was receiving services from the health care provider, or (2) after the period the client received services from the health care provider if the former client was emotionally dependent on the provider at the time of sexual contact, or (3) if the sexual contact occurred by means of therapeutic deception. The employer is liable if: (1) the employer failed to take action when he/she knew that the provider was engaging in sexual activity with a client, and (2) the employer failed to ask the provider's previous employers about his/her sexual conduct with clients, or (3) the employer failed to pass on such information to subsequent employers who asked for it. Employers who comply in good faith with the law cannot be sued.

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Attm # 4-4

KANSAS PSYCHOLOGICAL ASSOCIATION

February 27, 1991

TESTIMONY ON HB 2253

Madam Chairperson, members of the committee, I am Dr. William L. Albott and I am appearing before you today on behalf of the Kansas Psychological Association and to provide testimony in reference to HB 2253.

KPA is fully supportive of the intent of HB 2253. There are, however, a number of problems which the current bill does not address or leaves sufficiently vague, as to preclude effective and efficient enforcement. Some of our concerns can be addressed with specific technical changes. These are included in the attached balloon of House Bill #2253.

On page 1, line 16, insert the words or "patient" and on line 18 through 21, beginning with the word "for" delete. On line 17, delete the words "for remuneration".

On page 1, between lines 21 and 22 insert:

"(2)(a) all sexual contact between a provider and a "client/patient" shall be prohibited during which time the person is receiving mental health services; and
(b) all sexual contact between a provider and a client/patient within 2 years after termination of services; or
(c) during such period of time where the provider would have reason to believe the client/patient remains emotionally dependent upon the provider.

On page 1, line 40, delete the words, "for remuneration".

On page 2, between lines 23 and 24 insert the following language:

(7) An action for sexual misconduct shall be filed with the provider's board or regulation within 5 years after the alleged misconduct.
(8) All providers of mental health services shall provide all patients at the point of initiation of services with a Patient Rights statement. Such a statement shall include:
(a) The name, address and telephone number of the provider's regulatory board;
(b) A statement indicating that sexual contact between a provider and a client/patient is grounds for disciplinary action should the contact occur during therapy or within 2 years following formal termination;
(c) The 5 year reporting period limitation.

PH & W
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attm. #5

Central Office / 400 SW Croix / Topeka, Kansas 66611 / (913) 267-7435
Official Affiliate of the American Psychological Association

A major, and very serious problem with HB 2253 is found on page 1, section (5). Note that provider includes individuals neither registered or licensed. This raises a number of questions that if HB 2253 is enacted must be answered:

1. To whom will the complaint be made?
2. What is the penalty?
3. Who will bear the expense of investigation and litigation?
4. Who will serve as the hearing officer or panel?

My experience on the BSRB taught me that investigation and litigation of cases involving sexual misconduct are time consuming and very expensive. The also taught me that there are a number of issues that often preclude filing of complaints. These are not addressed in HB 2253. For example, there is no penalty for false reporting. There is no provision for hearings to be held in camera -- both to protect the client/patient from exposure in the media and to protect the practitioner if falsely accused.

It is our hope that Representatives Wagnon and Sebelius will take this opportunity to see appointment of a Special Committee made up of representatives of the Board of Healing Arts, the BSRB, the State Board of Nursing, members of the state professional associations for Psychiatrists, Psychologists and Clinical Social Workers, members of the legislature and at least representatives from the Kansas Mental Health Association and that this committee be charged with drafting a bill for the 1992 legislature that would address this area in a manner that would allow for effective and efficient enforcement.

I thank you for your attention. If I may answer any questions, I would be pleased to do so.

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Session of 1991

HOUSE BILL No. 2253

By Representatives Wagnon and Sebelius

2-13

AN ACT concerning mental health service providers; relating to certain acts of sexual abuse, misconduct or exploitation by such providers; amending K.S.A. 1990 Supp. 65-1120, 65-2837, 65-4209, 65-5809, 65-6311, 74-5324 and 74-5369 and repealing the existing sections.

Be it enacted by the Legislature of the State of Kansas:

New Section 1. (a) As used in this section:

(1) "Client" means a person who seeks or obtains mental health services ~~for remuneration~~ from a mental health services provider and who is not married to the mental health services provider. ~~For purposes of this section, a patient of a physician or nurse shall be considered a client if the patient seeks or obtains mental health services from the physician or nurse.~~

(3) ~~(2)~~ "Emotionally dependent" means that the nature of the patient's or former patient's emotional condition and the nature of the treatment provided by the mental health service provider are such that the mental health service provider knows or has reason to know that the patient or former patient is significantly impaired in the ability to withhold consent to sexual contact or sexual intercourse by the mental health service provider.

(4) ~~(3)~~ "Knowledge" means acquired information which is clearly not the product of delusional thinking or the imagination of a client.

(5) ~~(4)~~ "Mental health service" means the treatment, assessment or counseling of another person for a cognitive, behavioral, emotional, mental or social dysfunction, including any intrapersonal or interpersonal dysfunction.

(6) ~~(5)~~ "Mental health service provider" means a physician, psychologist, masters level psychologist, nurse, mental health technician, professional counselor, social worker, alcohol or drug counselor, member of the clergy or any other person, whether or not licensed or registered by the state, who provides or purports to provide mental health services ~~for remuneration.~~

(7) ~~(6)~~ "Sexual abuse, misconduct or exploitation" means sexual intercourse or sodomy, as defined by K.S.A. 21-3501 and amendments thereto, or any lewd fondling or touching of the person of either

or "patient"

"(2)(a) all sexual contact between a provider and a "client/patient" shall be prohibited during which time the person is receiving mental health services; and
(b) all sexual contact between a provider and a client/patient within 2 years after termination of services; or
(c) during such period of time where the provider would have reason to believe the client/patient remains emotionally dependent upon the provider.

the client or the mental health service provider, done or submitted to with the intent to arouse or to satisfy the sexual desires of either the client or the mental health service provider, or both.

(b) A mental health service provider who possesses knowledge that a second mental health service provider has committed an act of sexual abuse, misconduct or exploitation against a patient or former patient of such second mental health service provider shall lawfully report such knowledge to the state agency, if any, which licenses, registers or certifies such second mental health service provider after acquiring written permission from the patient or former patient of such second mental health service provider.

(c) Any mental health service provider who makes a report to a state agency as required by this section must appear in person at any subsequent investigative proceeding involving the alleged sexual abuse, misconduct or exploitation in order to corroborate such report and submit to questioning by members of the board or staff of the agency.

(d) Any person who, in good faith, makes a report as authorized by this section shall not be liable in a civil action for damages or other relief arising from the reporting except upon clear and convincing evidence that the report was completely false and that the falsity was actually known to the person making the report at the time thereof.

Sec. 2. K.S.A. 1990 Supp. 65-1120 is hereby amended to read as follows: 65-1120. (a) *Grounds for disciplinary actions.* The board shall have the power to deny, revoke, limit or suspend any license or certificate of qualification to practice nursing as a registered professional nurse, as a licensed practical nurse or as an advanced registered nurse practitioner that is issued by the board or applied for in accordance with the provisions of this act in the event that the applicant or licensee is found after hearing:

(1) To be guilty of fraud or deceit in practicing nursing or in procuring or attempting to procure a license to practice nursing;

(2) to have been guilty of a felony if the board determines, after investigation, that such person has not been sufficiently rehabilitated to warrant the public trust;

(3) to have committed an act of professional incompetency;

(4) to be habitually intemperate in the use of alcohol or addicted to the use of habit-forming drugs;

(5) to be mentally incompetent;

(6) to be guilty of unprofessional conduct;

(7) to have willfully or repeatedly violated any of the provisions of the Kansas nurse practice act or any rule and regulation adopted

(8) An action for sexual misconduct shall be filed with the provider's board or regulation within 5 years after the alleged misconduct.

(9) All providers of mental health services shall provide all patients at the point of initiation of services with a Patient Rights statement. Such a statement shall include:

(a) The name, address and telephone number of the provider's regulatory board;

(b) A statement indicating that sexual contact between a provider and a client/patient is grounds for disciplinary action should the contact occur during therapy or within 2 years following formal termination;

(c) The 5 year reporting period limitation.

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Good Afternoon. My name is Cheryl DeBrot and I am a Respiratory Therapist Registered with the National Board of Respiratory Care as well as the State Board of Healing Arts. I am here as a representative of the Kansas Respiratory Care Society to testify in support of HB 2336. My area of work in Respiratory Therapy is in Pulmonary Rehabilitation. On a daily basis, I work to help people who have chronic lung disease live as best as possibly with the devastating physical, emotional, and psychological effects of it. In the majority of cases, active and/or passive smoking is the major contributing factor in the development of their lung disease.

It takes 20-35 years for lung disease to develop badly enough for the signs and symptoms to be experienced. By the time these symptoms and signs are evident, the disease is in the middle to late stages. There is no cure present today for chronic lung disease. One out of every seven smokers is devloping chronic lung disease such as emphysema, chronic bronchitis, bronchiectasis, asthma, and/or combinations thereof. Without a doubt, there are smoking employees of the State of Kansas who are developing any one or more of these disease state and have yet to be diagnosed. Since moving to Topeka from Wichita in October, I have already cared for many former employees of the State and in some cases current employees who are suffering now because they were unable to quit smoking. These former employees are not all of retirement age but in some cases have had to quit work because of cancer and their inability to do their work due to chronic lung disease.

With the current state regarding smoking in the State Capitol, smoking employees as well asthe public can smoke in the hallways, Rotounda, and other public areas. They are not only damaging their own healthbut also those who passively have to smoke the toxic substances in their cigarette smoke. A Study published by the Center for Disease Control states that in 1988, 3825 American non-smokers died of lung cancer. This number does not include

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Attach

those who died of chronic lung disease. I have recently cared for an individual who have developed severe emphysema because of living with smokers. This individual who is 61 years of age has lost approximately 30 pounds over the past year and was working here in Topeka until recently. This individual is now disabled and since being hospitalized for lung illness has suffered a stroke. This individual is paying the ultimate sacrifice and degree of suffering because of someone else's smoking.

If smokers are allowed to continue to smoke in the hallways, Rotounda, and other public areas of this State Capitol, both the non-smoking and smoking public are affected. Smokers are not able to smell how offensive the odors of cigarette smoke are. It can be an absolute health risk for a person with asthma, allergies, and/or chronic lung disease to walk by someone who is smoking. The State Capitol is a building intended to be used by all the people, so that they can participate in their State Government. With the passage of HB 2336, the health of all Kansans will be protected in a better way in this building. Perhaps some of the smoking employees will do something to learn to become non-smokers as a result of having to go to designated smoking areas of the State Capitol.

It is because of our concern for the respiratory health of Kansans, that on behalf of the Kansas Respiratory Care Society, I strongly urge you to vote in favor of HB 2336.

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STATE OF KANSAS

KANSAS STATE EMPLOYEES HEALTH CARE COMMISSION

MEMORANDUM

TO: Arthur H. Griggs, Acting Chairman
Health Care Commission and
Secretary of Administration

Ron Todd, Member
Health Care Commission

Robert Harder, Member
Health Care Commission

FROM: Dave Charay
Health Benefits Administrator

DATE: February 12, 1991

SUBJECT: Blue Cross Annual Report comparing Smoker versus Non-Smoker Utilization for the Kansas State Health Plan

Enclosed is the annual report comparing smoker versus non-smoker Utilization from Blue Cross and Blue Shield of Kansas. The report covers claims (for employees only) during the period January 1, 1990 through November 30, 1990 as paid through November 30, 1990.

As you review the statistics you will notice certain categories reported significant differences between smokers and non-smokers. For example, in the admissions per 1,000 category, smokers incurred **33%** more hospital admissions than non-smokers, **106.50** to **71.06.** In the days per 1,000, smokers averaged **41%** more days than non-smokers, **597.30** to **352.51** as shown in Exhibit A and B. The other categories also showed differences between smokers and non-smokers.

The Health Care Commission should note that the total average claim payment per employee was **$282.62** more for smokers than non-smokers as illustrated in Exhibit C. Consideration may want to be given to changing the disincentive given to smokers in order to recognize the additional cost (**$25.69** more per month) smokers are adding to the health plan.

A recent report by the Environment Protection Agency reported 3,800 cancer deaths a year are caused by direct smoking as reported in the Washington Post, December 6, 1990. (Please see attachment.)

Landon State Office Building, Room 553-S., 900 S.W. Jackson, Topeka, Kansas 66612-1251, (913) 296-7483

Texas instruments recently implemented a non-smokers discount plan in their health similar to the State of Kansas. One major difference is that Texas Instruments health plan also decreases the premium rates $10 for each dependent that does not smoke.

The Topeka Capital Journal last week reported that the number of smokers in the United States has decreased over **20%** in the past 20 years. More significantly, was the increase in deaths attributable to smoking, going from **188,000** in 1965 to **434,000** in 1988 (a **65%** increase). (Please see Exhibit D.)

This is the third year Blue Cross and Blue Shield has provided the Health Care Commission statistics on smokers and non-smokers. As charts A, B, C and D illustrate, smokers continue to incur higher claim payments than non-smokers.

Please call me if you have any questions or would like to discuss this memorandum further.

DC:bcm
Enclosures

cc: Dick Brock ✓

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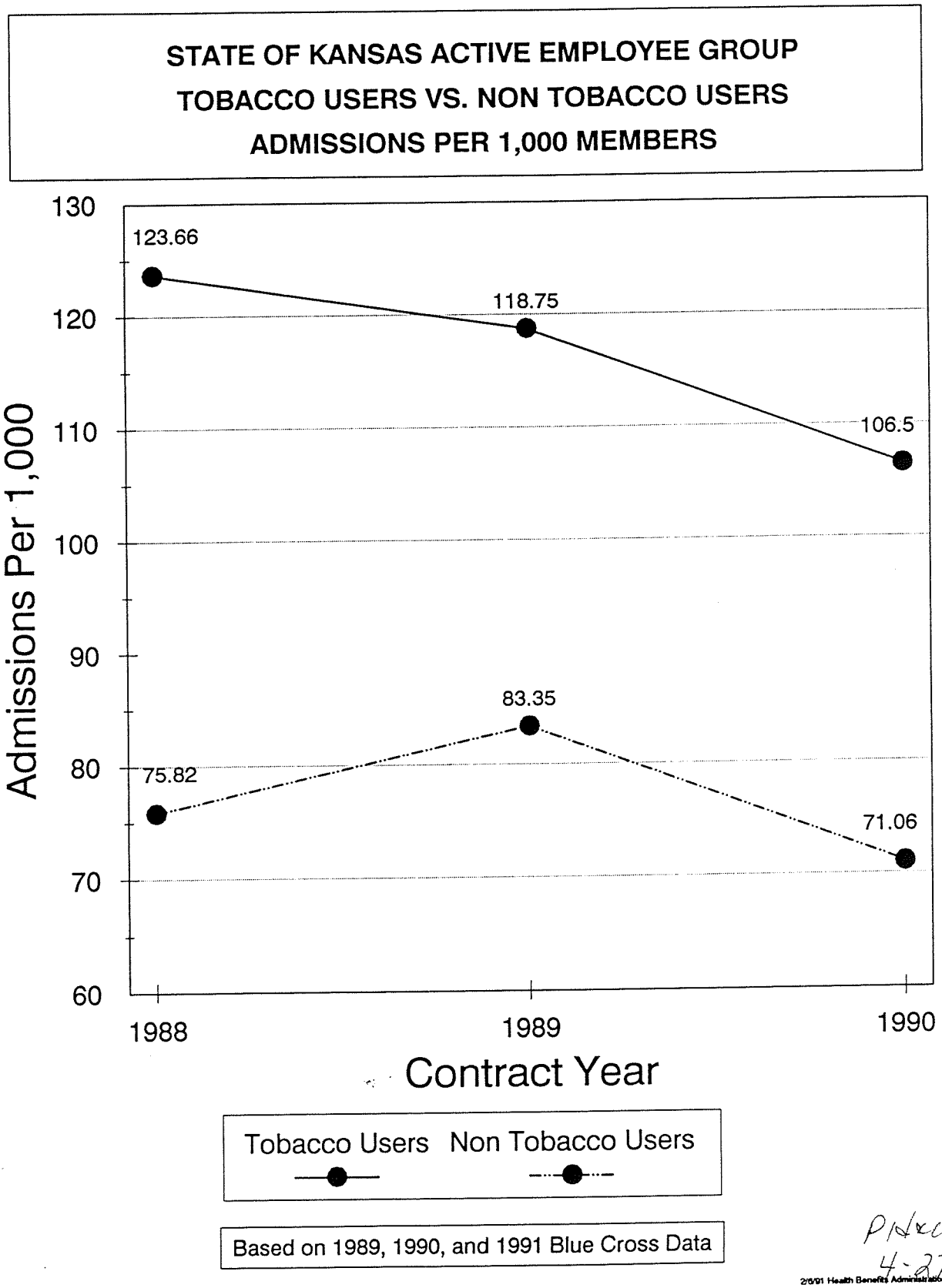
Attn #7-2



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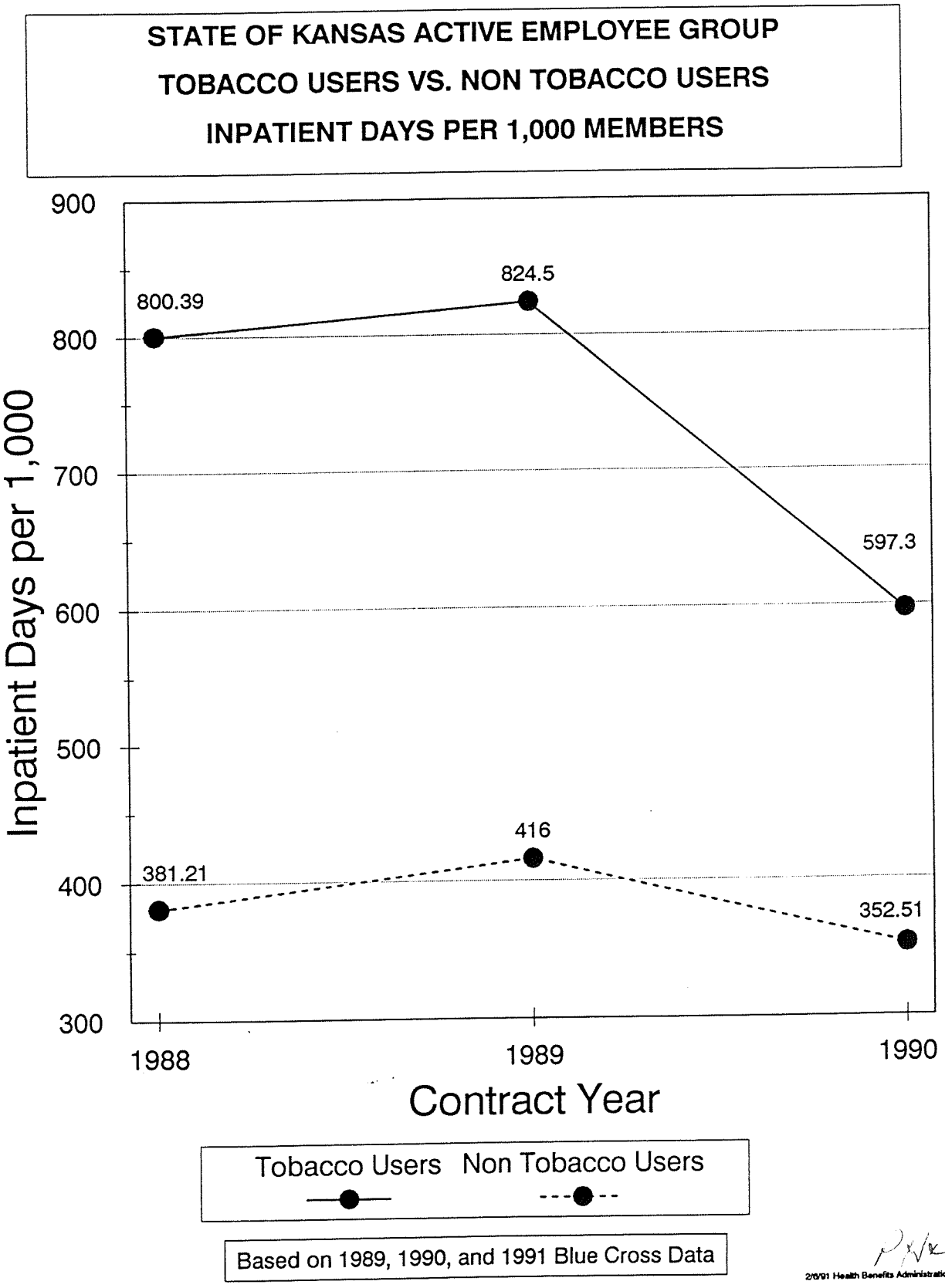

2/6/91 Health Benefits Administration

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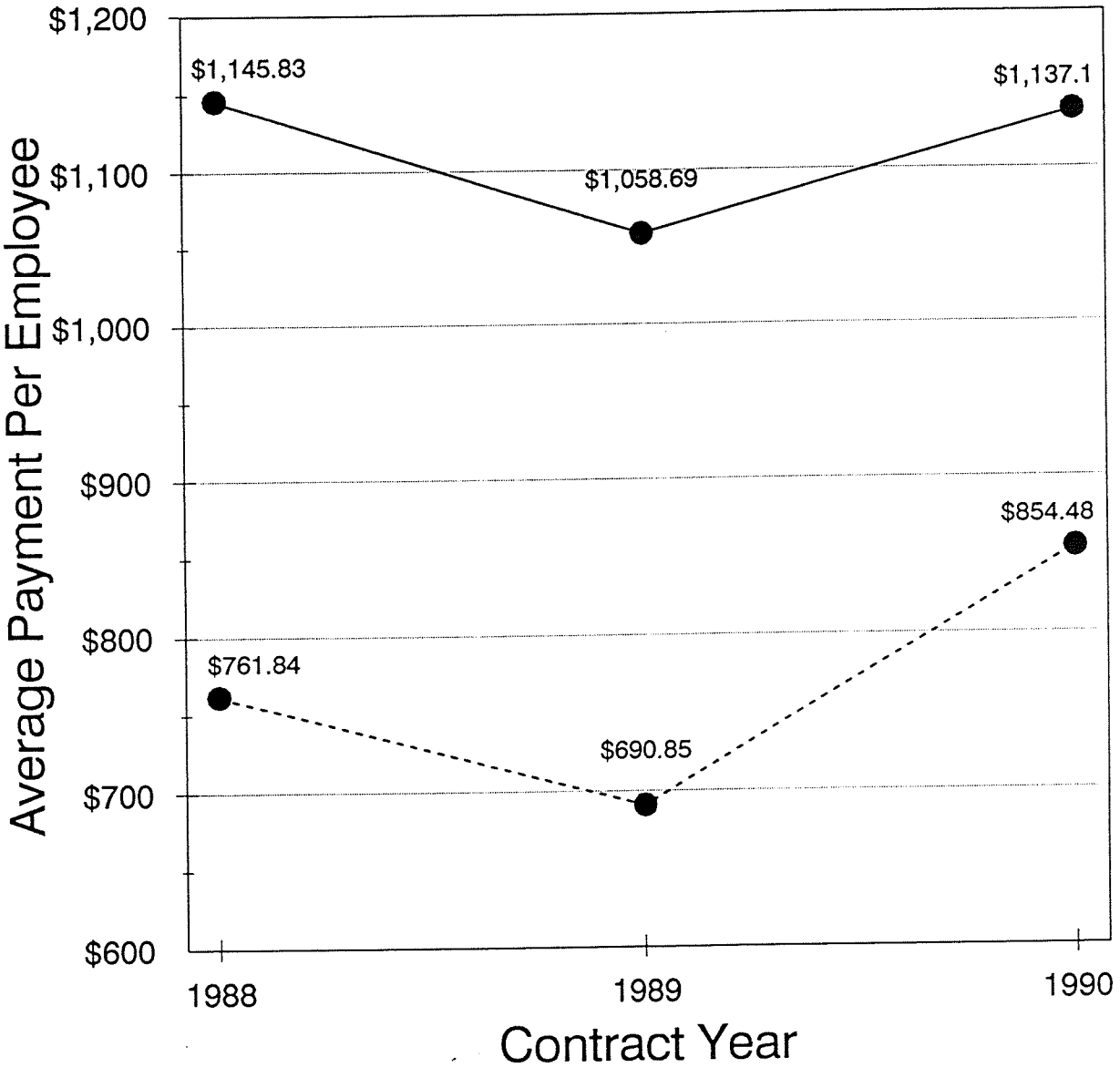
STATE OF KANSAS ACTIVE EMPLOYEE GROUP
TOBACCO USERS VS. NON TOBACCO USERS
AVERAGE PAYMENT PER EMPLOYEE



Based on 1988,1989, and 1990 Blue Cross Data

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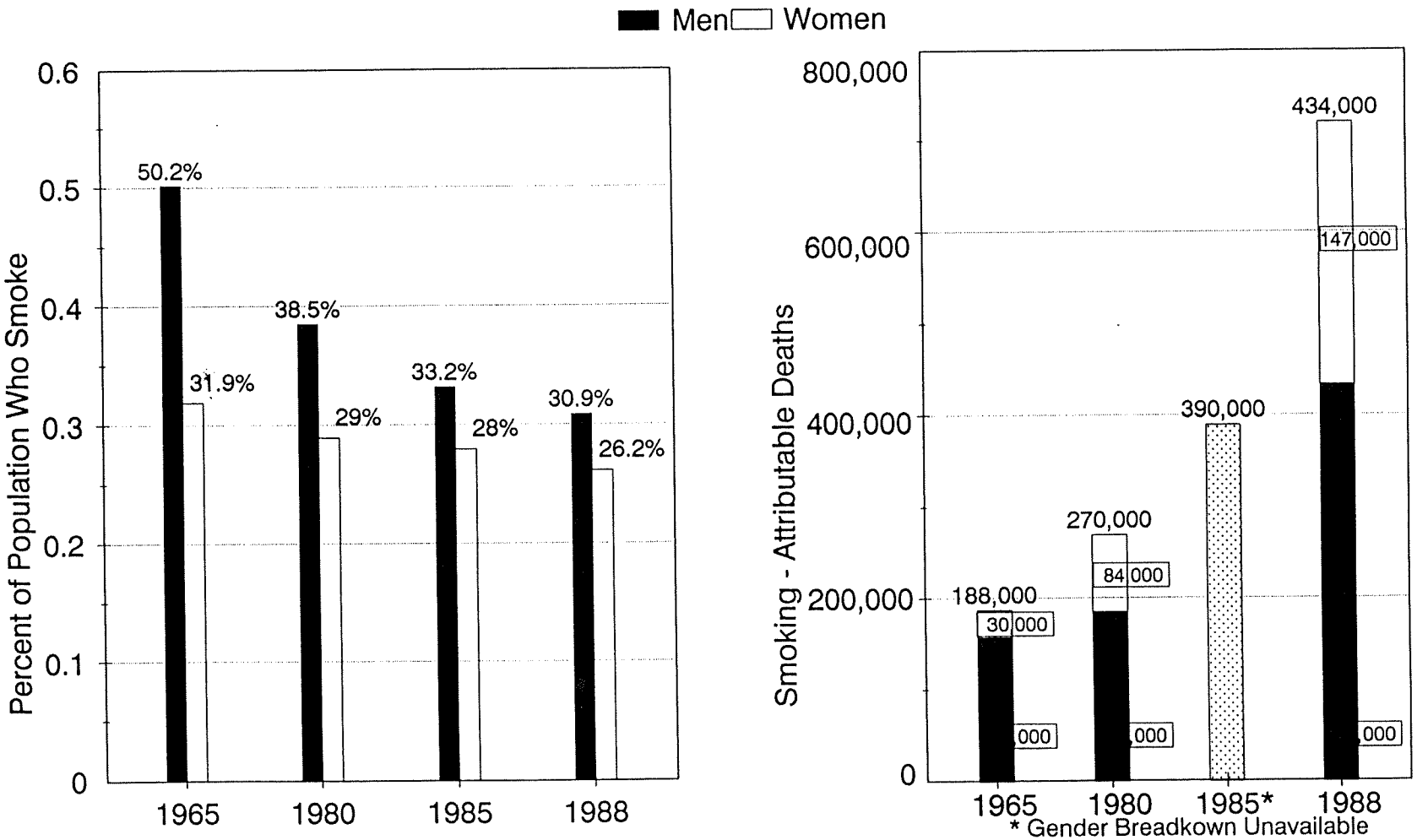
Exhibit D

THE UPS AND DOWNS OF SMOKING



Source: The National Centers for Disease Control, Office on Smoking and Health
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Parker

A Prevalent Problem
U.S. Public Health Service,
Pre[illegible]ion Report, December 1990

... the previous year.

In 1986, dental-related illnesses accounted for 22.9 million lost workdays, 6.4 million days of bed disability, and 14.3 million days of restricted activity. The total cost of dental care for the nation in 1988 was approximately $27 billion.

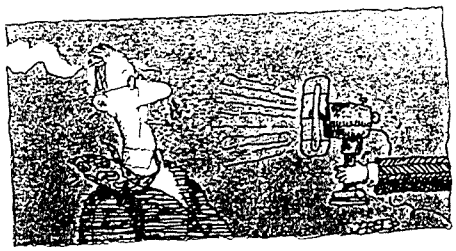
In addition to dental caries and periodontal disease, cancers of the oral cavity have a major impact on oral health. Approximately 30,500 new cases of cancer of the oral cavity and pharynx will be diagnosed in 1990 and only about one-half of these victims will be alive in five years. Tobacco and alcohol use are responsible for about 75 percent of oral cancers. Men are twice as likely to develop oral cancers as women and the incidence in blacks is 30 percent higher than for whites.

Regular contact with dental health professionals increases the chances of identifying cancerous lesions at an

population over age 2 had seen a dentist in the previous year. The larges[illegible]ntage of visits were mad[illegible] by th[illegible]h higher incomes and educational levels, children age 6 to 11, and people with dental insurance. The populations least likely to receive regular dental care included blacks, Hispanics, older Americans, and people who had lost their teeth.

With well under half the population (about 100 million people) receiving dental health insurance benefits, the cost of regular use of services may be a primary barrier."

Passive Poison



JARED D LEE

Passive Smoke a Cause of Cancer, Panel Concludes
Michael Weisskopf, *The Washington Post*, December 6, 1990

"A panel of independent science advisers to the Environmental Protection Agency concluded that involuntary exposure to tobacco smoke causes lung cancer in nonsmokers and increases risk of respiratory illness in children.

The decision is expected to solidify plans by the EPA to rank environmental tobacco smoke (ETS) as a known human carcinogen, a move that would have major implications for employers nationwide. The Labor Department is waiting for a final EPA assessment, at least six months off, to determine whether ETS should be regulated in the workplace.

"Environmental tobacco smoke's toll: 3,800 lung cancer deaths a year, the third largest cause after radon and direct smoking.

Morton Lippmann, a scientist who chairs the indoor air quality panel of the EPA's Science Advisory Board, emphasized that the panel's judgment was tentative, based on its initial review of an EPA study that he said was 'not fully developed.' He called for further refinement of the data, saying EPA 'should be able to make that case.'

The 16-member panel was asked to review the EPA study because of controversy last May over its designation of passive smoke as one of just a handful of substances known as human carcinogens. That study also offered the first official estimate of ETS's toll: 3,800 lung cancer deaths a year, the third largest cause after radon and direct smoking."

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Helgerson #8

Since 1964, when the federal government issued its first report linking smoking to lung cancer and other diseases, millions of smokers have quit, and many who might otherwise have started have not. Airlines have banned smoking. In public areas and workplaces all across the country, smoking is restricted or prohibited.

The happy result is that more than 750,000 smoking-related deaths have been avoided. Experts estimate that by the year 2000, the number of lives saved will be close to 3 million. These statistics don't cover the millions more who will live healthier, happier lives because they don't smoke.

What have these fortunate people avoided?

TOBACCO AND CANCER

Every year about 136,000 Americans die of cancer because they smoked. Nearly 30 percent of all cancer deaths are caused by smoking.

Smokers coat their airway, mouth, throat, and the delicate passageways of their lungs with tar, the solid component of cigarette smoke. Tar contains thousands of different chemicals, of which 43 are known carcinogens. Cigarette smoke damages and finally destroys the cilia, which are tiny hairlike structures that sweep foreign substances from the lungs, leading to a buildup of carcinogenic tar. About 90 percent of all lung cancer deaths are caused by smoking. Other cancers known to be caused by smoking are those of the larynx, mouth, esophagus, bladder, pancreas, kidney, and cervix.

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COPD CAN KILL

Every year, 60,000 American smokers die from chronic obstructive pulmonary disease (COPD). Put simply, they destroy their lungs by smoking.

Some are deaths from emphysema. In emphysema, the alveoli, tiny air sacs in the lungs where the exchange of carbon dioxide and oxygen takes place, break down. Breathing gets harder and harder, until the overburdened body can no longer cope. Death comes from heart failure or suffocation.

Some are deaths from chronic bronchitis. One of the ways the lungs clean themselves is by producing mucus, which traps dirt and then is swept out of the lungs by the cilia. With the cilia destroyed by smoking, only coughing can expel the mucus. Infection sets in. The lungs are inflamed and great quantities of mucus are produced, providing a good place for bacteria to grow. The passageways of the lungs narrow and breathing becomes difficult. Serious, even life threatening, infection can be the result.

THE SMOKER'S HEART

Every year, about 115,000 Americans die of heart disease because of smoking. Nicotine makes the heart beat faster so it requires more oxygen. At the same time, it causes the blood vessels to narrow, carrying less oxygen-rich blood to the heart muscle. The carbon monoxide in smoke takes the place of oxygen in the red blood cells, further reducing the oxygen that gets to the heart muscle. The scene is set for serious heart damage that can end in death.

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About 27,000 Americans die from stroke every year because they were smokers. Smoking causes the blood to clot more easily. If a clot travels to the blood vessels in the head or neck it can obstruct cirulation, causing tissue damage by depriving areas of the brain of oxygen. Another effect of smoking is atherosclerosis, or hardening of the arteries. This condition narrows arteries in the brain, in some cases completely closing them, and causes stroke.

FETAL DAMAGE AND SICK CHILDREN

Pregnant smokers expose their unborn babies to grave risks. They have more miscarriages, premature births, low-birth-weight babies, and babies who die early in infancy. Their babies are more likely to develop slowly.

Parents who smoke have children at high risk for a variety of lung disorders. Hospital admissions for pneumonia, bronchitis, and other lung disorders are twice as frequent for children whose parents smoke. The symptoms of childhood allergies and asthma are worsened by breathing cigarette smoke.

PASSIVE SMOKING: MAKING OTHER PEOPLE SICK

It's not just the children of smokers who are at risk. Everybody who comes into contact with them--spouses, co-workers, other diners at a restaurant--shares their smoke, taking in tar, carbon monoxide, and nicotine, although in smaller doses than the smoker. Nonsmokers who have heavy exposure to smokers in effect become smokers themselves.

The facts from several recent studies give new emphasis to this: Passive smoking is a health hazard. It increases

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the nonsmoker's chance of getting lung cancer and other respiratory diseases.

There are four major reasons why I believe this legislation should be passed.

First, we are setting a bad example to children, state employees, and the general citizens of Kansas by prohibiting smoking in most public areas but not in our own state capitol. We ban it in over 1500 schools, almost all state offices, and our state office building. Most cities and counties have adopted smoking bans in public areas and offices. In fact, if it was not for a provision that allowed the state buildings an exception of local ordinances, the capitol would be required to be "non-smoking" in public areas.

Second, our capitol is a treasure, not only for its architecture, but for the murals on the wall. Smoking increases the damage done our facility and increases our cost of maintenance.

According to one researcher, William Weis of Seattle University, those costs are $1,250 more annually for a smoking employee than for a nonsmoking employee. In addition, various employers have reported reductions in maintenance costs after implementing strong restrictions on smoking:

- When a West Coast insurance company adopted a policy that permitted smoking only in a designated area, in the lunchroom, the company's cleaning service voluntarily dropped its cleaning charge by 10% per month.

- An electronic components wholesaler banned smoking in the workplace and reduced its cleaning costs by more than half.

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- A motel chain that now provides only nonsmoking rooms reduced its cleaning staff after adopting its no-smoking policy. Moreover, it claims that smoking rooms needed painting five time more often than did non-smoking rooms.

A third reason is that we should do everything possible to limit and discourage smoking because of the additional health care costs.

Most people will grant that smoking causes cancer, more illnesses, and more hospitalization to smokers. But, for the first time I know of, we have information provided by our own state employees' health plan that corroborates the cost. Smokers incurred 33% more hospital admissions than non-smokers. Smokers averaged 41% more days in the hospital than non-smokers. and the average claim payment per employee was $282.62 more for smokers than non-smokers.

This does not even consider the 390,000 people who die every year, or calculate the loss of work, and loss of productivity from smoking.

The fourth and final reason is that indirect smoke, or second-hand smoke, causes the same effects on non-smokers as smoking does on smokers only to a lesser degree.

Two new studies reinforce this point. In a draft report, the EPA concluded that secondhand smoke is causing 3,800 lung-cancer deaths in the United States every year. If approved, the document will declare airborne tobacco smoke a "Class-A carcinogen"--a substance known to cause cancer in humans. The second new study by San Francisco heart researcher Stanton

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Glantz, suggests that lung cancer is only the beginning of the problem. Indeed, Glantz calculates that passive smoking causes 10 times as much heart disease as lung disease, making it the nation's third leading cause of preventable death. The only bigger killers, he says, are active smoking and alcohol abuse.

According to the American Heart Association, passive cigarette smoke kills 53,000 Americans each year, making it the third leading preventable cause of death. This was based on studies done at the University of California--San Francisco, where they established a link between passive smoke and the development of heart disease.

Finally, I just want to add that I believe it is my right to breathe clean air. Now that my -- and your -- health is at risk because of someone else's smoking, I believe that we should further restrict smoking in public areas.

Thank you for your time.

Rep. Henry Helgerson
Eighty-Sixth District

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State of Kansas
Joan Finney, Governor
Department of Health and Environment
Division of Health
Landon State Office Bldg., Topeka, KS 66612-1290

Acting
Stanley C. Grant, Ph.D., Secretary

Reply to: _____
FAX (913) 296-6231

J. Konigsberg

Testimony presented to

House Public Health and Welfare Committee

by

The Kansas Department of Health and Environment

House Bill 2336

Smoking has proven negative effects on the public health and safety. It is the number one preventable cause of death. As documented in the Surgeon General's 1989 report, smoking is responsible for about 390,000 deaths each year in the United States. That accounts for more than one of every six deaths in our country.

The Kansas Department of Health and Environment supports the intent of House Bill 2336 which serves as a step toward the elimination of smoking in public places. However, the provision in H.B. 2336 to designate small, enclosed office spaces as allowable smoking areas does pose an increased risk for those working within an enclosed, smoke-filled space.

As the State public health agency, the Kansas Department of Health and Environment clearly supports measures which reduce the risk of public health and environmental damage. To that end, the Kansas Department of Health and Environment recommends that the committee members give consideration to the clear intent of this bill, and that they take steps necessary for its implementation.

Testimony presented by: Charles Konigsberg, Jr., M.D., M.P.H.
Director
Division of Health
February 27, 1991

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Non-smokers face threat

Passive smoke, bad hearts linked

NEW YORK (AP) — Non-smokers who live with smokers have a 20 percent to 30 percent higher risk of dying from heart disease than do other non-smokers, a researcher said Sunday.

"Passive smoking causes heart disease, and the number of deaths due to heart disease is 10 times the number due to cancer," said Stanton Glantz of the University of California, San Francisco.

In remarks presented Sunday at the World Conference on Lung Health in Boston, Glantz said research is beginning to show exactly how cigarette smoke alters the heart, blood and arteries to increase the heart disease risk. Glantz presented a study in which he reviewed others' research on the subject.

In his 1986 annual report on smoking and health, the U.S. surgeon general concluded that passive smoking causes lung cancer in non-smokers. At that time, the evidence was insufficient to link passive smoking with heart disease, the report said.

Newer studies have changed that, Glantz said Friday in a telephone interview.

"The evidence that passive smoking causes heart disease is stronger today than the evidence was in 1986 that passive smoking caused lung cancer," Glantz said.

Glantz's study follows one week after the Environmental Protection Agency said it will soon declare environmental tobacco smoke a known carcinogen.

The EPA concluded that passive smoking annually causes 3,000 cases of lung cancer, a usually fatal disease. Glantz said passive smoking also causes 32,000 heart disease deaths per year.

"The heart disease deaths combined with the cancer deaths make passive smoking the third leading cause of preventable death, behind smoking and alcohol," he said.

Glantz is a researcher and statistician who conducts research in cardiology, has written two textbooks on biostatistics and serves on the California State Scientific Review Panel on toxic air contaminants.

His collaborator in the study, Dr. William Parmley, is a cardiologist, chief of the division of cardiology at University of California, San Francisco, and a past president of the American College of Cardiology.

The Tobacco Institute, which represents cigarette makers, said the surgeon general had failed to find proof that passive smoking causes heart disease.

Brennan Dawson, a spokeswoman for the institute, said in a telephone interview Friday that there have been only three studies since the surgeon general's 1986 report, "and they continue to support the conclusions" that there is no proven link between passive smoking and heart disease.

Glantz disagreed.

"There are now 11 studies of the effects of passive smoking on heart disease deaths" in non-smokers, he said. "All but one the tobacco industry funded show an increased risk." The individual studies show increased risks of between 20 percent and 30 percent.

Furthermore, he said, "There's evidence from several areas that passive smoking reduces the ability of the heart to obtain and profit from oxygen."

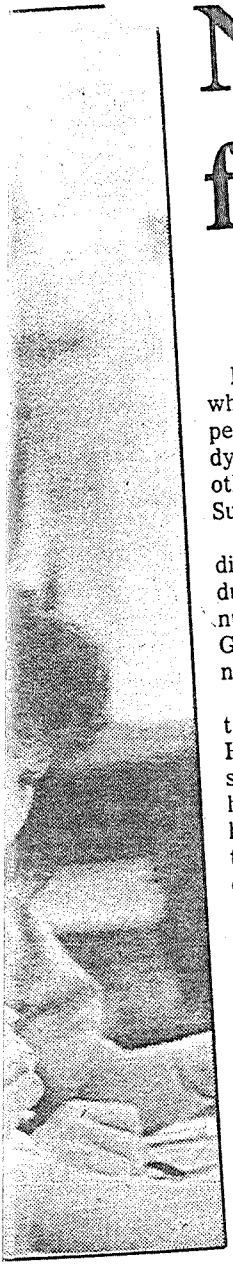
Carbon monoxide in cigarette smoke binds with hemoglobin in the blood, reducing its capacity to carry oxygen, Glantz said.

The smoke also reduces the ability of cells in the heart to convert oxygen to a chemical called adenosine triphosphate, or ATP, which provides energy to the heart, he said.

Missile attack injures 2 diplomats in Kabul

ISLAMABAD, Pakistan (AP) — A U.N. envoy and a Yugoslav charge d'affaires were injured in a missile attack on the Afghan capital of Kabul, the official Soviet news agency Tass reported.

In the bombardment of the capital, missiles hit the Wazir Akbar Khan area, where diplomatic missions are located, Tass said. The Soviet-backed government blamed the attack on the Moslem rebels.



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