Report to the General Assembly

Scope of Practice Review Committee Report on
a Definition of Surgery

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State of Connecticut
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Executive Summary

In accordance with Connecticut General Statutes Section 19a-16d, the Connecticut Chapter of the American College of Surgeons Professional Association, Inc. (CCACS) submitted a scope of practice request to the Department of Public Health to adopt a definition of surgery in the Connecticut General Statutes. The definition proposed is based on formal definition adopted by the American Medical Association with the approval of various national specialty societies.

The term "surgery" is referenced in the Connecticut General Statutes but undefined. The CCACS believes that the lack of a definition can make standards and requirements for surgery difficult for the public to understand. The CCACS states that public health and safety will not technically be harmed without establishing a definition in statute, but that quality and safety can be improved with a standard definition.

The CCACS' request states that adopting a definition of surgery is not expected to impact access to health care and not expected to increase healthcare costs. The CCACS asserts that the proposed definition of surgery will not impact other professions ability to practice to the full extent of their training, education and licensure in Connecticut.

The Department received impact statements from physician and non-physician professional associations and individuals. Physician associations were in favor of establishing a definition of surgery. However, non-physician associations and individuals expressed varied ranges of concern and opposition to establishing a definition of surgery in statute. The primary concern expressed by those opposed to the proposal was that it would have a negative impact on their ability to practice their profession to the full extent of their training, education and licensure.

A scope of practice review committee was established to review and evaluate the request as well as impact statements submitted in response to the request. The committee met three times and opinions remained divided between the physician and non-physician members represented on the committee. The physician participants expressed almost unanimous strong support for adopting a definition of surgery. The non-physician participants expressed opinions to the proposal that ranged from concern to strong opposition.

Background

Connecticut General Statutes Sections 19a-16d through 19a-16f delineate a process for the submission and review of requests from health care professions seeking to revise or establish a scope of practice prior to consideration by the General Assembly. Under the provisions of this act, persons or entities acting on behalf of a health care profession that may be directly impacted by a scope of practice request may submit a written impact statement to the Department of Public Health. The Commissioner of Public Health shall, within available appropriations, establish and appoint members to a scope of practice review committee for each timely scope of practice request received by the Department. Committees shall consist of the following members:

1. Two members recommended by the requestor to represent the health care profession making the scope of practice request;

2. Two members recommended by each person or entity that has submitted a written impact statement, to represent the health care profession(s) directly impacted by the scope of practice request; and

3. The Commissioner of Public Health or the Commissioner's designee, who shall serve as an ex-officio, non-voting member of the committee.

Scope of practice review committees shall review and evaluate the scope of practice request, subsequent written responses to the request and any other information the committee deems relevant to the scope of practice request. Such review and evaluation shall include, but not be limited to, an assessment of any public health and safety risks that may be associated with the request, whether the request may enhance access to quality and affordable health care and whether the request enhances the ability of the profession to practice to the full extent of the profession's education and training. Upon concluding its review and evaluation of the scope of practice request, the committee shall provide its findings to the joint standing committee of the General Assembly having cognizance of matters relating to public health. The Department of Public Health is responsible for receiving requests and for establishing and providing support to the review committees, within available appropriations.

Scope of Practice Request

The Connecticut Chapter of the American College of Surgeons Professional Association, Inc. (CCACS) submitted a scope of practice request to adopt a formal definition of surgery in the Connecticut General Statutes (Appendix C). The request was submitted by the CCACS in cooperation with the American College of Surgeons, the Connecticut State Medical Society, the Connecticut Dermatology and Dermatologic Surgery Society, the Connecticut Ear, Nose and Throat (ENT) Society, the Connecticut Society of Eye Physicians, the Connecticut Orthopaedic Society, and the Connecticut Urology Society. The request highlights that the

term “surgery” is referenced many times in the Connecticut General Statutes with privileges granted to a number of licensed professionals, but there is not a specific definition in the Connecticut General Statutes.

The definition of surgery proposed by the CCACS was based on the American Medical Association’s definition of surgery as taken from the American College of Surgeons Statement ST-11:

“Surgery” is defined as the structural alteration of the human body by cutting into, destroying, transposing, adding or removing live human tissue for the diagnosis and/or treatment of medical conditions.

“Surgery” may be performed by mechanical instruments such as scalpels, probes, and needles, or by instruments that use thermal or light based energies, electromagnetic or chemical means, and high pressure water jets to cut, burn, vaporize, freeze, probe or re-approximate living tissue.

“Surgery” includes the injection of diagnostic or therapeutic products into body cavities, joints, internal organs, the central nervous system, and the sensory organs, excluding the skin. It also includes the closed reduction of dislocations and/or fractures that require anesthesia.

After reviewing the impact statements submitted in response to the request and prior to the first committee meeting, the CCACS submitted an additional paragraph to include with the proposed definition to address concerns that the above definition would cause any loss of scope for any practitioner (Appendix H)

Nothing in this definition shall be construed to restrict, limit, change, or expand the scope of practice in effect on <date of adoption>, of any profession licensed by any of the health regulatory boards within the Department of Public Health.

Impact Statements and Responses to Impact Statements

Written impact statements in response to the scope of practice request submitted by CCACS were received from several individuals and organizations (Appendix D):

- Connecticut Academy of Physician Assistants
- Connecticut Advanced Practice Registered Nurse Society
- Connecticut Association of Nurse Anesthetists
- Connecticut Association of Optometrists
- Connecticut Chiropractic Association
- Connecticut Coalition of Advanced Practice Nurses
- Connecticut College of Emergency Physicians

- Connecticut Dental Hygienists' Association
- Connecticut Dermatology and Dermatologic Surgery Society
- Connecticut Ear, Nose and Throat (ENT) Society
- Connecticut Hospital Association
- Connecticut Naturopathic Medical Association
- Connecticut Nurses' Association
- Connecticut Occupational Therapy Association
- Connecticut Orthopaedic Society
- Connecticut Physical Therapy Association
- Connecticut Podiatric Medical Association
- Connecticut Society for Respiratory Care
- Connecticut Society of Eye Physicians
- Connecticut State Dental Association
- Connecticut State Electrology Association
- Connecticut State Medical Society
- Connecticut Urology Society
- International Aesthetic & Laser Association
- Merry Schlamowitz (Licensed Electrologist)
- Nikki Rasmussen, APRN-FNP-C (Med Spa)
- University of Bridgeport - Division of Health Sciences

The organizations that represent physicians licensed to practice medicine and surgery were generally supportive of establishing a formal definition of surgery in the Connecticut General Statutes. The impact statements of the organizations representing non-physician professions ranged from concern to strong opposition. The opposition and concerns of these non-physician professions focused on the impact that the proposed definition of surgery would have on their ability to practice to the fullest extent of their training and possible prohibition from engaging in future advancements that may fall under the proposed definition.

Scope of Practice Review Committee Membership (Appendix B)

In accordance with the provisions Connecticut General Statutes Section 19a-16e, a scope of practice review committee was established to review and evaluate the scope of practice request submitted by CCACS. Membership on the scope of practice review committee included representation from:

- Connecticut Academy of Physician Assistants
- Connecticut Advanced Practice Registered Nurse Society
- Connecticut Association of Nurse Anesthetists
- Connecticut Association of Optometrists
- Connecticut Chiropractic Association

- Connecticut Coalition of Advanced Practice Nurses
- Connecticut College of Emergency Physicians
- Connecticut Dental Hygienists' Association
- Connecticut Dermatology and Dermatologic Surgery Society
- Connecticut Ear, Nose and Throat Society
- Connecticut Hospital Association
- Connecticut Naturopathic Medical Association
- Connecticut Nurses' Association
- Connecticut Occupational Therapy Association
- Connecticut Orthopaedic Society
- Connecticut Physical Therapy Association
- Connecticut Podiatric Medical Association
- Connecticut Society for Respiratory Care
- Connecticut Society of Eye Physicians
- Connecticut State Dental Association
- Connecticut State Electrology Association
- Connecticut State Medical Society
- Connecticut Urology Society
- International Aesthetic & Laser Association
- Med Spa Owners of Connecticut
- Nikki Rasmussen, APRN-FNP-C (Medical Spa)
- University of Bridgeport - Division of Health Sciences
- The Commissioner's designee (Chairperson and ex officio, non-voting member).

Scope of Practice Review Committee Evaluation of Request

The Connecticut Chapter of the American College of Surgeons' (CCACS) scope of practice request included all of the required elements identified in Connecticut General Statute Section 19a-16d as outlined below. The CCACS' scope of practice request differs somewhat from most other requests that have been reviewed. The CCACS' request will not impact the scope of practice for board certified surgeons or other physicians licensed to practice medicine and surgery pursuant to Chapter 379 of the Connecticut General Statute. The request as stated is to solely create a statutory definition of surgery in Connecticut General Statute.

Health & Safety Benefits

The CCACS acknowledges that the public health and safety will not be harmed without a statutory definition of surgery. However, the CCACS believes that the state will reap improvements in safety and quality related to the provision of surgical services with a standard definition of surgery in statute. The CCACS states that without a specific definition of surgery in statute, standards and requirements for surgery can be difficult for the public to understand. Specific examples, however, were not provided.

Many of those opposed to the request did not understand how a definition of surgery in statute would positively impact public health and safety since there is no evidence that the absence of a definition has created any harm to the public, or lack of access to needed and timely healthcare or surgical services.

Access to Healthcare

The CCACS does not expect a statutory definition of surgery to impact public access to health care. However, some of the non-physician participants expressed concerns that a statutory definition of surgery could decrease access by unnecessarily limiting care and services to the most expensive, highly trained level of provider (i.e. physicians). Members with concerns about the proposal also referenced the current physician shortage, and the potential unintended consequence of limiting anything considered surgery to physicians could impact access for residents.

Proponents of the proposal reiterated that the intention of the proposal was simply to define surgery in statute. The proponents state that they had no intention of changing any professions current scope of practice, nor in limiting procedures that other professions currently perform, to surgeons.

Laws Governing the Profession

Physicians are licensed and regulated under Connecticut General Statute, Chapter 370. This chapter delineates licensure requirements as well as a requirement for ongoing Continuing Medical Education (CME). Connecticut General Statutes also require that any office where certain surgical procedures are performed obtain a certificate of need and be licensed as an outpatient surgical center. Physicians must also obtain a permit from the Department of Consumer Protection to prescribe controlled substances.

Although the title of Connecticut General Statute, Chapter 370 is "Medicine and Surgery", there are other professions that are allowed to practice surgery within their scope of practice including, but not limited to, podiatrists, dentists and optometrists.

Current Requirements for Education and Training and Applicable Certification Requirements

The scope of practice request was submitted by the CCACS that represents practicing surgeons and others involved in surgery. All Connecticut physicians are licensed pursuant to Chapter 370 of the Connecticut General Statutes (Medicine and Surgery). The requirements for licensure for those trained in the United States to practice medicine and surgery in Connecticut are 1) an M.D. or D.O. degree from an appropriately accredited medical school, 2) at least two years of post-graduate training as a resident in an appropriately accredited program and 3) successful completion of a medical licensing exam. The attached scope of practice request from the CCACS includes the requirements for a physician to become board certified in surgery (Appendix C). However, a physician

does not necessarily need board certification to obtain a license or to practice surgery. Also, there are other professions that can practice surgery, but are not licensed to practice medicine or surgery under Chapter 370 of the Connecticut General Statutes. This includes, but is not limited to podiatry, dentistry and optometry. Other professions, such as Physician Assistants, Physical Therapists and Advanced Practice Registered Nurses also engage in procedures that fall under the proposed definition of surgery.

Summary of Known Scope of Practice Changes

None have been requested by the CCACS nor have any others that pertain to surgery.

Impact on Existing Relationships within the Health Care Delivery System

The CCACS perceives that the adoption of the definition of surgery will enhance existing relationships in the health care delivery system in Connecticut. Clearly defining the definition of surgery in the Connecticut General Statutes may eliminate the "fights" that, from time-to-time, have had a negative impact on the delivery of quality patient care. Committee members, however, were not aware of any examples of such "fights" or the impact they might have had on the delivery of care.

Economic Impact

The CCACS does not foresee that the adoption of a statutory definition will increase healthcare costs in Connecticut. The CCACS believes that by codifying the definition of surgery in the Connecticut General Statutes that Connecticut, over time, will see a reduction in medical errors and a concurrent improvement in the quality of surgical care in the state as surgical procedures will be performed by physicians who are properly trained and/or certified. However, they offered no data to document the current healthcare landscape in terms of cost or surgical error rates.

Other committee members shared concerns that a definition of surgery may increase costs by unnecessarily limiting care and services to the highest paid level of provider (i.e. physicians). Others expressed that the use of the proposed language may become overly restrictive and counterproductive as technologies evolve, become less expensive and more readily available. Other non-physician committee members were concerned that a definition of surgery may have the unintended consequence of limiting them from practicing to the full extent of the training and education, thereby impacting them economically.

Regional and National Trends

According to the CCACS proposal, 23 states have defined "surgery" in statute or regulation, AL, AK, AZ, FL, IL, IN, KS, LA, ME, MD, MN, MS, MT, NV, NH, NJ, OH, PA, RI, VA, WV, WI and WY. The definitions that exist in other states vary greatly according to members of the committee.

Other Health Care Professions that May be Impacted by the Scope of Practice Request as Identified by the Requestor

The requestor, the CCACS, did not identify other professions that may be impacted by the scope of practice request. According to the CCACS, the proposed definition of surgery would apply to all Doctors of Medicine (M.D.) and Doctors of Osteopathic Medicine (D.O.) who are licensed by the state of Connecticut to perform surgery as the practice of medicine, regardless of specialty or board certification. The CCACS does not envision a definition of surgery impacting other practitioners, such as Podiatrists, who are licensed to perform surgery within certain parameters defined under their scope. In addition, the CCACS believes the proposed definition would allow practitioners who practice by statute under physician supervision to continue to be able to do so.

Other committee participants had concerns that their profession may be impacted by the scope of practice request to define surgery. Certified Registered Nurse Anesthetists (CRNAs) were concerned that the proposed definition of surgery could impact their ability to provide spinal anesthesia by injection or other procedures. Advanced Practice Registered Nurses (APRNs) are concerned this definition could impact APRNs who perform common office-based procedures that involve the alteration of live tissue. APRNs were also concerned that such a definition would limit APRNs, who may practice independently after working in collaboration with a physician for three years, from working within their full scope. Professionals involved in aesthetics and laser cosmetic procedures expressed concerns that the definition may cause confusion among non-physicians that currently provide services that alter live tissue, and that a definition may prevent APRNs and Physician Assistants (PAs) from utilizing future technological advances as they occur. The representative from podiatry was concerned about the potential negative impact on non-physician providers. Podiatry representation shared concerns that insurance payers could use the definition to impact reimbursement; and that a definition of surgery could cause confusion and bias public opinion of non-physician providers.

Non-physician members of the committee posed questions to the CCACS regarding specific procedures and whether or not they would be considered surgery under the proposed definition. For example, the CCACS responded that a cortisone injection into a knee (a body cavity) is invasive and would be considered surgery.

Regarding concerns from those in the field of laser hair treatments and cosmetic procedures being surgical procedures, the CCACS responded that the surface of the skin is not considered live tissue so this would not be an issue. However, physicians representing the practice of dermatology explained that chemical peels and laser treatments can potentially fall under the definition of surgery because those treatments can affect deeper layers of live tissue. The CCAS and dermatology representation reiterated that the intention of the proposal was not to limit anyone's scope of practice.

Description of How the Request Relates to the Profession's Ability to Practice to the Full Extent of the Profession's Education and Training

Licensed members of the CCACS, board certified surgeons, are already able to practice surgery in Connecticut and practice to the full extent of their education. A definition of surgery in statute will not change their scope of practice. The CCACS assert that the adoption of a definition of surgery into the CGS will allow each and every surgical health care practitioner in Connecticut to provide quality patient care to the fullest extent of their individual education, training, certification and licensure.

However, committee representatives not licensed as a physician/surgeon under Chapter 370 of the Connecticut General Statutes have concerns that adopting a definition of surgery may inhibit their ability to practice to the full extent of their education and training.

The CCACS asserts that the proposal is not a threat to other professions and not intended to limit scopes of practice.

Findings/Conclusions

The Connecticut Chapter of the American College of Surgeons Professional Association's (CCACS) scope of practice request was to establish a statutory definition of surgery. The content of the request would not impact the scope of practice for physicians/surgeons licensed in Connecticut pursuant to Connecticut General Statutes, Chapter 370 (Medicine and Surgery). The request also stated that the intention of the request to adopt a definition of surgery in Connecticut General Statute, will allow each and every surgical health care practitioner in Connecticut to provide quality patient care to the fullest extent of their individual education, training, certification and licensure.

The committee membership that represented CCACS and other physician organizations supported the adoption of a definition of surgery in statute. These committee members asserted that such a definition would help patients understand what surgery is and contribute to surgical quality and safety. The committee members in support of the proposal stated that the proposed statutory definition would not limit or change any other licensed profession's current scope of practice; it would however, clearly define the term "surgery" that exists in current statute.

Many of the non-physician professions on the committee had concerns that establishing a definition of surgery in statute might have the unintended consequence of impacting their ability to practice to the full extent of their education and training. Some of the concerns expressed by non-physician committee members about a statutory definition of surgery included:

- Insurers may interpret the statute to exclude reimbursing anyone but a licensed physician/surgeon for procedures that would fall under the definition of surgery.
- The definition may impact the ability of non-physician/surgeons from participating in future surgical advancements that may not require a physician/surgeon to perform.
- The definition may impact patients by limiting access, changing care delivery and the payment process.
- Some employers may limit credentialing of providers based on a new definition of surgery.
- The purpose of the proposal is to restrict surgical procedures to physicians and create roadblocks for future scope expansion requests by non-physicians.

The final concern listed above was further fueled by a sentence in a 2012 bulletin published by the American College of Surgeons entitled *State of the States: Defining Surgery* (Appendix F). The sentence in this document that contributed to the concern among many committee members stated, *"A statutory definition of surgery at the state level can help to limit non-physicians' attempts to expand their scope into the performance of surgery."*

In response to the concerns related to the wording in the 2012 bulletin, the CCACS obtained a letter from the Executive Director of the American College of Surgeons (Appendix G). The letter reiterated the CCACS' assertion that the intent of the bulletin was to clarify the role of all healthcare providers engaged in surgical procedures to ensure patient safety. The letter also reiterated that establishing a definition of surgery should not impede the ability of healthcare providers from performing their services as defined in the Connecticut General Statutes and that the American College of Surgeons believes that establishing a definition of surgery is in the best interest of patient health care quality and safety. However, many of the non-physician committee members were not convinced that limiting non-physicians scope of practice was not among the intentions of the proposal.

During the third and final meeting of the committee and in an effort to gain more support from non-physician members, the representatives from the CCACS and other proponents proposed a revised definition of surgery:

"Surgery" is defined as the structural alteration of the living tissue of the human body, including but not limited to incising, destroying, transposing, adding or removing tissue, by any means.

Nothing in this definition shall be construed to restrict, limit, change, or expand the scope of practice of any profession licensed by the Department of Public Health.

The committee, however, did not come to an agreement over establishing a definition of surgery in statute. The CCACS and other supporters reassured the group and reiterated that the intention of their proposal was for clarity and patient safety. Some members expressed being supportive of the concept of a definition of surgery, but were still concerned that there would be unintended consequences to non-physician professions that perform procedures that would fall under the definition. Others were adamantly opposed and convinced there would be at least several unintended consequences. Many non-physician committee members, even those not worried about an impact to their profession, felt there was no true benefit to having a definition of surgery in statute in the absence of evidence that a definition is needed.

Should the Public Health Committee decide to raise a bill related to the CCACS' scope of practice request, the Department of Public Health, along with the pertinent organizations that were represented on the scope of practice review committee, respectfully request the opportunity to work with the Public Health Committee on such a proposal.

Appendices Table of Contents

Appendix A

Scope of Practice Law

Scope of Practice Law

Connecticut General Statutes
19a-16d - 19a-6f

Sec. 19a-16d. Submission of scope of practice requests and written impact statements to Department of Public Health. Requests for exemption. Notification and publication of requests. (a) Any person or entity, acting on behalf of a health care profession that seeks to establish a new scope of practice or change a profession's scope of practice, may submit a written scope of practice request to the Department of Public Health not later than August fifteenth of the year preceding the commencement of the next regular session of the General Assembly.

(b) (1) Any written scope of practice request submitted to the Department of Public Health pursuant to subsection (a) of this section shall include the following information:

(A) A plain language description of the request;

(B) Public health and safety benefits that the requestor believes will be achieved should the request be implemented and, if applicable, a description of any harm to public health and safety should the request not be implemented;

(C) The impact that the request will have on public access to health care;

(D) A brief summary of state or federal laws that govern the health care profession making the request;

(E) The state's current regulatory oversight of the health care profession making the request;

(F) All current education, training and examination requirements and any relevant certification requirements applicable to the health care profession making the request;

(G) A summary of known scope of practice changes either requested or enacted concerning the health care profession in the five-year period preceding the date of the request;

(H) The extent to which the request directly impacts existing relationships within the health care delivery system;

(I) The anticipated economic impact of the request on the health care delivery system;

(J) Regional and national trends concerning licensure of the health care profession making the request and a summary of relevant scope of practice provisions enacted in other states;

(K) Identification of any health care professions that can reasonably be anticipated to be directly impacted by the request, the nature of the impact and efforts made by the requestor to discuss the request with such health care professions; and

(L) A description of how the request relates to the health care profession's ability to practice to the full extent of the profession's education and training.

(2) In lieu of submitting a scope of practice request as described in subdivision (1) of this subsection, any person or entity acting on behalf of a health care profession may submit a request for an exemption from the processes described in this section and section 19a-16e. A request for exemption shall include a plain language description of the request and the reasons for the request for exemption, including, but not limited to: (A) Exigent circumstances which necessitate an immediate response to the scope of practice request, (B) the lack of any dispute concerning the scope of practice request, or (C) any outstanding issues among health care professions concerning the scope of practice request can easily be resolved. Such request for exemption shall be submitted to the Department of Public Health not later than August fifteenth of the year preceding the commencement of the next regular session of the General Assembly.

(c) In any year in which a scope of practice request is received pursuant to this section, not later than September fifteenth of the year preceding the commencement of the next regular session of the General Assembly, the Department of Public Health, within available appropriations, shall: (1) Provide written notification to the joint standing committee of the General Assembly having cognizance of matters relating to public health of any health care profession that has submitted a scope of practice request, including any request for exemption, to the department pursuant to this section; and (2) post any such request, including any request for exemption, and the name and address of the requestor on the department's web site.

(d) Any person or entity, acting on behalf of a health care profession that may be directly impacted by a scope of practice request submitted pursuant to this section, may submit to the

department a written statement identifying the nature of the impact not later than October first of the year preceding the next regular session of the General Assembly. Any such person or entity directly impacted by a scope of practice request shall indicate the nature of the impact taking into consideration the criteria set forth in subsection (b) of this section and shall provide a copy of the written impact statement to the requestor. Not later than October fifteenth of such year, the requestor shall submit a written response to the department and any person or entity that has provided a written impact statement. The requestor's written response shall include, but not be limited to, a description of areas of agreement and disagreement between the respective health care professions.

Sec. 19a-16e. Scope of practice review committees. Membership. Duties. (a) On or before November first of the year preceding the commencement of the next regular session of the General Assembly, the Commissioner of Public Health shall, within available appropriations allocated to the department, establish and appoint members to a scope of practice review committee for each timely scope of practice request submitted to the department pursuant to section 19a-16d. Committees established pursuant to this section shall consist of the following members: (1) Two members recommended by the requestor to represent the health care profession making the scope of practice request; (2) two members recommended by each person or entity that has submitted a written impact statement pursuant to subsection (d) of section 19a-16d to represent the health care professions directly impacted by the scope of practice request; and (3) the Commissioner of Public Health or the commissioner's designee, who shall serve as an ex-officio, nonvoting member of the committee. The Commissioner of Public Health or the commissioner's designee shall serve as the chairperson of any such committee. The Commissioner of Public Health may appoint additional members to any committee established pursuant to this section to include representatives from health care professions having a proximate relationship to the underlying request if the commissioner or the commissioner's designee determines that such expansion would be beneficial to a resolution of the issues presented. Any member of such committee shall serve without compensation.

(b) Any committee established pursuant to this section shall review and evaluate the scope of practice request, subsequent written responses to the request and any other information the committee deems relevant to the scope of practice request. Such review and evaluation shall include, but not be limited to, an

assessment of any public health and safety risks that may be associated with the request, whether the request may enhance access to quality and affordable health care and whether the request enhances the ability of the profession to practice to the full extent of the profession's education and training. The committee, when carrying out the duties prescribed in this section, may seek input on the scope of practice request from the Department of Public Health and such other entities as the committee determines necessary in order to provide its written findings as described in subsection (c) of this section.

(c) The committee, upon concluding its review and evaluation of the scope of practice request, shall provide its findings to the joint standing committee of the General Assembly having cognizance of matters relating to public health. The committee shall provide the written findings to said joint standing committee not later than the February first following the date of the committee's establishment. The committee shall include with its written findings all materials that were presented to the committee for review and consideration during the review process. The committee shall terminate on the date that it submits its written findings to said joint standing committee.

Sec. 19a-16f. Report to General Assembly on scope of practice review processes. On or before January 1, 2013, the Commissioner of Public Health shall evaluate the processes implemented pursuant to sections 19a-16d and 19a-16e and report to the joint standing committee of the General Assembly having cognizance of matters relating to public health, in accordance with the provisions of section 11-4a, on the effectiveness of such processes in addressing scope of practice requests. Such report may also include recommendations from the committee concerning measures that could be implemented to improve the scope of practice review process.

Appendix B

Committee Membership

Definition of Surgery Committee Membership

All participating organizations are reflected, however substituted individual committee members may not be listed

Name of Organization	Committee Members
CT Department of Public Health	Christian Andresen, Chairperson, Ex-Oficio Wendy Furniss, Ex-Oficio
CT Chapter of the American College of Surgeons Professional Association, Inc (CCACS)	Christopher Tasik Kathleen LaVorgna
Connecticut State Electrology Association (CSEA)	Marsha Adams Sawdon Kathryn Boris
CT Physical Therapy Association (CPTA)	Michael Gans Katherine Harris
CT Chiropractic Association	Richard Duenas Joanne Santiago
CT Coalition of Advanced Practice Nurses	Lynn Rapsilber Donna Montesi
CT Occupational Therapy Association (ConnOTA)	Moira Ethier Nancy Perrotta
CT Hospital Association (CHA)	Karen Buckley Jen Cox
CT Dental Hygienists Association	Marie R. Paulis Linda Kowalski
International Aesthetic & Laser Association	Nicole Strothman Amy (Zilis) Murray
CT Naturopathic Physicians Association (CNPA)	Rick Liva Jacqueline Germain
CT Society for Respiratory Care	Connie Dills
CT APRN Society	Donna Montesi Monte Wagner
CT Podiatric Medical Association (CPMA)	Joseph Treadwell
Medical Spa Owners of CT	Nikki Rasmussen Mark Ginella
University of Bridgeport Health Sciences	David Brady Marcia Prenguber
CT State Dental Association (CSDA)	Jeffrey Berkley Michael Safian
CT Association of Optometrists (CAO)	David Palozej Brian Lynch
CT Academy of PAs (ConnAPA)	Jonathan Weber Andrew Turczak
CT Association of Nurse Anesthetists	Donna Sanchez Christopher Bartels
Connecticut Nurses Association (CTANA)	Kimberly Sandor Mary Jane Williams
CT State Medical Society (CSMS)	Ken Ferrucci David Emmel
CT College of Emergency Physicians (CCEP)	Tom Brunell Mike Zanker
CT Orthopaedic Society	Mariam Hakim-Zargar Susan Schaffman
CT Society of Eye Physician (CSEP)	David McCullough Steve Thornquist
CT Urology Society	Marlene Murphy-Setzko Art Tarrantino
CT Dermatological Society	Donna Aiudi Frank Castiglione
CT Ear, Nose & Throat Society (CTENT)	Ray Winicki Debbie Osborn

Appendix C

Original Scope of Practice Request and Attachments

American College of Surgeons
Inspiring Quality:
Highest Standards, Better Outcomes

Connecticut Chapter
of the American College of Surgeons
Professional Association, Inc.

Submitted via email to *Karen.Wilson@ct.gov*

August 9, 2016

Karen G. Wilson, HPA
Practitioner Licensing & Investigations
Connecticut Department of Public Health
410 Capitol Avenue, MS#12APP
P.O. Box 340308
Hartford, CT 06134

Dear Ms. Wilson:

As the Department of Public Health (DPH) is aware, the Connecticut Chapter of the American College of Surgeons Professional Association (CTACSPA) seeks to better serve the needs of surgical patients in the state of Connecticut through the establishment in state statute of a clear and concise definition of surgery as written by the American College of Surgeons and adopted by the American Medical Association.

In addition to the named parties on the submission, the CTACSPA and the Connecticut State Medical Society have worked diligently to increase support for this proposal from other stakeholders. At the suggestion of Commissioner Pino and Public Health Committee Co-Chairs Gerratana and Ritter, we are requesting selection for a scope of practice review as established under Public Act 11-209.

We believe that recent and ongoing changes to various scopes of practices established in state statute make it imperative that this request receive the benefit of the process during this cycle. As more and more health care provider groups seek and receive legislative approval to increase their autonomy as well as the range of services provided a thorough review of our request should be undertaken to clarify what constitutes surgery.

We therefore respectfully submit the attached request for review under PA 11-209.

Thank you for your assistance with this request. If you have any questions please do not hesitate to contact Mr. Christopher Tasik (203-912-1636 or info@ctacs.org)

Sincerely,

Michael Deren, MD, FACS
President

AMERICAN COLLEGE OF SURGEONS
Inspiring Quality:
Highest Standards, Better Outcomes

CONNECTICUT CHAPTER
of the American College of Surgeons
Professional Association, Inc.

EXECUTIVE DIRECTOR
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O: 203-674-0747
F: 203-621-3023

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Uniting Surgeons to Advance Patient Care in Connecticut[SM]

The Connecticut Chapter of the American College of Surgeons Professional Association, Inc.

In cooperation with and support of:
The American College of Surgeons
The Connecticut State Medical Society
The Connecticut Dermatology and Dermatologic Surgery Society
The Connecticut State ENT Society
Connecticut Society of Eye Physicians
The Connecticut Orthopaedic Society
The Connecticut Urology Society

Submission for Scope of Practice Request to
the Department of Public Health pursuant to HB6549

August 9, 2016

Background:

The Connecticut Chapter of the American College of Surgeons Professional Association, Inc. ("CTACSPA") is the professional society that represents surgeons, surgical residents and surgical allied health professionals in Connecticut.

The Chapter has served surgeons and patients in Connecticut for 45 years. We are an active advocate for surgical education for our members and surgical residents in the states seven (7) residency programs. In 2011, the Chapter formed the Connecticut Surgical Quality Collaborative ("CtSQC") to provide a forum in which surgeons share knowledge and best practices in the treatment of surgical patients in Connecticut. Presently, this nationally recognized Collaborative has the active participation of over 18 hospitals in the state

(1) A plain language description of the request;
While there are several places in the Connecticut General Statutes ("CGS") where the word "surgery" is referenced, there is no place where surgery is formally defined. However, the American Medical Association ("AMA") with the approval of various national specialty societies has formally adopted a Definition of Surgery. We are requesting that the Department of Public Health, under Public Act 11-209 review this request and submit its findings to the Connecticut General Assembly ("CGA") such that they may consider adopting the same definition in the CGS.

(2). public health and safety benefits that the requestor believes will occur if the request is implemented and, if applicable, a description of any harm to public health and safety if it is not implemented;

Currently, the term "surgery" is referenced many times in Connecticut General Statutes (CGS) (Appendix A). However, although surgical privileges are granted to several classes of licensed professionals, no one specific definition of surgery exists in state statute. Therefore, standards and requirements can be difficult for the public to understand. Codifying one specific and clear definition, as proposed within this document, will provide consistency. A strong definition will ensure trained professionals are practicing to the highest standards. This in turn will benefit public health and safety.

While public health and safety will not technically be harmed without implementation, a definition codified in the CGS will allow the state to reap the safety and quality that can be improved with a standard definition.

(3) the impact of the request on public access to health care;
Adopting the definition of surgery is not expected to impact public access to health care. It will impact public safety and quality of care particularly as it relates to the provision of surgical services. For many years, medicine and surgery have collaborated to improve quality of care through the development of various quality guidelines for medical practice. In addition,

numerous regulations abound relating to Continuing Medical Education requirements (CME) for physicians; residency training and Board certification along with periodic maintenance of certification; hospital and health system medical staff membership requirements for evidence of quality medical practice; etc.

In fact, medical associations were often founded with the purpose of improving patient safety and quality care. For example, the American College of Surgeons (ACS) -- www.facs.org -- was founded in 1913 as a scientific and educational association of surgeons to improve the quality of care for the surgical patient by setting high standards for surgical education and practice. To achieve this, the ACS:

- Sponsors a variety of continuing medical education programs, such as the Clinical Congress, to help surgeons keep abreast of the latest information on surgical subjects.
- Conducts various programs through its Commission on Cancer (http://www.facs.org/cancer/index.html) to improve the care of the cancer patient. Promotes a program that encourages hospitals to develop programs for optimal care of cancer patients and to seek, on a voluntary basis, College approval of these programs.
- Through its Committee on Trauma (http://www.facs.org/trauma/index.html), works to improve the care of injured and critically ill patients--before, en route to, and during hospitalization. Conducts training courses in emergency care for ambulance personnel; sponsors courses for the management and prevention of injuries for trauma specialists as well as for physicians who do not treat trauma victims on a regular basis; and works to encourage hospitals to upgrade their trauma care capabilities. Maintains a voluntary verification/consultation program for trauma centers.
- Monitors and analyzes socioeconomic, legislative, and regulatory issues affecting the field of surgery through its Division of Advocacy and Health Policy (http://www.facs.org/ahp/index.html), which is based in Washington, DC. Participates in policy development on these issues and prepares responses to Congress and federal agencies.
- Serves as a sponsoring organization for the Residency Review Committees for Colon and Rectal Surgery, Neurological Surgery, Otolaryngology, Plastic Surgery, Surgery, Thoracic Surgery, and Urology. Supports postdoctoral education in surgery through several scholarship programs.
- Through its Office of Public Information (http://www.facs.org/public_info/ppserv.html) , provides general information to the public about surgeons and surgical care. A patient education Web site, which was developed by the College's Division of Education, helps individuals contemplating elective procedures make informed decisions about surgical care, and provides a variety of resources on frequently performed surgical procedures and related issues.
- The College has developed the Surgical Education and Self-Assessment Program (SESAP) (http://www.facs.org/education/sesap/index.html) to provide practicing

surgeons with an excellent resource for lifelong learning. SESAP is based on the opinions of expert surgeons, and the published literature, and may be used to stay current, earn CME credits, or prepare for certification or recertification.

Continuous Quality Improvement (CQI) -- http://www.facs.org/cqi/index.html -- a part of the ACS Division of Research and Optimal Patient Care, promotes the highest standards of surgical care through evaluation of surgical outcomes in clinical practice. CQI provides the infrastructure for conducting health services research and clinical research, outcome studies, meta-analyses, research hypothesis generation, and the development of evidence based practice guidelines at the College. This area also collaborates with the Divisions of Education (http://www.facs.org/education/index.html) and Advocacy and Health Policy (http://www.facs.org/ahp/index.html) to provide educational programs and promote public policy initiatives in clinical research and forms partnerships with outside groups and organizations involved in evaluation of surgical outcomes.

CQI is responsible for the ACS National Surgical Quality Improvement Program ("NSQIP" -- http://site.acsnsqip.org/. This program is a nationally validated, risk-adjusted, outcomes-based approach to measure and improve the quality of surgical care. It employs a prospective, peer-controlled, validated database to quantify 30-day, risk-adjusted surgical outcomes, which provide a valid comparison of outcomes among all hospitals in the program. Currently, about 400 hospitals use the ACS NSQIP tools, analyses, reports and support to make informed decisions about improving the quality of their care. Peer-reviewed studies have shown that ACS NSQIP is effective in improving the quality of surgical care while also reducing complications and costs. **On average, a hospital can prevent in one year 250-500 complications, save 12-36 lives, and reduce costs by millions of dollars.**

In 2011, the CTACSPA formed the Connecticut Surgical Quality Collaborative ("CtSQC") to provide a forum in which surgeons share knowledge and best practices in the treatment of surgical patients in Connecticut. Currently, 18 Connecticut hospitals are active members of the CtSQC and 12 Connecticut hospitals are utilizing the ACS' NSQIP risk-adjusted database as the primary data gathering tool for their quality improvement programs. CtSQC members that use NSQIP sign a data sharing agreement so that each facility is able to benchmark itself against other hospitals in the state as well as nationally on various quality measurements. The CtSQC meets on a quarterly basis to allow members to share best practices which facilitates the improvement of surgical quality here in Connecticut. Please refer to Exhibit 1.

(4) a brief summary of state or federal laws governing the profession;

Health care is probably the most regulated industry in the United States. On the federal level, Medicare and other programs of care (Medicaid, Veterans Administration, etc) affect a majority of physicians in the United States. New initiatives through Medicare are starting to link physician payment to quality and to increase implementation of quality guidelines.

From a national perspective, the Federation of State Medical Boards (FSMB) – www.fsmb.org – supports state licensing boards with useful resources to assist them in regulating modern medical practice. The Accreditation Council for Graduate Medical Education (ACGME) – www.acgme.org -- sets the standards for accreditation of all residency training programs, and the Accreditation Council for Continuing Medical Education (ACCME) – www. accme.org – has as its mission the identification, development, and promotion of standards for quality continuing medical education (CME) utilized by physicians in their maintenance of competence and incorporation of new knowledge to improve quality medical care for patients and their communities.

The ACCME fulfills this mission through a voluntary self-regulated system for accrediting CME providers and a peer-review process responsive to changes in medical education and the health care delivery system.

Physicians are licensed and regulated under CGS Chapter 379. This chapter delineates licensure requirements as well as a comprehensive requirement for ongoing Continuing Medical Education (CME). Furthermore, CGS requires that any physician providing certain levels on Office Based Surgery obtain both a Certificate of Need as well as a license from the Department of Public Health to provide such services. Once again demonstrating that physician services are some of the most highly regulated of any profession.

Please refer to Exhibit 2 for a summary of the occurrence of the word “surgery” in the Connecticut General Statutes.

(5) the state's current regulatory oversight of the profession;
Physician regulatory oversight falls under the Department of Public Health as discussed in section 4. In addition, physicians much obtain a state license from the Department of Consumer Protection for prescribing abilities.

(6) all current education, training, and examination requirements and any relevant certification requirements applicable to the profession;

A detailed description of education, training, examination and certification requirements for surgeons is attached. In summary, a surgeon must complete four years of undergraduate education, four years of medical school, and five years of a surgical residency including a minimum of 750 operative procedures. Following residency, a surgeon may enter a fellowship which could last from 1-2 years depending on area of specialization.

Within three years of completion of residency, a surgeon seeking board certification needs to apply for this certification. A qualifying exam is taken, then a certifying exam. Once certified, the surgeon must recertify within 10 years, and is required to engage in maintenance of certification (MOC) over this ten-year period. MOC consists of four parts: professional standing, lifelong learning and self-assessment, cognitive expertise, and evaluation of

performance in practice. To assist surgeons in meeting MOC requirements, professional associations such as the American College of Surgeons are enhancing and tailoring their CME offerings to reflect the MOC requirements.

Please refer to exhibits 3, 4, and 5.

(7) a summary of known scope of practice changes requested or enacted concerning the profession in the five years preceding the request;

None have been requested by the CTACSPA nor have any that pertain to surgery.

(8) **the extent to which the request directly affects existing relationships within the health care delivery system;**
We see the adoption of the Definition of Surgery as an enhancement to existing relationships in the health care delivery system in CT. By having surgery clearly defined in the CGS it eliminates that fights that have, from time-to-time, had a negative impact on the delivery of quality patient care. As this is a definition that has already been adopted by the AMA House of Delegates it is simply inserting accepted national standards into the CGS so that health care relationships are equally defined in Connecticut.

(9).the anticipated economic impact of the request on the health care delivery system;
We do not foresee that the implementation of this request will increase healthcare costs in Connecticut. By codifying the definition of surgery in the CGS we believe that we will, over time, see a reduction in medical errors and a concurrent improvement in the quality of surgical care in the state as surgical procedures will be performed by those physicians who are properly trained and/or certified.

Based on the extensive data from MI and TN and the more limited data from CT hospitals that are using the ACS' NSQIP risk-adjusted quality database tool to lead their quality improvement programs there is evidence that strongly links reduction in errors and improvement in quality care to meaningful cost savings across the system.

(10) regional and national trends in licensing of the health profession making the request and a summary of relevant scope of practice provisions enacted in other states;
Currently twenty-three states have defined "surgery" in statute or regulation, including AL, AK, AZ, FL, IL, IN, KS, LA, ME, MD, MN, MS, MT, NV, NH, NJ, OH, PA, RI, VA, WV, WI and WY.

As proposed, the Definition of Surgery applies to all Doctors of Medicine (M.D.) and Doctors of Osteopathic Medicine (D.O.) who are already licensed by the state of Connecticut to perform surgery as the practice of medicine. We do not envision it impacting other physicians who practice in Connecticut as they are not licensed to perform surgery except within certain parameters as defined under their scope (i.e. podiatrists who are licensed to perform surgical

procedures limited to the ankle and feet). In addition, practitioners who practice by statute under physician supervision would continue to be able to do so.

We believe that this Definition ensures that patients are receiving quality surgical care by those professionals who are uniquely trained, qualified and licensed by the state to provide such care.

(11) identification of any health care professions that can reasonably be anticipated to be directly affected by the request, the nature of the impact, and efforts made by the requestor to discuss it with such health care professions;

A history of the development of the requested definition of surgery is helpful in understanding the genesis of the definition. In 1991, the American College of Surgeons adopted a statement on the use of laser surgery, which was reflective of current technology at the time and focused solely on lasers. In late 2005, a review of the statement made it clear that an update was needed to not only address the use of lasers in surgery, but also pulsed light, radiofrequency devices, or other techniques.

A national work group was formed and was composed of the ACS, American Academy of Ophthalmology, American Academy of Otolaryngology-Head and Neck Surgery, American Society of Plastic Surgeons, and American Academy of Facial Plastic and Reconstructive Surgery. This work group substantially edited the original statement on laser surgery, and an agreed-to draft was then submitted to the ACS Board of Governors Committee on Surgical Practices for further review. Following this, the draft was sent to the ACS Board of Regents for adoption at its February 2007 meeting -- http://www.facs.org/fellows_info/statements/st-11.html.

After adoption by the Board of Regents, a resolution was submitted in June 2007 by the Texas Medical Association to the American Medical Association (AMA) House of Delegates requesting the AMA adopt as policy the ACS definition of surgery. After considerable testimony in support of the definition as submitted to the House of Delegates, it was adopted.

H-475.983 Definition of Surgery
Based upon the AMA adopted definition of "surgery" as taken from American College of Surgeons Statement ST-11 (please see exhibit 6 for the full Statement):

""Surgery" is defined as the structural alteration of the human body by cutting into, destroying, transposing, adding or removing live human tissue for the diagnosis and/or treatment of medical conditions.

"Surgery" may be performed by mechanical instruments such as scalpels, probes, and needles, or by instruments that use thermal or light based energies, electromagnetic or chemical means, and high pressure water jets to cut, burn, vaporize, freeze, probe or re-approximate living tissue.

"Surgery" includes the injection of diagnostic or therapeutic products into body cavities, joints, internal organs, the central nervous system, and the sensory organs, excluding the skin. It also includes the closed reduction of dislocations and/or fractures that require anesthesia.

(12) a description of how the request relates to the health care profession's ability to practice to the full extent of the profession's education and training.

Very succinctly, we believe that the adoption of the above Definition of Surgery into the CGS allows each and every surgical health care practitioner in Connecticut to provide quality patient care to the fullest extent of their individual education, training, certification, and licensure.

Summary of Attachments

American Board of Surgery Booklet of Information - Surgery

ACGME Program Requirements for Graduate Medical Education
in General Surgery

American Board of Medical Specialties Maintenance of Certification (MOC) Process

American College of Surgeons Statement 11: Statement on surgery using lasers, pulsed light, radiofrequency devices, or other techniques

Connecticut Surgical Quality Collaborative ("CtSQC:)"), an initiative of the Connecticut Chapter of the American College of Surgeons Professional Association, Inc. - Mission/Vision/Pledge

Exhibit 1

Connecticut Surgical Quality Collaborative ("CtSQC:)"), an initiative of the Connecticut Chapter of the American College of Surgeons Professional Association, Inc. - Mission/Vision/Pledge

The Connecticut Surgical Quality Collaborative

Charter/Vision

The Connecticut Surgical Quality Improvement Collaborative, a CTACSPA initiative (CTSQC), was formed to provide a forum in which surgeons share knowledge and best practices in the treatment of surgical patients in Connecticut.

Mission

The CTSQC seeks to continually improve the quality of surgical care, prevent complications, and eliminate patient harm at all Connecticut hospitals using a patient-centered approach that is both data-driven, and cost-effective. The Collaborative will foster an environment of collaboration, learning, and innovative inquiry in order to achieve its goals. It will preferentially use available risk-adjusted clinical datasets including, but not limited to, the American College of Surgeons' National Surgical Quality Improvement Program (NSQIP) in order to identify improvement opportunities and to design interventions for eliminating performance gaps. As a learning community, it seeks to widely share all resulting quality improvement strategies and best practices with others regardless of enrollment in NSQIP or other programs. The Collaborative also seeks to participate in outreach efforts to educate other healthcare providers and the general public on patient safety and quality improvement in surgical patients.

Pledge

CTSQC Members jointly pledge to:

- Work collaboratively and collegially to create a community of learning and continuous process improvement
- Commit to developing and implementing a surgical Quality and Process Improvement program at their institutions
- Work jointly to provide the highest level of safety and quality for all patients;
- Respect the confidentiality of patients and Collaborative members
- Conduct themselves with highest levels of integrity

Exhibit 2

Occurrences of the word “Surgery” in the Connecticut General Statutes

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December 29, 2008

Mr. Ken Ferrucci
Connecticut State Medical Society
160 St. Ronan Street
New Haven, CT 06511

Re: The word "Surgery" used in Connecticut General Statutes

Dear Ken:

Enclosed is a copy of Connecticut General Statutes which include the word "surgery". Based on my review of this extensive use of the term, I believe you are correct to suggest that CSMS seek to define the term in the statutes.

The overwhelming benefit from defining the term "surgery" will ensure Connecticut citizens that each time a statute refers to a person "... licensed to practice surgery ...", it refers to a person that the legislature deems competent within the context of the statute.

I look forward to working with you on this in the coming legislative session.

Very truly yours,

Gregory J. Pepe

GJP/dll

MEMO

TO: GJP; File

FROM: JLC

DATE: December 29, 2008

RE: **CSMS/Legislative – Connecticut General Statutes – "Surgery"**

TITLE 14 MOTOR VEHICLES. USE OF THE HIGHWAY BY VEHICLES. GASOLINE

- **CHAPTER 246 MOTOR VEHICLES**

Conn. Gen. Stat. § 14-46b. Establishment of board. Membership. Compensation. Executive session.

(a) There is established within the department a Motor Vehicle Operator's License Medical Advisory Board which shall advise the commissioner on the medical aspects and concerns of licensing operators of motor vehicles. The board shall consist of not less than eight members or more than fifteen members appointed by the commissioner from a list of nominees submitted by the Connecticut State Medical Society and the Connecticut Association of Optometrists. The Connecticut State Medical Society shall submit nominees representing the specialties of (1) general medicine or **surgery**, (2) internal medicine, (3) cardiovascular medicine, (4) neurology or neurological **surgery**, (5) ophthalmology, (6) orthopedics, and (7) psychiatry. The Connecticut Association of Optometrists shall submit nominees representing the specialty of optometry.

(b) Initially, three members shall be appointed for a two-year term, three members for a three-year term and the remainder of the members for a four-year term. Appointments thereafter shall be for four-year terms. Any vacancy shall be filled by the commissioner for the unexpired portion of a term. The commissioner shall designate the chairman of the board.

(c) Board members shall serve without compensation but shall be reimbursed for necessary expenses or services incurred in performing their duties, including the giving of testimony at any administrative hearing when requested by the commissioner. Physicians who are not members of the board and conduct examinations at the request of the board shall be compensated for these examinations.

(d) The board shall meet at the call of the commissioner at least twice a year. Special meetings may be held to fulfill the responsibilities specified in section 14-46c.

(e) Any meeting of the board in which the medical condition of any individual is discussed for purposes of making a recommendation on his fitness to operate a motor vehicle shall be held in executive session.

History:

(P.A. 81-461, S. 6; P.A. 90-265, S. 5, 8; P.A. 02-70, S. 62; P.A. 03-278, S. 39.)

- **CHAPTER 248 VEHICLE HIGHWAY USE**

Conn. Gen. Stat. § 14-227c. Blood or breath samples required following accidents resulting in death or serious physical injury.

(a) As part of the investigation of any motor vehicle accident resulting in the death of a person, the Chief Medical Examiner, Deputy Chief Medical Examiner, an associate medical examiner, a pathologist as specified in section 19a-405, or an authorized assistant medical examiner, as the case may be, shall order that a blood sample be taken from the body of any operator or pedestrian who dies as a result of such accident. Such blood samples shall be examined for the presence and concentration of alcohol and any drug by the Division of Scientific Services within the Department of Public Safety or by the Office of the Chief Medical Examiner. Nothing in this subsection or section 19a-406 shall be construed as requiring such medical examiner to perform an autopsy in comection with obtaining such blood samples.

(b) A blood or breath sample shall be obtained from any surviving operator whose motor vehicle is involved in an accident resulting in the serious physical injury, as defined in section 53a-3, or death of another person, if (1) a police officer has probable cause to believe that such operator operated such motor vehicle while under the influence of intoxicating liquor or any drug, or both, or (2) such operator has been charged with a motor vehicle violation in connection with such accident and a police officer has a reasonable and articulable suspicion that such operator operated such motor vehicle while under the influence of intoxicating liquor or any drug, or both. The test shall be performed by or at the direction of a police officer according to methods and with equipment approved by the Department of Public Safety and shall be performed by a person certified or recertified for such purpose by said department or recertified by persons certified as instructors by the Commissioner of Public Safety. The equipment used for such test shall be checked for accuracy by a person certified by the Department of Public Safety immediately before and after such test is performed. If a blood test is performed, it shall be on a blood sample taken by a person licensed to practice medicine and **surgery** in this state, a qualified laboratory technician, a registered nurse, a physician assistant or a phlebotomist. The blood samples obtained from an operator pursuant to this subsection shall be examined for the presence and concentration of alcohol and any drug by the Division of Scientific Services within the Department of Public Safety.

History:

(1971, P.A. 328; P.A. 75-308, S. 2; P.A. 76-245; P.A. 77-614, S. 323, 610; P.A. 79-47, S. 4; P.A. 80-142, S. 1; 80-190, S. 3; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58; 95-314, S. 6; P.A. 99-218, S. 5, 16; P.A. 00-196, S. 11; May 9 Sp. Sess. P.A. 02-1, S. 110; P.A. 03-265, S. 4; P.A. 04-250, S. 5; P.A. 06-173, S. 1; P.A. 07-252, S. 37.)

TITLE 15 NAVIGATION AND AERONAUTICS

- CHAPTER 268 BOATING

Conn. Gen. Stat. § 15-140r. Evidence of alcohol or drugs in blood.

(a) Except as provided in subsection (d) of this section, in any criminal prosecution for the violation of subsection (d) of section 15-133, sections 15-140l and 15-140n and subsection (b) of section 53-206d, evidence respecting the amount of alcohol or drug in the defendant's blood or urine at the time of the alleged offense, as shown by a chemical analysis of the defendant's breath, blood or urine shall be admissible and competent provided: (1) The defendant was afforded a reasonable opportunity to telephone an attorney prior to the performance of the test and consented to the taking of the test upon which such analysis is made; (2) a true copy of the report of the test result was mailed to or personally delivered to the defendant within twenty-four hours or by the end of the next regular business day, after such result was known, whichever is later; (3) the test was performed by or at the direction of a certified law enforcement officer according to methods and with equipment approved by the Department of Public Safety. If a blood test is taken, it shall be on a blood sample taken by a person licensed to practice medicine and **surgery** in this state, a qualified laboratory technician, an emergency medical technician II or a registered nurse in accordance with the regulations adopted under subsection (b) of this section; (4) the device used for such test was checked for accuracy in accordance with the regulations adopted under subsection (b) of this section; (5) an additional chemical test of the same type was performed at least thirty minutes after the initial test was performed or, if requested by the peace officer for reasonable cause, an additional chemical test of a different type was performed to detect the presence of a drug or drugs other than or in addition to alcohol, provided the results of the initial test shall not be inadmissible under this subsection if reasonable efforts were made to have such additional test performed in accordance with the conditions set forth in this subsection and such additional test was not performed or was not performed within a reasonable time, or the results of such additional test are not admissible for failure to meet a condition set forth in this subsection; and (6) evidence is presented that the test was commenced within two hours of operation of the vessel. In any prosecution under this section it shall be a rebuttable presumption that the results of such chemical analysis establish the ratio of alcohol in the blood of the defendant at the time of the alleged offense, except that if the results of the additional test indicate that the ratio of alcohol in the blood of such defendant is ten-hundredths of one per cent or less of alcohol, by weight, and is higher than the results of the first test, evidence shall be presented that demonstrates that the test results and the analysis thereof accurately indicate the blood alcohol content at the time of the alleged offense.

(b) The Commissioner of Public Safety shall ascertain the reliability of each method and type of device offered for chemical testing and analysis of blood, of breath and of urine and certify those methods and types which said commissioner finds suitable for use in testing and analysis of blood, breath and urine, respectively, in this state. The Commissioner of Public Safety, after consultation with the Commissioner of Public Health, shall adopt regulations governing the conduct of chemical tests, the operation and use of chemical test devices and the training and certification of operators of such devices and the drawing or obtaining of blood, breath or urine samples as said commissioner finds necessary to protect the health and safety of persons who submit to chemical tests and to insure reasonable accuracy in testing results. Such regulations shall not require recertification of a peace officer solely because such officer terminates such officer's employment with the law enforcement agency for which certification was originally issued and commences employment with another such agency.

(c) If a person is charged with a violation of subsection (d) of section 15-133, the charge may not be reduced, nolled or dismissed unless the prosecuting authority states in open court such prosecutor's reasons for the reduction, nolle or dismissal.

(d) In any criminal prosecution for a violation of subsection (d) of section 15-133 or section 15-140l or 15-140n evidence that the defendant refused to submit to a blood, breath or urine test requested in accordance with section 15-140q shall be admissible provided the requirements of subsection (a) of said section have been satisfied. If a case involving a violation of subsection (d) of section 15-133 or section 15-140l or 15-140n is tried to a jury, the court shall instruct the jury as to any inference that may or may not be drawn from the defendant's refusal to submit to a blood, breath or urine test.

History:

(P.A. 89-388, S. 20, 27; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58; P.A. 00-142, S. 5; P.A. 03-244, S. 6.)

TITLE 17a SOCIAL AND HUMAN SERVICES AND RESOURCES

- **CHAPTER 319 DEPARTMENT OF CHILDREN AND FAMILIES**

Conn. Gen. Stat. § 17a-10. Custody of committed children. Support and health services. Extension or termination of commitment.

(a) Any child committed to the department by the Superior Court shall be deemed to be within the custody of the commissioner until such commitment has been terminated.

(b) The commissioner shall pay for the support and maintenance of any delinquent child who is in residence in any of the department's institutions or facilities or in transit from one institution or facility to another. The commissioner, in the commissioner's sole discretion, may, if the

commissioner has sufficient funds, pay for the support and maintenance of any other child or youth who is in the custody of the commissioner. If a child is in the custody of the commissioner and is also committed to the Commissioner of Social Services, the Commissioner of Social Services shall pay for such child's support and maintenance when such child is living elsewhere than in an institution or facility of the Department of Children and Families, unless there is other provision for such child's support. Nothing in this section shall exempt any person from liability of support of children or youths under the supervision of the commissioner, when otherwise provided by law.

(c) When deemed in the best interests of a child in the custody of the commissioner, the commissioner, his designee, a superintendent or assistant superintendent or, when the child is in transit between department facilities, a designee of the commissioner, may authorize, on the advice of a physician licensed to practice in the state, medical treatment, including **surgery**, to insure the continued good health or life of the child. Any of said persons may, when he deems it in the best interests of the child, authorize, on the advice of a dentist licensed to practice in the state, dentistry, including dental **surgery**, to insure the continued good health of the child. Upon such authorization, the commissioner shall exercise due diligence to inform the parents or guardian prior to taking such action, and in all cases shall send notice to the parents or guardian by letter to their last-known address informing them of the actions taken, of their necessity and of the outcome, but in a case where the commissioner fails to notify, such failure will not affect the validity of the authorization.

(d) If the Superior Court requests a report on any committed child, the commissioner shall be responsible for preparing and transmitting such report to the requesting court. Not more than sixty days nor less than thirty days prior to the expiration of the original commitment of any child to the department, the commissioner may file a motion for an extension of commitment pursuant to the provisions of section 46b-141. If the commissioner, or the board of review pursuant to the provisions of section 17a-15, at any time during the commitment of any child, determines that termination of commitment of a child is in the best interest of such child, the commissioner or the board may terminate the commitment and such termination shall be effective without further action by the court.

History:

(1969, P.A. 664, S. 11; 1971, P.A. 295, S. 1; P.A. 75-420, S. 4, 6; P.A. 75-524, S. 7, 30; P.A. 76-436, S. 593, 681; P.A. 77-614, S. 521, 610; P.A. 93-91, S. 1, 2; 93-262, S. 1, 87; P.A. 01-142, S. 10; P.A. 06-196, S. 107.)

Conn. Gen. Stat. § 17a-78. Hospitalization of child for diagnosis or treatment of mental disorder. Examination. Discharge. Rights to be explained. Hearing. Duties of hospital. Order for continued hospitalization. Immediate discharge, when.

(a) If a physician determines that a child is in need of immediate hospitalization for evaluation or treatment of a mental disorder, the child may be hospitalized under an emergency or diagnostic certificate as provided in this section for not more than fifteen days without order of any court,

unless a written application for commitment of such child has been filed in the Court of Probate prior to the expiration of the fifteen days, in which event such hospitalization shall be continued under the emergency certificate for an additional fifteen days or twenty-five days if the matter has been transferred to the Superior Court, or until the completion of court proceedings, whichever occurs first. At the time of delivery of such child to such hospital, there shall be left, with the persons in charge of such hospital, a certificate, signed by a physician licensed to practice medicine or **surgery** in Connecticut and dated not more than three days prior to its delivery to the person in charge of the hospital. Such certificate shall state the findings of the physician and the date of personal examination of the child to be hospitalized, which shall be not more than three days prior to the date of the signature of the certificate.

(b) Any child hospitalized under this section shall be examined by a physician specializing in psychiatry within twenty-four hours of admission. If such physician is of the opinion that the child does not require hospitalization for emergency evaluation or treatment of a mental disorder, such child shall be immediately discharged. The physician shall record his or her findings in a permanent record.

(c) If any child is hospitalized under this section, the child and the guardian of such child shall be promptly informed by the hospital that such child has the right to consult an attorney and the right to a hearing under subsection (d) of this section, and that if such a hearing is requested or an application for commitment is filed, such child has the right to be represented by counsel, and that counsel will be provided at the state's expense if the child is unable to pay for such counsel. The reasonable compensation for counsel provided to persons unable to pay shall be established by, and paid from funds appropriated to, the Judicial Department, however, if funds have not been included in the budget of the Judicial Department for such purposes, such compensation shall be established by the Probate Court Administrator and paid from the Probate Court Administration Fund.

(d) At any time prior to the initiation of proceedings under section 17a-76, any child hospitalized under this section or his or her representative, may, in writing, request a hearing. Such hearing shall be held within seventy-two hours of receipt of such request, excluding Saturdays, Sundays and holidays. At such hearing, the child shall have the right to be present, to cross-examine all witnesses testifying, and to be represented by counsel as provided in section 17a-76. The hearing shall be held by the court of probate having jurisdiction for commitment as provided in section 17a-76, and the hospital shall immediately notify such court of any request for a hearing by a child hospitalized under this section. At the conclusion of the hearing, if the court finds that there is probable cause to conclude that the child is subject to involuntary hospitalization under this section, considering the condition of the child at the time of the admission and at the time of the hearing, the effects of medication, if any, and the advisability of continued treatment based on testimony from the hospital staff, the court shall order that such child's hospitalization continue for the remaining time provided for in the emergency certificate or until the completion of probate proceedings under section 17a-76. If the court does not find there is probable cause to conclude that the child is subject to involuntary hospitalization under this section, the child shall be immediately discharged.

(e) The superintendent or director of any hospital for mental illness of children shall immediately discharge any child admitted under this section who is later found not to meet the standards for emergency treatment.

History: (P.A. 79-511, S. 4; P.A. 93-197; P.A. 96-170, S. 3, 23; P.A. 97-90, S. 5, 6.)

- **CHAPTER 319b DEPARTMENT OF DEVELOPMENTAL SERVICES**

Conn. Gen. Stat. § 17a-238. Rights of persons under supervision of Commissioner of Developmental Services.

(a) No person placed or treated under the direction of the Commissioner of Developmental Services in any public or private facility shall be deprived of any personal, property or civil rights, except in accordance with due process of law.

(b) Each person placed or treated under the direction of the Commissioner of Developmental Services in any public or private facility shall be protected from harm and receive humane and dignified treatment which is adequate for such person's needs and for the development of such person's full potential at all times, with full respect for such person's personal dignity and right to privacy consistent with such person's treatment plan as determined by the commissioner. No treatment plan or course of treatment for any person placed or treated under the direction of the commissioner shall include the use of an aversive device which has not been tested for safety and efficacy and approved by the federal Food and Drug Administration except for any treatment plan or course of treatment including the use of such devices which was initiated prior to October 1, 1993. No treatment plan or course of treatment prescribed for any person placed or treated under the direction of the commissioner shall include the use of aversive procedures except in accordance with procedures established by the Commissioner of Developmental Services. For purposes of this subsection, "aversive procedure" means the contingent use of an event which may be unpleasant, noxious or otherwise cause discomfort to alter the occurrence of a specific behavior or to protect an individual from injuring himself or herself or others and may include the use of physical isolation and mechanical and physical restraint. Nothing in this subsection shall prohibit persons who are not placed or treated under the direction of the Commissioner of Developmental Services from independently pursuing and obtaining any treatment plan or course of treatment as may otherwise be authorized by law. The commissioner shall adopt regulations, in accordance with chapter 54, to carry out the provisions of this subsection.

(c) The Commissioner of Developmental Services shall adopt regulations, in accordance with the provisions of chapter 54, with respect to each facility or institution under the jurisdiction of the commissioner, with regard to the following: (1) Prohibiting the use of corporal punishment; (2) when and by whom therapies may be used; (3) which therapies may be used; and (4) when a person may be placed in restraint or seclusion or when force may be used upon a person.

(d) A copy of any order prescribing the use of therapy, restraint or seclusion in accordance with the regulations adopted under subsection (c) of this section shall be made a part of the person's

permanent clinical record together with the reasons for each such order and made available in compliance with existing statutes relating to the right to know.

(e) The Commissioner of Developmental Services shall ensure that each person placed or treated under the commissioner's direction in any public or private facility is afforded the following rights and privileges: (1) The right to prompt, sufficient and appropriate medical and dental treatment; (2) the right to communicate freely and privately with any person, including, but not limited to, an attorney or other legal representative of the person's choosing; (3) the right to reasonable access to a telephone, both to make and receive calls in private, unless such access is used in violation of any federal or state statute; (4) the right to send and receive unopened mail and to make reasonable requests for assistance in the preparation of correspondence; (5) the safety of each person's personal effects shall be assured including the provision of reasonably accessible individual storage space; (6) the right to be free from unnecessary or excessive physical restraint; (7) the right to voice grievances without interference; (8) the right to a nourishing and well-balanced diet; (9) the right to be employed outside a facility and to receive assistance in his or her efforts to secure suitable employment. The department shall encourage the employment of such persons and shall promote the training of such persons for gainful employment, and all benefits of such employment shall accrue solely to the person employed; (10) the right to have the complete record maintained by the Department of Developmental Services concerning such person released for review, inspection and copying to such person's attorney or other legal representative notwithstanding any provisions of subsection (g) of section 4-193 or section 4-194; and (11) the right to receive or purchase his or her own clothing and personal effects, including toilet articles, and the right to wear such clothing and use such personal effects except where determined to be dangerous to the health or safety of the individual or others.

(f) The Commissioner of Developmental Services shall require the attending physician of any person placed or treated under the direction of the commissioner to obtain informed written consent from the following persons prior to authorizing any surgical procedure or any medical treatment, excluding routine medical treatment which is necessary to maintain the general health of a resident or to prevent the spread of any communicable disease: (1) The resident if such resident is eighteen years of age or over or is legally emancipated and competent to give such consent; (2) the parent of a resident under eighteen years of age who is not legally emancipated; or (3) the legal guardian or conservator of a resident of any age who is adjudicated unable to make informed decisions about matters relating to such resident's medical care. The person whose consent is required shall be informed of the nature and consequences of the particular treatment or surgical procedure, the reasonable risks, benefits and purpose of such treatment or surgical procedure and any alternative treatment or surgical procedures which are available. The consent of any resident or of any parent, guardian or conservator of any resident may be withdrawn at any time prior to the commencement of the treatment or surgical procedure. The regional or training school director having custody and control of a resident of any facility may authorize necessary **surgery** for such resident where, in the opinion of the resident's attending physician, the **surgery** is of an emergency nature and there is insufficient time to obtain the required written consent provided for in this section. The attending physician shall prepare a report describing the nature of the emergency which necessitated such **surgery** and shall file a

copy of such report in the patient's record.

(g) The commissioner's oversight and monitoring of the medical care of persons placed or treated under the direction of the commissioner does not include the authority to make treatment decisions, except in limited circumstances in accordance with statutory procedures. In the exercise of such oversight and monitoring responsibilities, the commissioner shall not impede or seek to impede a properly executed medical order to withhold cardiopulmonary resuscitation. For purposes of this subsection, "properly executed medical order to withhold cardiopulmonary resuscitation" means (1) a written order by the attending physician; (2) in consultation and with the consent of the patient or a person authorized by law; (3) when the attending physician is of the opinion that the patient is in a terminal condition, as defined in section 19a-570, which condition will result in death within days or weeks; and (4) when such physician has requested and obtained a second opinion from a Connecticut licensed physician in the appropriate specialty that confirms the patient's terminal condition; and includes the entry of such an order when the attending physician is of the opinion that the patient is in the final stage of a terminal condition but cannot state that the patient may be expected to expire during the next several days or weeks, or, in consultation with a physician qualified to make a neurological diagnosis, deems the patient to be permanently unconscious, provided the commissioner has reviewed the decision with the department's director of community medical services, the family and guardian of the patient and others whom the commissioner deems appropriate, and determines that the order is a medically acceptable decision.

(h) Any person applying for services from the Commissioner of Developmental Services or any person placed by a probate court under the direction of the Commissioner of Developmental Services, and such person's parents or guardian, shall be informed orally and in writing at the time of application or placement of the rights guaranteed by this section and the provisions of subdivision (5) of section 46a-11. A summary of such rights shall be posted conspicuously in the public areas of every public or private facility providing services to persons under the care of the Commissioner of Developmental Services.

History:

(P.A. 76-152, S. 1-3; P.A. 80-311, S. 1, 5; P.A. 81-150; P.A. 82-86; P.A. 86-41, S. 10, 11; P.A. 88-317, S. 81, 107; P.A. 93-253; 93-303; P.A. 01-140, S. 2; 01-195, S. 130, 181; P.A. 06-195, S. 60; P.A. 07-73, S. 2(a),(b); 07-252, S. 3.)

- **CHAPTER 319i PERSONS WITH PSYCHIATRIC DISABILITIES**

Conn. Gen. Stat. § 17a-502. Commitment under emergency certificate. Examination of patient. Discharge. Explanation of rights. Hearing. Order for detention to continue. Private hospitals' notification to commissioner. Immediate discharge of patient. Notification of next of kin. Prohibited commitments to chronic disease hospitals.

(a) Any person who a physician concludes has psychiatric disabilities and is dangerous to himself or others or gravely disabled, and is in need of immediate care and treatment in a

hospital for psychiatric disabilities, may be confined in such a hospital, either public or private, under an emergency certificate as hereinafter provided for not more than fifteen days without order of any court, unless a written application for commitment of such person has been filed in a probate court prior to the expiration of the fifteen days, in which event such commitment is continued under the emergency certificate for an additional fifteen days or until the completion of probate proceedings, whichever occurs first. In no event shall such person be admitted to or detained at any hospital, either public or private, for more than fifteen days after the execution of the original emergency certificate, on the basis of a new emergency certificate executed at any time during the person's confinement pursuant to the original emergency certificate; and in no event shall more than one subsequent emergency certificate be issued within fifteen days of the execution of the original certificate. If at the expiration of the fifteen days a written application for commitment of such person has not been filed, such person shall be discharged from the hospital. At the time of delivery of such person to such hospital, there shall be left, with the person in charge thereof, a certificate, signed by a physician licensed to practice medicine or **surgery** in Connecticut and dated not more than three days prior to its delivery to the person in charge of the hospital. Such certificate shall state the date of personal examination of the person to be confined, which shall be not more than three days prior to the date of signature of the certificate, shall state the findings of the physician relative to the physical and mental condition of the person and the history of the case, if known, and shall state that it is the opinion of the physician that the person examined has psychiatric disabilities and is dangerous to himself or herself or others or gravely disabled and is in need of immediate care and treatment in a hospital for psychiatric disabilities. Such physician shall state on such certificate the reasons for his or her opinion.

(b) Any person admitted and detained under this section shall be examined by a physician specializing in psychiatry not later than forty-eight hours after admission as provided in section 17a-545, except that any person admitted and detained under this section at a chronic disease hospital shall be so examined not later than thirty-six hours after admission. If such physician is of the opinion that the person does not meet the criteria for emergency detention and treatment, such person shall be immediately discharged. The physician shall enter the physician's findings in the patient's record.

(c) Any person admitted and detained under this section shall be promptly informed by the admitting facility that such person has the right to consult an attorney, the right to a hearing under subsection (d) of this section, and that if such a hearing is requested or a probate application is filed, such person has the right to be represented by counsel, and that counsel will be provided at the state's expense if the person is unable to pay for such counsel. The reasonable compensation for counsel provided to persons unable to pay shall be established by, and paid from funds appropriated to, the Judicial Department, however, if funds have not been included in the budget of the Judicial Department for such purposes, such compensation shall be established by the Probate Court Administrator and paid from the Probate Court Administration Fund.

(d) If any person detained under this section, or his or her representative, requests a hearing, in writing, such hearing shall be held within seventy-two hours of receipt of such request, excluding Saturdays, Sundays and holidays. At such hearing, the person shall have the right to be present,

to cross-examine all witnesses testifying, and to be represented by counsel as provided in section 17a-498. The hearing may be requested at any time prior to the initiation of proceedings under section 17a-498. The hearing shall be held by the court of probate having jurisdiction for commitment as provided in section 17a-497, and the hospital shall immediately notify such court of any request for a hearing by a person detained under this section. At the conclusion of the hearing, if the court finds that there is probable cause to conclude that the person is subject to involuntary confinement under this section, considering the condition of the respondent at the time of the admission and at the time of the hearing, and the effects of medication, if any, and the advisability of continued treatment based on testimony from the hospital staff, the court shall order that such person's detention continue for the remaining time provided for emergency certificates or until the completion of probate proceedings under section 17a-498.

(e) The person in charge of every private hospital for psychiatric disabilities in the state shall, on a quarterly basis, supply the Commissioner of Mental Health and Addiction Services, in writing with statistics that state for the preceding quarter, the number of admissions of type and the number of discharges for that facility. Said commissioner may adopt regulations to carry out the provisions of this subsection.

(f) The superintendent or director of any hospital for psychiatric disabilities shall immediately discharge any patient admitted and detained under this section who is later found not to meet the standards for emergency detention and treatment.

(g) Any person admitted and detained at any hospital for psychiatric disabilities under this section shall, upon admission to such hospital, furnish the name of his or her next of kin or close friend. The superintendent or director of such hospital shall notify such next of kin or close friend of the admission of such patient and the discharge of such patient, provided such patient consents, in writing, to such notification of his or her discharge.

(h) No person, who a physician concludes has active suicidal or homicidal intent, may be admitted to or detained at a chronic disease hospital under an emergency certificate issued pursuant to this section.

(i) For purposes of this section, "hospital" includes a licensed chronic disease hospital with a separate psychiatric unit.

History:

(1949 Rev., S. 2649; 1953, 1955, S. 1492d; 1959, P.A. 454; 1967, P.A. 555, S. 68; 1971, P.A. 760, S. 2; June, 1971, P.A. 7, S. 1; P.A. 76-227, S. 4, 7; P.A. 77-4, S. 1, 2; 77-595, S. 4, 9; P.A. 78-126, S. 2; P.A. 79-515, S. 4, 6; P.A. 80-189, S. 1; P.A. 83-295, S. 20; P.A. 90-31, S. 1, 9; P.A. 95-257, S. 11, 48, 58; P.A. 96-170, S. 12, 23; P.A. 97-90, S. 5, 6; P.A. 00-196, S. 51; P.A. 07-49, S. 1; 07-252, S. 38.)

Conn. Gen. Stat. § 17a-514. Emergency confinement in hospital for psychiatric disabilities of inmates of correctional institutions.

Any person who is in the custody of the Commissioner of Correction who has suddenly become in need of care and treatment in a hospital for a psychiatric disorder, other than drug dependence, whom a physician designated by the Commissioner of Correction finds is a danger to himself or others or to the security or order of the institution wherein he is confined may be confined in a hospital under an emergency certificate as hereinafter provided, for not more than fifteen days without order of any court. If a written complaint for commitment of such person has been filed in the court of probate for the district wherein such person is hospitalized prior to the expiration of such fifteen days such confinement shall be continued under such emergency certificate for an additional thirty days, without further order, not more than forty-five days in all, until the completion of the probate proceedings. At any time such person is found not to be a person with psychiatric disabilities, the superintendent of such hospital shall immediately return him to any institution administered by the Department of Correction as the Commissioner of Correction shall designate, unless his custody in the Commissioner of Correction has terminated, in which case he shall be discharged. The emergency certificate provided for in this section shall be left with the person in charge of such hospital at the time of delivery of the person to such hospital and such certificate shall be dated not more than three days prior to its delivery, signed by a physician licensed to practice medicine and **surgery under the provisions of chapter 370,** who is designated by the Commissioner of Correction. Such certificate shall state the date of the personal examination of the person to be confined, which shall be not more than three days prior to the date of signature of the certificate, shall state the findings of the physician relative to the physical and mental condition of the person and the history of the case, if known, and shall state that it is the opinion of the physician that the person examined by him is in need of immediate care in a hospital. Prior to hospitalization under the provisions of this section, any person shall have the right to be examined by a physician of his own choosing, and if such physician concludes from his examination that such person does not have psychiatric disabilities, such person shall not be admitted to or detained in a hospital under the provisions of this section. If a person with psychiatric disabilities has been admitted to any hospital under the provisions of this section, the person in charge thereof shall cause proceedings to be instituted for the commitment, pursuant to the provisions of section 17a-498, of such person in the court of probate having jurisdiction in the town where such hospital is located. Any irregularity in the temporary confinement of such person shall be deemed cured by the judge of probate ordering his commitment, and no such commitment shall be invalid because of such irregularity.

History:

(P.A. 76-190, S. 3, 12; P.A. 81-472, S. 31, 159; P.A. 90-209, S. 17; P.A. 95-257, S. 48, 58.)

Conn. Gen. Stat. § 17a-540. Definitions.

As used in sections 17a-540 to 17a-550, inclusive, unless otherwise expressly stated or unless the context otherwise requires:

(1) "Facility" means any inpatient or outpatient hospital, clinic or other facility for the diagnosis,

observation or treatment of persons with psychiatric disabilities;

(2) "Patient" means any person being treated in a facility;

(3) "Persons with psychiatric disabilities" means those children and adults who are suffering from one or more mental disorders, as defined in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders";

(4) "Voluntary patient" means any patient sixteen years of age or older who applies in writing for and is admitted to a hospital for observation, diagnosis or treatment of a mental disorder or any patient under sixteen years of age whose parent or legal guardian applies in writing for such observation, diagnosis or treatment;

(5) "Involuntary patient" means any patient hospitalized pursuant to an order of a judge of the Probate Court after an appropriate hearing or a patient hospitalized for emergency diagnosis, observation or treatment upon certification of a qualified physician;

(6) "Family" means spouse or next of kin;

(7) "Head of the hospital" or "head of the facility" means the superintendent or medical director of a hospital or facility, or his designated delegate;

(8) "Informed consent" means permission given competently and voluntarily after a patient has been informed of the reason for treatment, the nature of the proposed treatment, the advantages or disadvantages of the treatment, medically acceptable alternative treatment, the risks associated with receiving the proposed treatment and the risk of no treatment;

(9) "Medically harmful" means capable of inflicting serious mental or physical injury on the patient, or producing in the patient a disturbed mental state or impaired judgment which may be grossly detrimental to his physical or mental well being;

(10) "Psychosurgery" means those operations defined as lobotomy, **psychiatric surgery, behavioral surgery** and **all other forms of brain surgery**, if the **surgery** is performed for the purpose of modification or control of thoughts, feelings, actions or behavior rather than the treatment of a known and diagnosed physical disease of the brain;

(11) "Shock therapy" means a form of psychiatric treatment in which electric current, insulin, carbon dioxide or indoklon, or other similar agent, is administered to the patient and results in a loss of consciousness or a convulsive or comatose reaction;

(12) "Direct threat of harm" means that the patient's clinical history demonstrates a pattern of serious physical injury or life-threatening injury to self or to others which is caused by the psychiatric disabilities with which the patient has been diagnosed and is documented by objective medical and other factual evidence. Such evidence of past pattern of dangerous behavior shall be manifested in the patient's medical history and there shall exist a high

probability that the patient will inflict substantial harm on himself or others; and

(13) "Special limited conservator" means a licensed health care provider with specialized training in the treatment of persons with psychiatric disabilities appointed by a judge of the Probate Court with specific authority to consent to the administration of medication to a defendant during the pendency of such defendant's placement in the custody of the Commissioner of Mental Health and Addiction Services pursuant to section 54-56d. Upon the termination of the patient's placement in the custody of the commissioner pursuant to section 54-56d, the special limited conservatorship shall automatically terminate.

History:

(1971, P.A. 834, S. 1; P.A. 74-8, S. 1, 2; 74-9, S. 1, 2; P.A. 78-219, S. 5; P.A. 93-369, S. 2; P.A. 95-257, S. 48, 58; P.A. 04-160, S. 1.)

TITLE 18 CORRECTIONAL INSTITUTIONS AND DEPARTMENT OF CORRECTION

- **CHAPTER 325 DEPARTMENT OF CORRECTION**

Conn. Gen. Stat. § 18-81d. Medical and dental treatment of inmates under age of eighteen.

(a) When he deems it in the best interest of any inmate under the age of eighteen committed to the custody of the Commissioner of Correction, the commissioner or his designee may authorize medical or dental treatment, including **surgery** and **oral surgery**, to insure the continued good health of such inmate. Any such authorization for medical treatment or **surgery** shall be made on the advice of a physician licensed to practice in the state under the provisions of chapter 370, except that if any such **surgery** is not of an emergency nature, the advice of two such physicians shall be required. Any such authorization for dental treatment or **oral surgery** shall be made on the advice of a dentist licensed to practice in the state under the provisions of chapter 379, except that if any such **oral surgery** is not of an emergency nature the advice of two such dentists shall be required.

(b) Prior to such authorization, the commissioner shall exercise due diligence to obtain the consent of the parents or guardian of such inmate for such treatment or **surgery**, and in all cases shall send notice to the parents or guardian by letter to their last-known address informing them of the actions taken, of their necessity and of the outcome. In any case where the commissioner fails to notify such parents or guardian, such failure will not affect the validity of the authorization. All costs incurred for any such treatment or **surgery** shall be paid by the state.

History:

(P.A. 85-295.)

TITLE 19a PUBLIC HEALTH AND WELL-BEING

- CHAPTER 368a DEPARTMENT OF PUBLIC HEALTH

Conn. Gen. Stat. § 19a-7. Public health planning. State health plan. Access to certain health care data. Regulations.

(a) The Department of Public Health shall be the lead agency for public health planning and shall assist communities in the development of collaborative health planning activities which address public health issues on a regional basis or which respond to public health needs having state-wide significance. The department shall prepare a multiyear state health plan which will provide an assessment of the health of Connecticut's population and the availability of health facilities. The plan shall include: (1) Policy recommendations regarding allocation of resources; (2) public health priorities; (3) quantitative goals and objectives with respect to the appropriate supply, distribution and organization of public health resources; and (4) evaluation of the implications of new technology for the organization, delivery and equitable distribution of services. In the development of the plan the department shall consider the recommendations of any advisory bodies which may be established by the commissioner.

(b) For the purposes of establishing a state health plan as required by subsection (a) of this section and consistent with state and federal law on patient records, the department is entitled to access hospital discharge data, emergency room and ambulatory **surgery** encounter data, data on home health care agency client encounters and services, data from community health centers on client encounters and services and all data collected or compiled by the Office of Health Care Access pursuant to section 19a-613.

(c) The Commissioner of Public Health shall adopt regulations in accordance with the provisions of chapter 54 to assure the confidentiality of personal data and patient-identifiable data collected or compiled pursuant to this section.

History:

(P.A. 75-562, S. 7, 8; P.A. 77-614, S. 323, 610; P.A. 78-109, S. 4-6; P.A. 80-66; P.A. 84-163; P.A. 87-420, S. 1, 14; P.A. 93-381, S. 3, 39; P.A. 95-257, S. 12, 21, 25, 58; P.A. 98-87, S. 1; June Sp. Sess. P.A. 98-1, S. 86, 121; June Sp. Sess. P.A. 99-2, S. 33.)

Conn. Gen. Stat. § 19a-17n. Malpractice insurance purchase program. Regulations. Limitations.

(a) The Department of Public Health shall adopt regulations concerning the conditions of participation in the liability insurance program by physicians pursuant to section 19a-17m at clinics utilizing such physicians for the purposes of this section and section 19a-17m. These conditions shall include, but are not limited to, the following:

(1) The participating physician associated with the clinic shall hold a valid license to practice medicine and **surgery** in this state and otherwise be in conformity with current requirements for licensure as a physician, including any continuing education required by the Medical Examining Board;

(2) The participating physician shall limit the scope of practice in the clinic to primary care. Primary care shall be limited to noninvasive procedures and shall not include obstetrical care or any specialized care or treatment. Noninvasive procedures include injections, suturing of minor lacerations and incisions of boils or superficial abscesses;

(3) The provision of liability insurance coverage shall not extend to acts outside the scope of rendering medical services pursuant to this section and section 19a-17m;

(4) The participating physician shall limit the provision of health care services to low-income persons provided clinics may, but are not required to, provide means tests for eligibility as a condition for obtaining health care services.

(b) The participating physician shall not accept compensation for providing health care services from patients served pursuant to this section and section 19a-17m, nor from clinics serving these patients. As used in this section and section 19a-17m, "compensation" means any remuneration of value to the participating physician for services provided by the physician, but shall not be construed to include any nominal copayments charged by the clinic, nor reimbursement of related expenses of a participating physician authorized by the clinic in advance of being incurred.

(c) The use of mediation or arbitration for resolving questions of potential liability may be used, however any mediation or arbitration agreement format shall be expressed in terms clear enough for a person with a sixth-grade level of education to understand and on a form no longer than one page in length.

History:

(May Sp. Sess. P.A. 94-3, S. 23, 28; P.A. 95-257, S. 12, 21, 58; P.A. 00-27, S. 8, 24.)

Conn. Gen. Stat. § 19a-53. Reports of physical defects of children.

Each person licensed to practice medicine, **surgery**, midwifery, chiropractic, natureopathy, podiatry or nursing or to use any other means or agencies to treat, prescribe for, heal or otherwise alleviate deformity, ailment, disease or any other form of human ills, who has professional knowledge that any child under five years of age has any physical defect shall, within forty-eight hours from the time of acquiring such knowledge, mail to the Department of Public Health a report, stating the name and address of the child, the name and address of the child's parents or

guardians, the nature of the physical defect and such other information as may reasonably be required by the department. The department shall prepare and furnish suitable blanks in duplicate for such reports, shall keep each report on file for at least six years from the receipt thereof and shall furnish a copy thereof to the State Board of Education within ten days.

History:

(1949 Rev., S. 3825; P.A. 77-614, S. 323, 610; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58; P.A. 99-102, S. 16.)

Conn. Gen. Stat. § 19a-88. License renewal by certain healthcare providers. On-line license renewal system.

(a) Each person holding a license to practice dentistry, optometry, midwifery or dental hygiene shall, annually, during the month of such person's birth, register with the Department of Public Health, upon payment of the professional services fee for class I, as defined in section 33-182l in the case of a dentist, except as provided in sections 19a-88b and 20-113b, the professional services fee for class H, as defined in section 33-182l in the case of an optometrist, five dollars in the case of a midwife, and fifty dollars in the case of a dental hygienist, on blanks to be furnished by the department for such purpose, giving such person's name in full, such person's residence and business address and such other information as the department requests. Each person holding a license to practice dentistry who has retired from the profession may renew such license, but the fee shall be ten per cent of the professional services fee for class I, as defined in section 33-182l. Any license provided by the department at a reduced fee pursuant to this subsection shall indicate that the dentist is retired.

(b) Each person holding a license to practice medicine, **surgery**, podiatry, chiropractic or natureopathy shall, annually, during the month of such person's birth, register with the Department of Public Health, upon payment of the professional services fee for class I, as defined in section 33-182l, on blanks to be furnished by the department for such purpose, giving such person's name in full, such person's residence and business address and such other information as the department requests.

(c) (1) Each person holding a license to practice as a registered nurse, shall, annually, during the month of such person's birth, register with the Department of Public Health, upon payment of one hundred dollars, on blanks to be furnished by the department for such purpose, giving such person's name in full, such person's residence and business address and such other information as the department requests. Each person holding a license to practice as a registered nurse who has retired from the profession may renew such license, but the fee shall be ten per cent of the professional services fee for class B, as defined in section 33-182l. Any license provided by the department at a reduced fee shall indicate that the registered nurse is retired.

(2) Each person holding a license as an advanced practice registered nurse shall, annually, during the month of such person's birth, register with the Department of Public Health, upon payment of

one hundred twenty dollars, on blanks to be furnished by the department for such purpose, giving such person's name in full, such person's residence and business address and such other information as the department requests. No such license shall be renewed unless the department is satisfied that the person maintains current certification as either a nurse practitioner, a clinical nurse specialist or a nurse anesthetist from one of the following national certifying bodies which certify nurses in advanced practice: The American Nurses' Association, the Nurses' Association of the American College of Obstetricians and Gynecologists Certification Corporation, the National Board of Pediatric Nurse Practitioners and Associates or the American Association of Nurse Anesthetists. Each person holding a license to practice as an advanced practice registered nurse who has retired from the profession may renew such license, but the fee shall be ten per cent of the professional services fee for class C, as defined in section 33-182l. Any license provided by the department at a reduced fee shall indicate that the advanced practice registered nurse is retired.

(3) Each person holding a license as a licensed practical nurse shall, annually, during the month of such person's birth, register with the Department of Public Health, upon payment of the professional services fee for class C, as defined in section 33-182l, on blanks to be furnished by the department for such purpose, giving such person's name in full, such person's residence and business address and such other information as the department requests. Each person holding a license to practice as a licensed practical nurse who has retired from the profession may renew such license, but the fee shall be ten per cent of the professional services fee for class A, as defined in section 33-182l. Any license provided by the department at a reduced fee shall indicate that the licensed practical nurse is retired.

(4) Each person holding a license as a nurse-midwife shall, annually, during the month of such person's birth, register with the Department of Public Health, upon payment of one hundred twenty dollars, on blanks to be furnished by the department for such purpose, giving such person's name in full, such person's residence and business address and such other information as the department requests. No such license shall be renewed unless the department is satisfied that the person maintains current certification from the American College of Nurse-Midwives.

(5) (A) Each person holding a license to practice physical therapy shall, annually, during the month of such person's birth, register with the Department of Public Health, upon payment of the professional services fee for class B, as defined in section 33-182l, on blanks to be furnished by the department for such purpose, giving such person's name in full, such person's residence and business address and such other information as the department requests.

(B) Each person holding a physical therapist assistant license shall, annually, during the month of such person's birth, register with the Department of Public Health, upon payment of the professional services fee for class A, as defined in section 33-182l, on blanks to be furnished by the department for such purpose, giving such person's name in full, such person's residence and business address and such other information as the department requests.

(6) Each person holding a license as a physician assistant shall, annually, during the month of such person's birth, register with the Department of Public Health, upon payment of a fee of

seventy-five dollars, on blanks to be furnished by the department for such purpose, giving such person's name in full, such person's residence and business address and such other information as the department requests. No such license shall be renewed unless the department is satisfied that the practitioner has met the mandatory continuing medical education requirements of the National Commission on Certification of Physician Assistants or a successor organization for the certification or recertification of physician assistants that may be approved by the department and has passed any examination or continued competency assessment the passage of which may be required by said commission for maintenance of current certification by said commission.

(d) No provision of this section shall be construed to apply to any person practicing Christian Science.

(e) (1) Each person holding a license or certificate issued under section 19a-514, 20-65k, 20-74s, 20-195cc or 20-206ll and chapters 370 to 373, inclusive, 375, 378 to 381a, inclusive, 383 to 383c, inclusive, 384, 384b, 384d, 385, 393a, 395, 399 or 400a and section 20-206n or 20-206o shall, annually, during the month of such person's birth, apply for renewal of such license or certificate to the Department of Public Health, giving such person's name in full, such person's residence and business address and such other information as the department requests.

(2) Each person holding a license or certificate issued under section 19a-514 and chapters 384a, 384c, 386, 387, 388 and 398 shall apply for renewal of such license or certificate once every two years, during the month of such person's birth, giving such person's name in full, such person's residence and business address and such other information as the department requests.

(3) Each person holding a license or certificate issued pursuant to section 20-475 or 20-476 shall, annually, during the month of such person's birth, apply for renewal of such license or certificate to the department.

(4) Each entity holding a license issued pursuant to section 20-475 shall, annually, during the anniversary month of initial licensure, apply for renewal of such license or certificate to the department.

(5) Each person holding a license issued pursuant to section 20-162bb shall, annually, during the month of such person's birth, apply for renewal of such license to the Department of Public Health, upon payment of a fee of two hundred fifty dollars, giving such person's name in full, such person's residence and business address and such other information as the department requests.

(f) Any person or entity which fails to comply with the provisions of this section shall be notified by the department that such person's or entity's license or certificate shall become void ninety days after the time for its renewal under this section unless it is so renewed. Any such license shall become void upon the expiration of such ninety-day period.

(g) On or before July 1, 2008, the Department of Public Health shall establish and implement a secure on-line license renewal system for persons holding a license to practice medicine or

surgery under chapter 370, dentistry under chapter 379 or nursing under chapter 378. The department shall allow any such person who renews his or her license using the on-line license renewal system to pay his or her professional service fees on-line by means of a credit card or electronic transfer of funds from a bank or credit union account and may charge such person a service fee not to exceed five dollars for any such on-line payment made by credit card or electronic funds transfer.

History:

(1949 Rev., S. 3821; 1953, S. 2041d; 1959, P.A. 616, S. 1; 1961, P.A. 501; 1963, P.A. 143; 1969, P.A. 410, S. 1; June, 1971, P.A. 8, S. 38, 39; 1972, P.A. 223, S. 1, 2; P.A. 76-276, S. 12, 22; P.A. 77-467; 77-614, S. 323, 610; P.A. 80-484, S. 3, 176; P.A. 81-471, S. 3, 71; 81-472, S. 44, 159; 81-473, S. 13, 43; P.A. 88-357, S. 2; P.A. 89-251, S. 69, 203; 89-389, S. 17, 22; P.A. 90-40, S. 3, 4; 90-211, S. 17, 23; P.A. 92-89, S. 19, 20; May Sp. Sess. P.A. 92-16, S. 46, 89; P.A. 93-381, S. 9, 39; P.A. 94-210, S. 2, 30; 94-220, S. 2, 12; P.A. 95-196, S. 14; 95-257, S. 12, 21, 58; P.A. 97-186, S. 10; 97-311, S. 8, 16; P.A. 98-247, S. 11; June Sp. Sess. P.A. 98-1, S. 17, 121; P.A. 99-102, S. 17; 99-249, S. 4, 10; June Sp. Sess. P.A. 99-2, S. 61; P.A. 00-27, S. 14, 24; 00-226, S. 9, 18, 20; June Sp. Sess. P.A. 01-4, S. 4, 5, 58; P.A. 03-124, S. 2; June 30 Sp. Sess. P.A. 03-3, S. 18, 19; P.A. 05-213, S. 12; 05-280, S. 74, 75; P.A. 07-82, S. 1; 07-185, S. 11; June Sp. Sess. P.A. 07-1, S. 139.)

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Sec. 50. **Subsection (g) of section 19a-88** of the 2008 supplement to the general statutes is repealed and the following is substituted in lieu thereof (Effective July 1, 2008):

(g) On or before July 1, 2008, the Department of Public Health shall establish and implement a secure on-line license renewal system for persons holding a license to practice medicine or **surgery** under chapter 370, dentistry under chapter 379 or nursing under chapter 378. The department shall allow any such person who renews his or her license using the on-line license renewal system to pay his or her professional service fees on-line by means of a credit card or electronic transfer of funds from a bank or credit union account and may charge such person a service fee not to exceed five dollars for any such on-line payment made by credit card or electronic funds transfer. [A> ON OR BEFORE JANUARY 1, 2009, THE DEPARTMENT SHALL SUBMIT, IN ACCORDANCE WITH SECTION 11-4A, A REPORT ON THE FEASIBILITY AND IMPLICATIONS OF THE IMPLEMENTATION OF A BIENNIAL LICENSE RENEWAL SYSTEM FOR PERSONS HOLDING A LICENSE TO PRACTICE NURSING UNDER CHAPTER 378 TO THE JOINT STANDING COMMITTEE OF THE GENERAL ASSEMBLY HAVING COGNIZANCE OF MATTERS RELATING TO PUBLIC HEALTH. <A]

§ 19a-92a. Regulation of persons engaged in tattooing. Penalty.

(a) For the purposes of this section:

(1) "Advanced practice registered nurse" means a person licensed to perform advanced level nursing practice activities pursuant to subsection (b) of section 20-87a.

(2) "Physician" means a person licensed to practice medicine and **surgery** pursuant to chapter 370.

(3) "Physician assistant" means a person licensed pursuant to section 20-12b.

(4) "Registered nurse" means a person licensed to practice nursing pursuant to subsection (a) of section 20-87a.

(5) "Tattooing" means marking or coloring, in an indelible manner, the skin of any person by pricking in coloring matter or by producing scars.

(b) No person shall engage in tattooing except a physician, an advanced practice registered nurse rendering service under the direction of a physician, a registered nurse rendering service under the supervision, control and responsibility of a physician, a physician assistant rendering service under the supervision, control and responsibility of a physician, or a technician rendering service under the supervision of a physician in accordance with regulations adopted by the Department of Public Health pursuant to subsection (d) of this section.

(c) No person shall tattoo an unemancipated minor under eighteen years of age without the permission of the parent or guardian of such minor.

(d) The Department of Public Health shall, in accordance with chapter 54, adopt such regulations as are necessary to implement the provisions of this section.

(e) Any person who violates any provision of this section shall be fined not more than one hundred dollars or imprisoned not more than ninety days, or both.

History:

(P.A. 94-105, S. 1, 4; P.A. 95-257, S. 12, 21, 58; P.A. 99-102, S. 18.)

- **CHAPTER 368g LUNG DISEASE, TUBERCULOSIS, CHRONIC ILLNESS AND BREAST AND CERVICAL CANCER**

Conn. Gen. Stat. § 19a-266. Breast and cervical cancer early detection and treatment referral program.

(a) For purposes of this section:

(1) "Breast cancer screening and referral services" means necessary breast cancer screening services and referral services for a procedure intended to treat cancer of the human breast, including, but not limited to, **surgery**, radiation therapy, chemotherapy, hormonal therapy and related medical follow-up services.

(2) "Cervical cancer screening and referral services" means necessary cervical cancer screening services and referral services for a procedure intended to treat cancer of the human cervix, including, but not limited to, **surgery**, radiation therapy, cryotherapy, electrocoagulation and related medical follow-up services.

(3) "Unserved or underserved populations" means women who are: (A) At or below two hundred per cent of the federal poverty level for individuals; (B) without health insurance that covers breast cancer screening mammography or cervical cancer screening services; and (C) nineteen to sixty-four years of age.

(b) There is established, within existing appropriations, a breast and cervical cancer early detection and treatment referral program, within the Department of Public Health, to (1) promote screening, detection and treatment of breast cancer and cervical cancer among unserved or underserved populations, (2) educate the public regarding breast cancer and cervical cancer and the benefits of early detection, and (3) provide counseling and referral services for treatment.

(c) The program shall include, but not be limited to:

(1) Establishment of a public education and outreach initiative to publicize breast cancer and cervical cancer early detection services and the extent of coverage for such services by health insurance; the benefits of early detection of breast cancer and the recommended frequency of screening services, including clinical breast examinations and mammography; and the medical assistance program and other public and private programs and the benefits of early detection of cervical cancer and the recommended frequency of pap tests;

(2) Development of professional education programs, including the benefits of early detection of breast cancer and the recommended frequency of mammography and the benefits of early detection of cervical cancer and the recommended frequency of pap tests;

(3) Establishment of a system to track and follow up on all women screened for breast cancer and cervical cancer in the program. The system shall include, but not be limited to, follow-up of abnormal screening tests and referral to treatment when needed and tracking women to be screened at recommended screening intervals;

(4) Assurance that all participating providers of breast cancer and cervical cancer screening are in compliance with national and state quality assurance legislative mandates.

(d) The Department of Public Health shall provide unserved or underserved populations, within existing appropriations and through contracts with health care providers: (1) Clinical breast examinations, screening mammograms and pap tests, as recommended in the most current breast

and cervical cancer screening guidelines established by the United States Preventive Services Task Force, for the woman's age and medical history; (2) a sixty-day follow-up pap test for victims of sexual assault; and (3) a pap test every six months for women who have tested HIV positive.

(e) The Commissioner of Public Health shall report annually to the joint standing committees of the General Assembly having cognizance of matters relating to public health and appropriations. The report shall include, but not be limited to, a description of the rate of breast cancer and cervical cancer morbidity and mortality in this state and the extent of participation in breast cancer and cervical cancer screening.

(f) The organizations providing the testing and treatment services shall report to the Department of Public Health the names of the insurer of each underinsured woman being tested to facilitate recoupment.

History:

(P.A. 96-238, S. 4-8, 25; June 18 Sp. Sess. P.A. 97-8, S. 54, 88; P.A. 98-36, S. 2; P.A. 00-216, S. 4, 28; P.A. 06-195, S. 5.)

- **CHAPTER 368i ANATOMICAL DONATIONS**

Conn. Gen. Stat. § 19a-279a. Anatomical gifts: Definitions.

As used in sections 19a-279a to 19a-279l, inclusive:

(1) "Anatomical gift" means a donation of all or part of a human body to take effect upon or after death.

(2) "Decedent" means a deceased person and includes a stillborn infant or fetus.

(3) "Document of gift" means an organ and tissue donor card, inclusion in a donor registry, a statement attached to or imprinted on a motor vehicle operator's or chauffeur's license, an indication on a signed motor vehicle operator's license application or renewal form, a will or other writing used to make an anatomical gift.

(4) "Donor" means a person who makes an anatomical gift of all or part of his or her body.

(5) "Hospital" means a hospital licensed under chapter 368v or licensed, accredited or approved as a hospital under the law of any state or a facility operated as a hospital by the United States government, a state or a subdivision of a state.

(6) "Donor registry" means an electronic database developed and maintained by any procurement organization to identify donors.

(7) "Part" means an organ, tissue, eye, bone, artery, blood, fluid or other portion of a human body.

(8) "Person" means an individual, corporation, limited liability company, business trust, estate, trust, partnership, joint venture, association, government, governmental subdivision or agency or any other legal or commercial entity.

(9) **"Physician" or "surgeon"** means a person licensed to practice **medicine and surgery** under **chapter 370** ***or the law of any other state.***

(10) "Procurement organization" means a person licensed, accredited or approved under federal law or the laws of any state as a nonprofit organ and tissue procurement organization for procurement, distribution or storage of human bodies or parts.

(11) "State" means a state, territory or possession of the United States, the District of Columbia or the Commonwealth of Puerto Rico.

(12) "Technician" means a technician of an organ or tissue procurement organization which meets the requirements of the American Association of Tissue Banks or the Eyebank Association of America.

History:

(P.A. 88-318, S. 1, 15; P.A. 95-79, S. 60, 189; P.A. 99-102, S. 19; P.A. 04-122, S. 3.)

- **CHAPTER 368v HEALTH CARE INSTITUTIONS**

Conn. Gen. Stat. § 19a-490m. Development of surgery protocols by hospitals and outpatient surgical facilities.

(a) Each hospital and outpatient surgical facility shall develop protocols for accurate identification procedures that shall be used by such hospital or outpatient surgical facility prior to **surgery.** Such protocols shall include, but need not be limited to, (1) procedures to be followed to identify the (A) patient, (B) surgical procedure to be performed, and (C) body part on which the surgical procedure is to be performed, and (2) alternative identification procedures in urgent or emergency circumstances or where the patient is nonspeaking, comatose or incompetent or is a child. After January 1, 2006, no hospital or outpatient surgical facility may anesthetize a patient or perform surgery unless the protocols have been followed. Each hospital and outpatient surgical facility shall make a copy of the protocols available to the Commissioner of Public Health upon request.

(b) Not later than October 1, 2006, the Department of Public Health shall report, in accordance with section 11-4a, to the joint standing committee of the General Assembly having cognizance of matters relating to public health describing the protocols developed pursuant to subsection (a)

of this section.

History:

(P.A. 05-275, S. 26.)

Conn. Gen. Stat. § 19a-550. Patients' bill of rights.

(a)(1) As used in this section, (A) "nursing home facility" shall have the same meaning as provided in section 19a-521, and (B) "chronic disease hospital" means a long-term hospital having facilities, medical staff and all necessary personnel for the diagnosis, care and treatment of chronic diseases; and (2) for the purposes of subsections (c) and (d) of this section, and subsection (b) of section 19a-537, "medically contraindicated" means a comprehensive evaluation of the impact of a potential room transfer on the patient's physical, mental and psychosocial well-being, which determines that the transfer would cause new symptoms or exacerbate present symptoms beyond a reasonable adjustment period resulting in a prolonged or significant negative outcome that could not be ameliorated through care plan intervention, as documented by a physician in a patient's medical record.

(b) There is established a patients' bill of rights for any person admitted as a patient to any nursing home facility or chronic disease hospital. The patients' bill of rights shall be implemented in accordance with the provisions of Sections 1919(b), 1919(c), 1919(c)(2), 1919(c)(2)(D) and 1919(c)(2)(E) of the Social Security Act. The patients' bill of rights shall provide that each such patient: (1) Is fully informed, as evidenced by the patient's written acknowledgment, prior to or at the time of admission and during the patient's stay, of the rights set forth in this section and of all rules and regulations governing patient conduct and responsibilities; (2) is fully informed, prior to or at the time of admission and during the patient's stay, of services available in the facility, and of related charges including any charges for services not covered under Titles XVIII or XIX of the Social Security Act, or not covered by basic per diem rate; (3) is entitled to choose the patient's own physician and is fully informed, by a physician, of the patient's medical condition unless medically contraindicated, as documented by the physician in the patient's medical record, and is afforded the opportunity to participate in the planning of the patient's medical treatment and to refuse to participate in experimental research; (4) in a residential care home or a chronic disease hospital is transferred from one room to another within the facility only for medical reasons, or for the patient's welfare or that of other patients, as documented in the patient's medical record and such record shall include documentation of action taken to minimize any disruptive effects of such transfer, except a patient who is a Medicaid recipient may be transferred from a private room to a nonprivate room, provided no patient may be involuntarily transferred from one room to another within the facility if (A) it is medically established that the move will subject the patient to a reasonable likelihood of serious physical injury or harm, or (B) the patient has a prior established medical history of psychiatric problems and there is psychiatric testimony that as a consequence of the proposed move there will be exacerbation of the psychiatric problem which would last over a significant period of time and require psychiatric intervention; and in the case of an involuntary transfer from one room to another within the facility, the patient and, if known, the patient's legally liable

relative, guardian or conservator or a person designated by the patient in accordance with section 1-56r, is given at least thirty days' and no more than sixty days' written notice to ensure orderly transfer from one room to another within the facility, except where the health, safety or welfare of other patients is endangered or where immediate transfer from one room to another within the facility is necessitated by urgent medical need of the patient or where a patient has resided in the facility for less than thirty days, in which case notice shall be given as many days before the transfer as practicable; (5) is encouraged and assisted, throughout the patient's period of stay, to exercise the patient's rights as a patient and as a citizen, and to this end, has the right to be fully informed about patients' rights by state or federally funded patient advocacy programs, and may voice grievances and recommend changes in policies and services to facility staff or to outside representatives of the patient's choice, free from restraint, interference, coercion, discrimination or reprisal; (6) shall have prompt efforts made by the facility to resolve grievances the patient may have, including those with respect to the behavior of other patients; (7) may manage the patient's personal financial affairs, and is given a quarterly accounting of financial transactions made on the patient's behalf; (8) is free from mental and physical abuse, corporal punishment, involuntary seclusion and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the patient's medical symptoms. Physical or chemical restraints may be imposed only to ensure the physical safety of the patient or other patients and only upon the written order of a physician that specifies the type of restraint and the duration and circumstances under which the restraints are to be used, except in emergencies until a specific order can be obtained; (9) is assured confidential treatment of the patient's personal and medical records, and may approve or refuse their release to any individual outside the facility, except in case of the patient's transfer to another health care institution or as required by law or third-party payment contract; (10) receives quality care and services with reasonable accommodation of individual needs and preferences, except where the health or safety of the individual would be endangered, and is treated with consideration, respect, and full recognition of the patient's dignity and individuality, including privacy in treatment and in care for the patient's personal needs; (11) is not required to perform services for the facility that are not included for therapeutic purposes in the patient's plan of care; (12) may associate and communicate privately with persons of the patient's choice, including other patients, send and receive the patient's personal mail unopened and make and receive telephone calls privately, unless medically contraindicated, as documented by the patient's physician in the patient's medical record, and receives adequate notice before the patient's room or roommate in the facility is changed; (13) is entitled to organize and participate in patient groups in the facility and to participate in social, religious and community activities that do not interfere with the rights of other patients, unless medically contraindicated, as documented by the patient's physician in the patient's medical records; (14) may retain and use the patient's personal clothing and possessions unless to do so would infringe upon rights of other patients or unless medically contraindicated, as documented by the patient's physician in the patient's medical record; (15) is assured privacy for visits by the patient's spouse or a person designated by the patient in accordance with section 1-56r and, if the patient is married and both the patient and the patient's spouse are inpatients in the facility, they are permitted to share a room, unless medically contraindicated, as documented by the attending physician in the medical record; (16) is fully informed of the availability of and may examine all current state, local and federal inspection reports and plans of correction; (17) may organize, maintain and participate in a patient-run resident council, as a means of fostering communication

among residents and between residents and staff, encouraging resident independence and addressing the basic rights of nursing home and chronic disease hospital patients and residents, free from administrative interference or reprisal; (18) is entitled to the opinion of two physicians concerning the need for **surgery**, except in an emergency situation, prior to such **surgery** being performed; (19) is entitled to have the patient's family or a person designated by the patient in accordance with section 1-56r meet in the facility with the families of other patients in the facility to the extent the facility has existing meeting space available which meets applicable building and fire codes; (20) is entitled to file a complaint with the Department of Social Services and the Department of Public Health regarding patient abuse, neglect or misappropriation of patient property; (21) is entitled to have psychopharmacologic drugs administered only on orders of a physician and only as part of a written plan of care developed in accordance with Section 1919(b)(2) of the Social Security Act and designed to eliminate or modify the symptoms for which the drugs are prescribed and only if, at least annually, an independent external consultant reviews the appropriateness of the drug plan; (22) is entitled to be transferred or discharged from the facility only pursuant to section 19a-535 or section 19a-535b, as applicable; (23) is entitled to be treated equally with other patients with regard to transfer, discharge and the provision of all services regardless of the source of payment; (24) shall not be required to waive any rights to benefits under Medicare or Medicaid or to give oral or written assurance that the patient is not eligible for, or will not apply for benefits under Medicare or Medicaid; (25) is entitled to be provided information by the facility as to how to apply for Medicare or Medicaid benefits and how to receive refunds for previous payments covered by such benefits; (26) on or after October 1, 1990, shall not be required to give a third party guarantee of payment to the facility as a condition of admission to, or continued stay in, the facility; (27) in the case of an individual who is entitled to medical assistance, is entitled to have the facility not charge, solicit, accept or receive, in addition to any amount otherwise required to be paid under Medicaid, any gift, money, donation or other consideration as a precondition of admission or expediting the admission of the individual to the facility or as a requirement for the individual's continued stay in the facility; and (28) shall not be required to deposit the patient's personal funds in the facility.

(c) The patients' bill of rights shall provide that a patient in a rest home with nursing supervision or a chronic and convalescent nursing home may be transferred from one room to another within a facility only for the purpose of promoting the patient's well-being, except as provided pursuant to subparagraph (C) or (D) of this subsection or subsection (d) of this section. Whenever a patient is to be transferred, the facility shall effect the transfer with the least disruption to the patient and shall assess, monitor and adjust care as needed subsequent to the transfer in accordance with subdivision (10) of subsection (b) of this section. When a transfer is initiated by the facility and the patient does not consent to the transfer, the facility shall establish a consultative process that includes the participation of the attending physician, a registered nurse with responsibility for the patient and other appropriate staff in disciplines as determined by the patient's needs, and the participation of the patient, the patient's family, a person designated by the patient in accordance with section 1-56r or other representative. The consultative process shall determine: (1) What caused consideration of the transfer; (2) whether the cause can be removed; and (3) if not, whether the facility has attempted alternatives to transfer. The patient shall be informed of the risks and benefits of the transfer and of any alternatives. If subsequent to

the completion of the consultative process a patient still does not wish to be transferred, the patient may be transferred without the patient's consent, unless medically contraindicated, only (A) if necessary to accomplish physical plant repairs or renovations that otherwise could not be accomplished; provided, if practicable, the patient, if the patient wishes, shall be returned to the patient's room when the repairs or renovations are completed; (B) due to irreconcilable incompatibility between or among roommates, which is actually or potentially harmful to the well-being of a patient; (C) if the facility has two vacancies available for patients of the same sex in different rooms, there is no applicant of that sex pending admission in accordance with the requirements of section 19a-533 and grouping of patients by the same sex in the same room would allow admission of patients of the opposite sex, which otherwise would not be possible; (D) if necessary to allow access to specialized medical equipment no longer needed by the patient and needed by another patient; or (E) if the patient no longer needs the specialized services or programming that is the focus of the area of the facility in which the patient is located. In the case of an involuntary transfer, the facility shall, subsequent to completion of the consultative process, provide the patient and the patient's legally liable relative, guardian or conservator if any or other responsible party if known, with at least fifteen days' written notice of the transfer, which shall include the reason for the transfer, the location to which the patient is being transferred, and the name, address and telephone number of the regional long-term care ombudsman, except that in the case of a transfer pursuant to subparagraph (A) of this subsection at least thirty days' notice shall be provided. Notwithstanding the provisions of this subsection, a patient may be involuntarily transferred immediately from one room to another within a facility to protect the patient or others from physical harm, to control the spread of an infectious disease, to respond to a physical plant or environmental emergency that threatens the patient's health or safety or to respond to a situation that presents a patient with an immediate danger of death or serious physical harm. In such a case, disruption of patients shall be minimized; the required notice shall be provided within twenty-four hours after the transfer; if practicable, the patient, if the patient wishes, shall be returned to the patient's room when the threat to health or safety which prompted the transfer has been eliminated; and, in the case of a transfer effected to protect a patient or others from physical harm, the consultative process shall be established on the next business day.

(d) Notwithstanding the provisions of subsection (c) of this section, unless medically contraindicated, a patient who is a Medicaid recipient may be transferred from a private to a nonprivate room. In the case of such a transfer, the facility shall (1) give at least thirty days' written notice to the patient and the patient's legally liable relative, guardian or conservator, if any, a person designated by the patient in accordance with section 1-56r or other responsible party, if known, which notice shall include the reason for the transfer, the location to which the patient is being transferred and the name, address and telephone number of the regional long-term care ombudsman; and (2) establish a consultative process to effect the transfer with the least disruption to the patient and assess, monitor and adjust care as needed subsequent to the transfer in accordance with subdivision (10) of subsection (b) of this section. The consultative process shall include the participation of the attending physician, a registered nurse with responsibility for the patient and other appropriate staff in disciplines as determined by the patient's needs, and the participation of the patient, the patient's family, a person designated by the patient in accordance with section 1-56r or other representative.

(e) Any facility that negligently deprives a patient of any right or benefit created or established for the well-being of the patient by the provisions of this section shall be liable to such patient in a private cause of action for injuries suffered as a result of such deprivation. Upon a finding that a patient has been deprived of such a right or benefit, and that the patient has been injured as a result of such deprivation, damages shall be assessed in the amount sufficient to compensate such patient for such injury. In addition, where the deprivation of any such right or benefit is found to have been wilful or in reckless disregard of the rights of the patient, punitive damages may be assessed. A patient may also maintain an action pursuant to this section for any other type of relief, including injunctive and declaratory relief, permitted by law. Exhaustion of any available administrative remedies shall not be required prior to commencement of suit under this section.

(f) In addition to the rights specified in subsections (b), (c) and (d) of this section, a patient in a nursing home facility is entitled to have the facility manage the patient's funds as provided in section 19a-551.

History:

(P.A. 75-468, S. 12, 17; P.A. 76-331, S. 15, 16; P.A. 79-265, S. 2; 79-378; P.A. 80-80; 80-120; P.A. 86-11; P.A. 89-348, S. 4, 10; P.A. 92-231, S. 3, 10; P.A. 93-262, S. 1, 87; 93-327, S. 3; 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58; P.A. 96-81, S. 1; P.A. 97-112, S. 2; P.A. 01-195, S. 161, 181; P.A. 02-105, S. 6; P.A. 04-158, S. 1.)

Conn. Gen. Stat. § 19a-555. Chronic and convalescent nursing homes. Medical director. Personal physicians.

(a) There shall be a medical director for each chronic and convalescent nursing home. The medical director shall be a person licensed to practice medicine and **surgery** in the state pursuant to section 20-13 (*infra*). The medical director, in conjunction with the medical staff, shall develop and put into effect medical care procedures and medical practice policies. Such procedures and policies shall specify the duties and responsibilities of any physician utilizing the facilities of the nursing home for the care of patients.

(b) The medical director shall be responsible for the quality of medical and nursing care delivered in the chronic and convalescent nursing home.

(c) Each patient in a chronic and convalescent nursing home shall have a personal physician while residing there. If the patient fails to express a preference for a personal physician, or for any reason the physician so selected fails or refuses to serve, the medical director shall assign, subject to the approval of the patient, a personal physician for such patient, which physician may be himself. The medical director shall call in the patient's personal physician in those instances when the clinical course of the patient indicates that medical attention is required. The personal physician of the patient shall determine the seriousness of the illness and assume responsibility for the validity of any diagnosis or treatment.

(d) The medical director and personal physician of the patient shall be responsible for making such special provisions as may be necessary for the medical and psychiatric care of patients with mental disorders, to insure the safety and well being of such patients and of persons in contact with them.

History:

(P.A. 76-331, S. 10, 16; P.A. 77-614, S. 323, 610; P.A. 89-350, S. 18.)

- **CHAPTER 368w REMOVAL OF LIFE SUPPORT SYSTEMS**

Conn. Gen. Stat. § 19a-570. Definitions.

For purposes of this section and sections 19a-571 to 19a-580c, inclusive:

(1) "Advance health care directive" or "advance directive" means a writing executed in accordance with the provisions of this chapter, including, but not limited to, a living will, or an appointment of health care representative, or both;

(2) "Appointment of health care representative" means a document executed in accordance with section 19a-575a or 19a-577 that appoints a health care representative to make health care decisions for the declarant in the event the declarant becomes incapacitated;

(3) "Attending physician" means the physician selected by, or assigned to, the patient, who has primary responsibility for the treatment and care of the patient;

(4) "Beneficial medical treatment" includes the use of medically appropriate treatment, including **surgery**, treatment, medication and the utilization of artificial technology to sustain life;

(5) "Health care representative" means the individual appointed by a declarant pursuant to an appointment of health care representative for the purpose of making health care decisions on behalf of the declarant;

(6) "Incapacitated" means being unable to understand and appreciate the nature and consequences of health care decisions, including the benefits and disadvantages of such treatment, and to reach and communicate an informed decision regarding the treatment;

(7) "Life support system" means any medical procedure or intervention which, when applied to an individual, would serve only to postpone the moment of death or maintain the individual in a state of permanent unconsciousness, including, but not limited to, mechanical or electronic devices, including artificial means of providing nutrition or hydration;

(8) "Living will" means a written statement in compliance with section 19a-575a, containing a

declarant's wishes concerning any aspect of his or her health care, including the withholding or withdrawal of life support systems;

(9) "Next of kin" means any member of the following classes of persons, in the order of priority listed: (A) The spouse of the patient; (B) an adult son or daughter of the patient; (C) either parent of the patient; (D) an adult brother or sister of the patient; and (E) a grandparent of the patient;

(10) "Permanently unconscious" means an irreversible condition in which the individual is at no time aware of himself or herself or the environment and shows no behavioral response to the environment and includes permanent coma and persistent vegetative state;

(11) "Terminal condition" means the final stage of an incurable or irreversible medical condition which, without the administration of a life support system, will result in death within a relatively short time period, in the opinion of the attending physician.

History:

(P.A. 85-606, S. 1; P.A. 91-283, S. 1; P.A. 93-407, S. 3; P.A. 06-195, S. 63; P.A. 07-252, S. 18.)

- **CHAPTER 368aa HEALTH CARE ACCREDITATION**

Conn. Gen. Stat. § 19a-691. Anesthesia accreditation.

(a) Any office or unlicensed facility operated by a licensed health care practitioner or practitioner group at which moderate sedation/analgesia, deep sedation/analgesia or general anesthesia, as such levels of anesthesia are defined from time to time by the American Society of Anesthesiology, is administered shall be accredited by at least one of the following entities: (1) The Medicare program; (2) the Accreditation Association for Ambulatory Health Care; (3) the American Association for Accreditation of Ambulatory **Surgery** Facilities, Inc.; or (4) the Joint Commission on Accreditation of Healthcare Organizations. Such accreditation shall be obtained not later than eighteen months after July 1, 2001, or eighteen months after the date on which moderate sedation/analgesia, deep sedation/analgesia or general anesthesia is first administered at such office or facility, whichever is later. Upon the expiration of the applicable eighteen-month period, no moderate sedation/analgesia, deep sedation/analgesia or general anesthesia may be administered at any such office or facility that does not receive accreditation as required by this section. Evidence of such accreditation shall be maintained at any such office or facility at which moderate sedation/analgesia, deep sedation/analgesia or general anesthesia is administered and shall be made available for inspection upon request of the Department of Public Health. The provisions of this section shall not apply to any such office or facility operated by a practitioner holding a permit issued under section 20-123b.

(b) Notwithstanding the provisions of subsection (a) of this section, any office or unlicensed facility that is accredited as provided in subsection (a) of this section shall continue to be subject to the obligations and requirements applicable to such office or facility, including, but not limited

to, any applicable certificate of need requirements as provided in chapter 368z and any applicable licensure requirements as provided in chapter 368v.

History:

(P.A. 01-50, S. 2, 4.)

TITLE 20 PROFESSIONAL AND OCCUPATIONAL LICENSING, CERTIFICATION, TITLE PROTECTION AND REGISTRATION. EXAMINING BOARDS

- **CHAPTER 370 MEDICINE AND SURGERY**

Conn. Gen. Stat. § 20-8. Connecticut Homeopathic Medical Examining Board.

There shall be within the Department of Public Health a Connecticut Homeopathic Medical Examining Board, which shall consist of three homeopathic physicians and two public members appointed by the Governor subject to the provisions of section 4-9a. The Governor shall fill any vacancy occurring in said board. Said board shall meet at least once during each calendar quarter and at such other times as the chairman deems necessary. Special meetings shall be held on the request of a majority of the board after notice in accordance with the provisions of section 1-225. A majority of the members of the board shall constitute a quorum. Members shall not be compensated for their services. Any member who fails to attend three consecutive meetings or who fails to attend fifty per cent of all meetings held during any calendar year shall be deemed to have resigned from office. Minutes of all meetings shall be recorded by the board. No member shall participate in the affairs of the board during the pendency of any disciplinary proceedings by the board against such member. No professional member shall be an elected official of a professional society of homeopathic physicians or have been such an official during the year immediately preceding his appointment. Said board shall (1) hear and decide matters concerning suspension or revocation of licensure, (2) adjudicate complaints against practitioners and (3) impose sanctions where appropriate.

History:

(1949 Rev., S. 4365; P.A. 76-276, S. 13, 22; P.A. 77-614, S. 347, 610; P.A. 78-303, S. 133, 136; P.A. 80-484, S. 16, 174, 176; P.A. 87-156; June Sp. Sess. P.A. 91-12, S. 13, 55; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58; P.A. 98-143, S. 2, 24.)

Conn. Gen. Stat. § 20-8a. Connecticut Medical Examining Board. Medical hearing panels.

(a) There shall be within the Department of Public Health a Connecticut Medical Examining Board. Said board shall consist of fifteen members appointed by the Governor, subject to the provisions of section 4-9a, in the manner prescribed for department heads in section 4-7, as follows: Five physicians practicing in the state; one physician who shall be a full-time member of the faculty of The University of Connecticut School of Medicine; one physician who shall be a full-time chief of staff in a general-care hospital in the state; one physician who shall be a

supervising physician for one or more physician assistants; one physician who shall be a graduate of a medical education program accredited by the American Osteopathic Association; one physician assistant licensed pursuant to section 20-12b and practicing in this state; and five public members. No professional member of said board shall be an elected or appointed officer of a professional society or association relating to such member's profession at the time of appointment to the board or have been such an officer during the year immediately preceding appointment or serve for more than two consecutive terms. Professional members shall be practitioners in good professional standing and residents of this state.

(b) All vacancies shall be filled by the Governor in the manner prescribed for department heads in section 4-7. Successors and appointments to fill a vacancy shall fulfill the same qualifications as the member succeeded or replaced. In addition to the requirements in sections 4-9a and 19a-8, no person whose spouse, parent, brother, sister, child or spouse of a child is a physician, as defined in section 20-13a, or a physician assistant, as defined in section 20-12a, shall be appointed as a public member.

(c) The Commissioner of Public Health shall establish a list of twenty-four persons who may serve as members of medical hearing panels established pursuant to subsection (g) of this section. Persons appointed to the list shall serve as members of the medical hearing panels and provide the same services as members of the Connecticut Medical Examining Board. Members from the list serving on such panels shall not be voting members of the Connecticut Medical Examining Board. The list shall consist of twenty-four members appointed by the commissioner, at least eight of whom shall be physicians, as defined in section 20-13a, with at least one of such physicians being a graduate of a medical education program accredited by the American Osteopathic Association, at least one of whom shall be a physician assistant licensed pursuant to section 20-12b, and nine of whom shall be members of the public. No professional member of the list shall be an elected or appointed officer of a professional society or association relating to such member's profession at the time of appointment to the list or have been such an officer during the year immediately preceding such appointment to the list. A licensed professional appointed to the list shall be a practitioner in good professional standing and a resident of this state. All vacancies shall be filled by the commissioner. Successors and members appointed to fill a vacancy on the list shall possess the same qualifications as those required of the member succeeded or replaced. No person whose spouse, parent, brother, sister, child or spouse of a child is a physician, as defined in section 20-13a, or a physician assistant, as defined in section 20-12a, shall be appointed to the list as a member of the public. Each person appointed to the list shall serve without compensation at the pleasure of the commissioner. Each medical hearing panel shall consist of three members, one of whom shall be a member of the Connecticut Medical Examining Board, one of whom shall be a physician or physician assistant, as appropriate, and one of whom shall be a public member. The physician and public member may be a member of the board or a member from the list established pursuant to this subsection.

(d) The office of the board shall be in Hartford, in facilities to be provided by the department.

(e) The board shall adopt and may amend a seal.

(f) The Governor shall appoint a chairperson from among the board members. Said board shall meet at least once during each calendar quarter and at such other times as the chairperson deems necessary. Special meetings shall be held on the request of a majority of the board after notice in accordance with the provisions of section 1-225. A majority of the members of the board shall constitute a quorum. Members shall not be compensated for their services. Any member who fails to attend three consecutive meetings or who fails to attend fifty per cent of all meetings held during any calendar year shall be deemed to have resigned from office. Minutes of all meetings shall be recorded by the board. No member shall participate in the affairs of the board during the pendency of any disciplinary proceedings by the board against such member. Said board shall (1) hear and decide matters concerning suspension or revocation of licensure, (2) adjudicate complaints against practitioners, and (3) impose sanctions where appropriate.

(g) The board shall refer all statements of charges filed with the board by the department pursuant to section 20-13e to a medical hearing panel within sixty days of the receipt of charges. The time period may be extended for good cause by the board in a duly recorded vote. The panel shall conduct a hearing in accordance with the provisions of chapter 54 and the regulations adopted by the Commissioner of Public Health concerning contested cases, except that the panel shall file a proposed final decision with the board not later than one hundred twenty days after the receipt of the issuance of the notice of hearing by the board. The time period for filing such proposed final decision with the board may be extended for good cause by the board in a duly recorded vote.

(h) The board shall review the panel's proposed final decision in accordance with the provisions of section 4-179, and adopt, modify or remand said decision for further review or for the taking of additional evidence. The board shall act on the proposed final decision within ninety days of the filing of said decision by the panel. This time period may be extended by the board for good cause in a duly recorded vote.

(i) Except in a case in which a license has been summarily suspended, pursuant to subsection (c) of section 19a-17 or subsection (c) of section 4-182, all three panel members shall be present to hear any evidence and vote on a proposed final decision. The chairperson of the Medical Examining Board may exempt a member from a meeting of the panel if the chairperson finds that good cause exists for such an exemption. Such an exemption may be granted orally but shall be reduced to writing and included as part of the record of the panel within two business days of the granting of the exemption or the opening of the record and shall state the reason for the exemption. Such exemption shall be granted to a member no more than once during any contested case and shall not be granted for a meeting at which the panel is acting on a proposed final decision on a statement of charges. The board may appoint a member to the panel to replace any member who resigns or otherwise fails to continue to serve on the panel. Such replacement member shall review the record prior to the next hearing.

(j) A determination of good cause shall not be reviewable and shall not constitute a basis for appeal of the decision of the board pursuant to section 4-183.

History:

(P.A. 76-276, S. 10, 22; P.A. 77-614, S. 348, 610; P.A. 80-484, S. 10, 176; P.A. 81-471, S. 5, 71; P.A. 90-211, S. 1, 23; P.A. 91-105, S. 1, 4; June Sp. Sess. P.A. 91-12, S. 14, 55; P.A. 93-381, S. 9, 39; P.A. 95-71, S. 1; 95-257, S. 12, 21, 58; P.A. 98-143, S. 3, 24; P.A. 99-102, S. 4; P.A. 00-205, S. 1; P.A. 05-275, S. 18, 19; P.A. 06-195, S. 33; P.A. 07-119, S. 1; 07-252, S. 22.)

Conn. Gen. Stat. § 20-9. Who may practice medicine or **surgery**.

(a) No person shall, for compensation, gain or reward, received or expected, diagnose, treat, operate for or prescribe for any injury, deformity, ailment or disease, actual or imaginary, of another person, nor practice **surgery**, until he has obtained such a license as provided in section 20-10, and then only in the kind or branch of practice stated in such license.

(b) The provisions of this chapter shall not apply to:

(1) Dentists while practicing dentistry only;

(2) Any person in the employ of the United States government while acting in the scope of his employment;

(3) Any person who furnishes medical or surgical assistance in cases of sudden emergency;

(4) Any person residing out of this state who is employed to come into this state to render temporary assistance to or consult with any physician or surgeon who has been licensed in conformity with the provisions of this chapter;

(5) Any physician or surgeon residing out of this state who holds a current license in good standing in another state and who is employed to come into this state to treat, operate or prescribe for any injury, deformity, ailment or disease from which the person who employed such physician, or the person on behalf of whom such physician is employed, is suffering at the time when such nonresident physician or surgeon is so employed, provided such physician or surgeon may practice in this state without a Connecticut license for a period not to exceed thirty consecutive days;

(6) Any person rendering service as (A) an advanced practice registered nurse if such service is rendered in collaboration with a licensed physician, or (B) an advanced practice registered nurse maintaining classification from the American Association of Nurse Anesthetists if such service is under the direction of a licensed physician;

(7) Any nurse-midwife practicing nurse-midwifery in accordance with the provisions of chapter 377;

(8) Any podiatrist licensed in accordance with the provisions of chapter 375;

(9) Any Christian Science practitioner who does not use or prescribe in his practice any drugs,

poisons, medicines, chemicals, nostrums or **surgery**;

(10) Any person licensed to practice any of the healing arts named in section 20-1, who does not use or prescribe in his practice any drugs, medicines, poisons, chemicals, nostrums or **surgery**;

(11) Any graduate of any school or institution giving instruction in the healing arts who has been issued a permit in accordance with subsection (a) of section 20-11a and who is serving as an intern, resident or medical officer candidate in a hospital;

(12) Any student participating in a clinical clerkship program who has the qualifications specified in subsection (b) of section 20-11a;

(13) Any person, otherwise qualified to practice medicine in this state except that he is a graduate of a medical school located outside of the United States or the Dominion of Canada which school is recognized by the American Medical Association or the World Health Organization, to whom the Connecticut Medical Examining Board, subject to such regulations as the Commissioner of Public Health, with advice and assistance from the board, prescribes, has issued a permit to serve as an intern or resident in a hospital in this state for the purpose of extending his education;

(14) Any person rendering service as a physician assistant licensed pursuant to section 20-12b, a registered nurse, a licensed practical nurse or a paramedic, as defined in subdivision (15) of section 19a-175, acting within the scope of regulations adopted pursuant to section 19a-179, if such service is rendered under the supervision, control and responsibility of a licensed physician;

(15) Any student enrolled in an accredited physician assistant program or paramedic program approved in accordance with regulations adopted pursuant to section 19a-179, who is performing such work as is incidental to his course of study;

(16) Any person who, on June 1, 1993, has worked continuously in this state since 1979 performing diagnostic radiology services and who, as of October 31, 1997, continued to render such services under the supervision, control and responsibility of a licensed physician solely within the setting where such person was employed on June 1, 1993;

(17) Any person practicing athletic training, as defined in section 20-65f;

(18) When deemed by the Connecticut Medical Examining Board to be in the public's interest, based on such considerations as academic attainments, specialty board certification and years of experience, to a foreign physician or surgeon whose professional activities shall be confined within the confines of a recognized medical school;

(19) Any technician engaging in tattooing in accordance with the provisions of section 19a-92a and any regulations adopted thereunder; or

(20) Any person practicing perfusion, as defined in section 20-162aa.

(c) This section shall not authorize anyone to practice optometry, as defined in chapter 380, or to practice dentistry, as defined in chapter 379, or dental hygiene, as defined in chapter 379a.

(d) The provisions of subsection (a) of this section shall apply to any individual whose practice of medicine includes any ongoing, regular or contractual arrangement whereby, regardless of residency in this or any other state, he provides, through electronic communications or interstate commerce, diagnostic or treatment services, including primary diagnosis of pathology specimens, slides or images, to any person located in this state. In the case of electronic transmissions of radiographic images, licensure shall be required for an out-of-state physician who provides, through an ongoing, regular or contractual arrangement, official written reports of diagnostic evaluations of such images to physicians or patients in this state. The provisions of subsection (a) of this section shall not apply to a nonresident physician who, while located outside this state, consults (A) on an irregular basis with a physician licensed by section 20-10 who is located in this state or (B) with a medical school within this state for educational or medical training purposes. Notwithstanding the provisions of this subsection, the provisions of subsection (a) of this section shall not apply to any individual who regularly provides the types of services described in this subsection pursuant to any agreement or arrangement with a short-term acute care general hospital, licensed by the Department of Public Health, provided such agreement or arrangement was entered into prior to February 1, 1996, and is in effect as of October 1, 1996.

(e) On and after October 1, 1999, any person licensed as an osteopathic physician or osteopath pursuant to chapter 371 shall be deemed licensed as a physician and surgeon pursuant to this chapter.

History:

(1949 Rev., S. 4363; 1949, 1951, S. 2191d; 1959, P.A. 393, S. 1; 1971, P.A. 717; 1972, P.A. 80, S. 1; P.A. 75-39, S. 1; P.A. 77-519, S. 4, 6; 77-614, S. 349, 610; P.A. 84-546, S. 157, 173; P.A. 86-20; 86-403, S. 130, 132; P.A. 88-362, S. 1; P.A. 89-389, S. 4, 22; P.A. 90-211, S. 2, 23; P.A. 93-296, S. 7, 10; 93-381, S. 9, 39; P.A. 94-105, S. 2, 4; P.A. 95-98; 95-257, S. 12, 21, 58; P.A. 96-148; P.A. 97-311, S. 17; P.A. 98-43, S. 3; P.A. 98-166, S. 5, 9; June Sp. Sess. P.A. 98-1, S. 18, 121; P.A. 99-102, S. 2; 99-168, S. 5; P.A. 00-47, S. 2; 00-226, S. 11, 20; P.A. 03-252, S. 8; P.A. 05-280, S. 76, 77.)

Conn. Gen. Stat. § 20-10. Qualification for licensure.

Except as provided in section 20-12, each person applying for a license under section 20-13 shall certify to the Department of Public Health that the applicant: (1) (A) Is a graduate of a medical school located in the United States or Canada accredited by the Liaison Committee on Medical Education or of a medical education program accredited by the American Osteopathic Association, or (B) is a graduate of a medical school located outside the United States or Canada and has received the degree of doctor of medicine, osteopathic medicine or its equivalent and

satisfies educational requirements specified in regulations adopted pursuant to this chapter and has either (i) successfully completed all components of a "fifth pathway program" conducted by an American medical school accredited by the American Medical Association or the American Osteopathic Association, or (ii) received certification from the Educational Commission for Foreign Medical Graduates; (2) has successfully completed not less than two years of progressive graduate medical training as a resident physician in a program accredited by the Accreditation Council for Graduate Medical Education, the American Osteopathic Association or an equivalent program approved by the board with the consent of the department; and (3) has passed an examination prescribed by the department with the advice and consent of the appropriate examining board. Examinations required under this section shall be administered by the Department of Public Health under the supervision of the appropriate examining board. Passing scores shall be established by said department with the consent of the appropriate examining board. The department may, under such regulations as the Commissioner of Public Health may adopt, with the advice and assistance of the appropriate board, deny eligibility for licensure to a graduate who has been found to have provided fraudulent or inaccurate documentation regarding either the graduate's school's educational program or academic credentials or to have failed to meet educational standards as prescribed in such regulations.

History:

(1949 Rev., S. 4364(a), (e); 1953, 1955, S. 2192d(a), (e); 1961, P.A. 363, S. 1; 1969, P.A. 45, S. 1; 225, S. 1; 1972, P.A. 80, S. 2; 127, S. 37; P.A. 73-673, S. 1, 3; P.A. 75-39, S. 2; 75-268, S. 4; P.A. 76-113, S. 1; 76-276, S. 14, 22; P.A. 77-614, S. 323, 350, 610; P.A. 78-303, S. 25, 136; P.A. 79-161, S. 1; P.A. 80-484, S. 11, 174, 176; P.A. 85-171, S. 1; 85-613, S. 124; P.A. 89-389, S. 19, 22; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58; 95-271, S. 1, 40; P.A. 99-102, S. 3.)

Conn. Gen. Stat. § 20-10a. Eligibility standards. Applicability.

The eligibility standards established by section 20-10 for obtaining a license shall not be applied in determining whether to renew any such license.

History:

(P.A. 79-161, S. 2; P.A. 84-546, S. 158, 173.)

Conn. Gen. Stat. § 20-10b. Continuing medical education. Definitions. Required number of contact hours. Qualifying activities. Record-keeping obligation. Exceptions. Waivers. Requirements for license reinstatement.

(a) As used in this section:

(1) "Active professional practice" includes, but is not limited to, activities of a currently licensed physician who functions as the medical director of a managed care organization or other

organization;

(2) "Commissioner" means the Commissioner of Public Health;

(3) "Contact hour" means a minimum of fifty minutes of continuing education activity;

(4) "Department" means the Department of Public Health;

(5) "Licensee" means any person who receives a license from the department pursuant to section 20-13; and

(6) "Registration period" means the one-year period for which a license has been renewed in accordance with section 19a-88 and is current and valid.

(b) Except as otherwise provided in subsections (d), (e) and (f) of this section, for registration periods beginning on and after October 1, 2007, a licensee applying for license renewal shall earn a minimum of fifty contact hours of continuing medical education within the preceding twenty-four-month period. Such continuing medical education shall (1) be in an area of the physician's practice; (2) reflect the professional needs of the licensee in order to meet the health care needs of the public; and (3) include at least one contact hour of training or education in each of the following topics: (A) Infectious diseases, including, but not limited to, acquired immune deficiency syndrome and human immunodeficiency virus, (B) risk management, (C) sexual assault, and (D) domestic violence. For purposes of this section, qualifying continuing medical education activities include, but are not limited to, courses offered or approved by the American Medical Association, American Osteopathic Medical Association, Connecticut Hospital Association, Connecticut State Medical Society, county medical societies or equivalent organizations in another jurisdiction, educational offerings sponsored by a hospital or other health care institution or courses offered by a regionally accredited academic institution or a state or local health department.

(c) Each licensee applying for license renewal pursuant to section 19a-88 shall sign a statement attesting that the licensee has satisfied the continuing education requirements of subsection (b) of this section on a form prescribed by the department. Each licensee shall retain records of attendance or certificates of completion that demonstrate compliance with the continuing education requirements of subsection (b) of this section for a minimum of three years following the year in which the continuing education activities were completed and shall submit such records or certificates to the department for inspection not later than forty-five days after a request by the department for such records or certificates.

(d) A licensee applying for the first time for license renewal pursuant to section 19a-88 is exempt from the continuing medical education requirements of this section.

(e) (1) A licensee who is not engaged in active professional practice in any form during a registration period shall be exempt from the continuing medical education requirements of this section, provided the licensee submits to the department, prior to the expiration of the

registration period, a notarized application for exemption on a form prescribed by the department and such other documentation as may be required by the department. The application for exemption pursuant to this subdivision shall contain a statement that the licensee may not engage in professional practice until the licensee has met the requirements set forth in subdivision (2) or (3) of this subsection, as appropriate.

(2) Any licensee who is exempt from the provisions of subsection (b) of this section for less than two years shall be required to complete twenty-five contact hours of continuing medical education that meets the criteria set forth in said subsection (b) within the twelve-month period immediately preceding the licensee's return to active professional practice.

(3) Any licensee who is exempt from the requirements of subsection (b) of this section for two or more years shall be required to successfully complete the Special Purpose Examination of the Federation of State Medical Boards prior to returning to active professional practice.

(f) In individual cases involving medical disability or illness, the commissioner may, in the commissioner's discretion, grant a waiver of the continuing education requirements or an extension of time within which to fulfill the continuing education requirements of this section to any licensee, provided the licensee submits to the department an application for waiver or extension of time on a form prescribed by the department, along with a certification by a licensed physician of the disability or illness and such other documentation as may be required by the commissioner. The commissioner may grant a waiver or extension for a period not to exceed one registration period, except that the commissioner may grant additional waivers or extensions if the medical disability or illness upon which a waiver or extension is granted continues beyond the period of the waiver or extension and the licensee applies for an additional waiver or extension.

(g) Any licensee whose license has become void pursuant to section 19a-88 and who applies to the department for reinstatement of such license pursuant to section 19a-14 shall submit evidence documenting successful completion of twenty-five contact hours of continuing education within the one-year period immediately preceding application for reinstatement.

History:

(P.A. 05-275, S. 24; P.A. 06-195, S. 32.)

Conn. Gen. Stat. § 20-10c. Renewal of license by person who practices medicine for no fee.

Any person who practices medicine for no fee, for at least one hundred hours per year at a public health facility, as defined in section 20-126l, and does not otherwise engage in the practice of medicine, shall be eligible to renew a license, as provided in subsection (b) of section 19a-88, without payment of the professional services fee specified in said subsection (b).

History:

(P.A. 07-82, S. 3.)

2008 Ct. ALS 31, 1
Section 1. **Section 20-10c** of the 2008 supplement to the general statutes is repealed and the following is substituted in lieu thereof (Effective October 1, 2008):

Any person who practices medicine for no fee, for at least one hundred hours per year at a public health facility, as defined in section 20-126l, [A> OR IN CONNECTION WITH A MOBILE HEALTH CLINIC THAT PROVIDES HEALTH CARE SERVICES TO INDIVIDUALS OF THIS STATE, OF THE 2008 SUPPLEMENT TO THE GENERAL STATUTES

Conn. Gen. Stat. § 20-11. Examination; fee.

The Department of Public Health under the supervision of the examining boards provided for by sections 20-8 and 20-8a shall hold examinations not less than twice each year at such places as the department designates. Applicants for licenses to practice medicine or **surgery** shall be examined in such medical subjects as the department may prescribe, with the advice and consent of the appropriate board, provided each applicant for examination shall be notified concerning the subjects in which he is to be examined. The Commissioner of Public Health, with advice and assistance from each board, shall make such rules and regulations for conducting examinations and for the operation of the board as, from time to time, he deems necessary. Passing scores for examinations shall be established by the department with the consent of the appropriate board. Each applicant for examination shall be examined with respect to the same school of practice in which the applicant was graduated except that an applicant for licensure in homeopathic medicine who is licensed as a physician or meets the requirements in section 20-10 may be examined in other than the school of practice in which such applicant was graduated. Before being admitted to the examination, an applicant shall pay the sum of four hundred fifty dollars and an applicant rejected by the department may be reexamined at any subsequent examination, upon payment of the sum of four hundred fifty dollars for each appearance.

History:

(1949 Rev., S. 4366; 1953, S. 2193d; 1959, P.A. 616, S. 2; 1967, P.A. 111; 1969, P.A. 26; 225, S. 2; 1971, P.A. 776, S. 1; June, 1971, P.A. 8, S. 40; 1972, P.A. 80, S. 3; P.A. 76-276, S. 15, 22; P.A. 77-614, S. 323, 351, 610; P.A. 80-484, S. 12, 174, 176; P.A. 86-77, S. 1, 2; P.A. 89-251, S. 73, 203; May Sp. Sess. P.A. 92-6, S. 17, 117; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58.)

Conn. Gen. Stat. § 20-11a. Permit for participation in intern, resident physician or medical officer candidate program. Requirements for participation in clinical clerkship programs.

(a) No person shall participate in an intern or resident physician program or United States medical officer candidate training program until such person has received a permit issued by the Department of Public Health. The permit shall be issued solely for purposes of participation in

graduate education as an intern, resident or medical officer candidate in a hospital or hospital-based program. No person shall receive a permit until a statement has been filed with the department on the applicant's behalf by the hospital administrator certifying that the applicant is to be appointed an intern, resident or medical officer candidate in the hospital or hospital-based program and that the applicant has received the degree of doctor of medicine, osteopathic medicine or its equivalent and, if educated outside the United States or Canada (1) has successfully completed all components of a "fifth pathway program" conducted by an American medical school accredited by the Liaison Committee on Medical Education or the American Osteopathic Association, (2) received certification from the Educational Commission for Foreign Medical Graduates, (3) has successfully completed the examination for licensure prescribed by the department pursuant to section 20-10, or (4) holds a current valid license in another state or territory.

(b) No person shall participate in a clinical clerkship program unless such person is (1) a student in a medical school located in the United States or Canada accredited by the Liaison Committee on Medical Education or the American Osteopathic Association; or (2) is a third or fourth year student in a medical school located outside the United States or Canada, provided the clerkship is conducted within a program that is based in a hospital that has a residency program accredited by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association in the clinical area of the clerkship or within a program that is based in a hospital that is a primary affiliated teaching hospital of a medical school accredited by the Liaison Committee on Medical Education.

History:

(P.A. 88-362, S. 2; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58; P.A. 98-166, S. 4, 9; P.A. 99-102, S. 5; P.A. 05-272, S. 7.)

Conn. Gen. Stat. § 20-11b. Professional liability insurance required. Reports from insurance companies. Exception to insurance requirement. Retired physician providing free services.

(a) Except as provided in subsection (c) of this section, each person licensed to practice medicine and **surgery** under the provisions of section 20-13 who provides direct patient care services shall maintain professional liability insurance or other indemnity against liability for professional malpractice. The amount of insurance which each such person shall carry as insurance or indemnity against claims for injury or death for professional malpractice shall not be less than five hundred thousand dollars for one person, per occurrence, with an aggregate of not less than one million five hundred thousand dollars.

(b) Each insurance company which issues professional liability insurance, as defined in subdivisions (1), (6), (7), (8) and (9) of subsection (b) of section 38a-393, shall on and after January 1, 1995, render to the Commissioner of Public Health a true record of the names and addresses, according to classification, of cancellations of and refusals to renew professional liability insurance policies and the reasons for such cancellation or refusal to renew said policies

for the year ending on the thirty-first day of December next preceding.

(c) A person subject to the provisions of subsection (a) of this section shall be deemed in compliance with such subsection when providing primary health care services at a clinic licensed by the Department of Public Health that is recognized as tax exempt pursuant to Section 501(c)(3) of the Internal Revenue Code of 1986 or any successor internal revenue code, as may be amended from time to time, provided: (1) Such person is not compensated for such services; (2) the clinic does not charge patients for such services; (3) the clinic maintains professional liability insurance coverage in the amounts required by subsection (a) of this section for each aggregated forty hours of service or fraction thereof for such persons; (4) the clinic carries additional appropriate professional liability coverage on behalf of the clinic and its employees in the amounts of five hundred thousand dollars per occurrence, with an aggregate of not less than one million five hundred thousand dollars; and (5) the clinic maintains total professional liability coverage of not less than one million dollars per occurrence with an annual aggregate of not less than three million dollars. Such person shall be subject to the provisions of subsection (a) of this section when providing direct patient care services in any setting other than such clinic. Nothing in this subsection shall be construed to relieve the clinic from any insurance requirements otherwise required by law.

(d) No person insured pursuant to the requirements of subsection (a) of this section with a claims-made medical malpractice insurance policy shall lose the right to unlimited additional extended reporting period coverage upon such person's permanent retirement from practice if such person solely provides professional services without charge at a clinic recognized as tax exempt under Section 501(c)(3) of said internal revenue code.

History:

(P.A. 94-71, S. 1; P.A. 95-257, S. 12, 21, 58; P.A. 96-180, S. 64, 166; P.A. 04-221, S. 30.)

Conn. Gen. Stat. § 20-12. Licensure without examination. Limited practice based on out-of-state or military license.

(a) Except as hereinafter provided, in lieu of the examination required in section 20-10, the department may, under such regulations as the Commissioner of Public Health, with advice and assistance from the appropriate board, may establish and, upon receipt of four hundred fifty dollars, accept a license from the board of medical examiners or any board authorized to issue a license to practice osteopathic medicine, osteopathy or its equivalent of any state or territory of the United States or the District of Columbia or the Medical Council of Canada or of any agency in such jurisdictions authorized to issue licenses to practice medicine, osteopathic medicine or osteopathy, provided the applicant obtained such license after an examination substantially similar to or of higher quality than that required for a license in this state, has met all the requirements of section 20-10 except for examination and is a currently practicing, competent practitioner of good professional standing. The department may issue to an applicant approved without examination as hereinbefore provided a license to practice medicine and **surgery**.

(b) Except as hereinafter provided, the department may, in its discretion, and on receipt of four hundred fifty dollars, likewise accept and approve, in lieu of the examination required in section 20-10, a diploma of the National Board of Medical Examiners or a certificate of the National Board of Osteopathic Medical Examiners, subject to the same conditions as hereinbefore set forth for acceptance, in lieu of examination, of a license from a board of medical examiners or any board authorized to issue a license to practice osteopathic medicine, osteopathy or its equivalent of any state or territory of the United States or the District of Columbia or the Medical Council of Canada, and may issue to such diplomate or certificate holder a statement certifying to the fact that the person named therein has been found qualified to practice medicine and **surgery**.

(c) In lieu of the examination required in section 20-10, the department may, under such regulations as the Commissioner of Public Health, with advice and assistance from the appropriate board, may establish, and upon the receipt of one hundred fifty dollars, accept and approve the application of any physician for a temporary license to practice solely in any state facility, and issue such license, subject to the same conditions set forth in subsection (a) of this section for the acceptance of a license from another jurisdiction or the application of a person who has been a resident student in and a graduate of a medical school listed in the World Health Organization Directory, and has received the degree of doctor of medicine, osteopathic medicine or other academic distinction that, in the judgment of such board, is equivalent to the degree of doctor of medicine or osteopathic medicine from such a school and has completed an additional year of postgraduate experience subsequent to the receipt of said degree. Such temporary license shall not be issued for a period longer than twelve months. During the period such temporary license is in effect, such physician shall make application for an examination administered or approved by the department under the supervision of the appropriate board.

(d) No license shall be issued under this section to any applicant against whom professional disciplinary action is pending or who is the subject of an unresolved complaint. The department shall inform the boards established under sections 20-8 and 20-8a annually of the number of applications it receives for licensure under this section.

(e) Any physician licensed in another state who is board-certified in pediatrics or family medicine, or whose state standards for licensure are equivalent to or greater than those required in this state, may practice as a youth camp physician in this state without a license for a period not to exceed nine weeks.

(f) Any physician licensed or otherwise authorized to practice medicine by the armed forces of the United States may practice as a physician without a license in a free clinic in this state provided (1) the physician does not receive payment for such practice, and (2) the physician carries, either directly or through the clinic, professional liability insurance or indemnity against liability for professional malpractice equal to or greater than that required of state-licensed physicians under section 20-11b.

History:

(1949 Rev., S. 4364(b), (c); 1953, 1955, S. 2192d(b), (c); 1959, P.A. 616, S. 3; 1961, P.A. 363, S. 2; 1969, P.A. 45, S. 2; 1971, P.A. 64; June, 1971, P.A. 8, S. 41; 1972, P.A. 80, S. 4; P.A. 73-673, S. 2, 3; P.A. 76-234, S. 1, 2; 76-276, S. 16, 22; 76-435, S. 72, 82; P.A. 77-519, S. 5, 6; 77-614, S. 352, 610; P.A. 80-484, S. 13, 174, 176; P.A. 81-130, S. 1, 2; P.A. 85-171, S. 2; May Sp. Sess. P.A. 92-6, S. 18, 117; P.A. 93-381, S. 9, 39; 93-435, S. 5, 95; P.A. 95-257, S. 12, 21, 58; P.A. 99-102, S. 6; P.A. 03-252, S. 20.)

Conn. Gen. Stat. § 20-12a. Physician assistants. Definitions.

As used in sections 20-12a to 20-12g, inclusive:

(1) "Accredited physician assistant program" means a physician assistant program accredited, at the time of the applicant's graduation, by the Committee on Allied Health Education and Accreditation of the American Medical Association, the Commission on Accreditation of Allied Health Education Programs or such successor organization for the accreditation of physician assistant programs as may be approved by the department.

(2) "Board" means the Connecticut Medical Examining Board, established pursuant to section 20-8a.

(3) "Department" means the Department of Public Health.

(4) "National commission" means the National Commission on Certification of Physician Assistants or a successor organization for the certification or recertification of physician assistants that may be approved by the department.

(5) "Physician assistant" means an individual who: (A) Functions in a dependent relationship with a physician licensed pursuant to this chapter; and (B) is licensed pursuant to section 20-12b to provide patient services under the supervision, control, responsibility and direction of said physician.

(6) "Supervising physician" means a physician licensed pursuant to this chapter who assumes responsibility for the supervision of services rendered by a physician assistant.

(7) (A) "Supervision" in hospital settings means the exercise by the supervising physician of oversight, control and direction of the services of a physician assistant. Supervision includes but is not limited to: (i) Continuous availability of direct communication either in person or by radio, telephone or telecommunications between the physician assistant and the supervising physician; (ii) active and continuing overview of the physician assistant's activities to ensure that the supervising physician's directions are being implemented and to support the physician assistant in the performance of his or her services; (iii) personal review by the supervising physician of the physician assistant's practice at least weekly or more frequently as necessary to ensure quality patient care; (iv) review of the charts and records of the physician assistant on a regular basis as

necessary to ensure quality patient care; (v) delineation of a predetermined plan for emergency situations; and (vi) designation of an alternate licensed physician in the absence of the supervising physician.

(B) "Supervision" in settings other than hospital settings means the exercise by the supervising physician of oversight, control and direction of the services of a physician assistant. Supervision includes, but is not limited to: (i) Continuous availability of direct communication either in person or by radio, telephone or telecommunications between the physician assistant and the supervising physician; (ii) active and continuing overview of the physician assistant's activities to ensure that the supervising physician's directions are being implemented and to support the physician assistant in the performance of his or her services; (iii) personal review by the supervising physician of the physician assistant's services through a face-to-face meeting with the physician assistant, at least weekly or more frequently as necessary to ensure quality patient care, at a facility or practice location where the physician assistant or supervising physician performs services; (iv) review of the charts and records of the physician assistant on a regular basis as necessary to ensure quality patient care and written documentation by the supervising physician of such review at the facility or practice location where the physician assistant or supervising physician performs services; (v) delineation of a predetermined plan for emergency situations; and (vi) designation of an alternate licensed physician in the absence of the supervising physician.

History:

(P.A. 80-362, S. 1, 2; P.A. 87-117, S. 2; P.A. 90-211, S. 3, 23; P.A. 93-381, S. 9, 39; P.A. 95-74, S. 1, 9; 95-257, S. 12, 21, 58; 95-271, S. 2, 40; P.A. 99-102, S. 7; P.A. 06-110, S. 1; P.A. 07-119, S. 2, 3.)

Conn. Gen. Stat. § 20-12b. Physician assistant license. Temporary permit. Penalties.

(a) The department may, upon receipt of a fee of one hundred fifty dollars, issue a physician assistant license to an applicant who: (1) Holds a baccalaureate or higher degree in any field from a regionally accredited institution of higher education; (2) has graduated from an accredited physician assistant program; (3) has passed the certification examination of the national commission; (4) has satisfied the mandatory continuing medical education requirements of the national commission for current certification by such commission and has passed any examination or continued competency assessment the passage of which may be required by the national commission for maintenance of current certification by such commission; and (5) has completed not less than sixty hours of didactic instruction in pharmacology for physician assistant practice approved by the department.

(b) The department may, upon receipt of a fee of seventy-five dollars, issue a temporary permit to an applicant who (1) is a graduate of an accredited physician assistant program; (2) has completed not less than sixty hours of didactic instruction in pharmacology for physician assistant practice approved by the department; and (3) if applying for such permit on and after

September 30, 1991, holds a baccalaureate or higher degree in any field from a regionally accredited institution of higher education. Such temporary permit shall authorize the holder to practice as a physician assistant only in those settings where the supervising physician is physically present on the premises and is immediately available to the physician assistant when needed, but shall not authorize the holder to prescribe or dispense drugs. Such temporary permit shall be valid for a period not to exceed one hundred twenty calendar days after the date of graduation and shall not be renewable. Such permit shall become void and shall not be reissued in the event that the applicant fails to pass a certification examination scheduled by the national commission following the applicant's graduation from an accredited physician assistant program. Violation of the restrictions on practice set forth in this subsection may constitute a basis for denial of licensure as a physician assistant.

(c) No license or temporary permit shall be issued under this section to any applicant against whom professional disciplinary action is pending or who is the subject of an unresolved complaint.

(d) No person shall practice as a physician assistant or represent himself as a physician assistant unless he holds a license or temporary permit pursuant to this section or training permit issued pursuant to section 20-12h.

(e) Any person, except a licensed physician assistant or a physician licensed to practice medicine under this chapter, who practices or attempts to practice as a physician assistant, or any person who buys, sells or fraudulently obtains any diploma or license to practice as a physician assistant, whether recorded or not, or any person who uses the title "physician assistant" or any word or title to induce the belief that he or she is practicing as a physician assistant, without complying with the provisions of this section, shall be fined not more than five hundred dollars or imprisoned not more than five years, or both. For the purposes of this section, each instance of patient contact or consultation that is in violation of any provision of this chapter shall constitute a separate offense. Failure to renew a license in a timely manner shall not constitute a violation for the purposes of this section.

History:

(P.A. 90-211, S. 4, 23; P.A. 91-112, S. 1, 2; P.A. 93-296, S. 1, 10; P.A. 95-74, S. 3, 9; P.A. 04-221, S. 1; P.A. 07-252, S. 41.)

Conn. Gen. Stat. § 20-12e. Physician assistant to have supervising physician. Exception for civil preparedness duty or training.

(a) Each physician assistant practicing in this state or participating in a resident physician assistant program shall have a clearly identified supervising physician who maintains the final responsibility for the care of patients and the performance of the physician assistant.

(b) A physician may function as a supervising physician for as many physician assistants as is medically appropriate under the circumstances, provided (1) the supervision is active and direct,

and (2) the physician is supervising not more than six full-time physician assistants concurrently, or the part-time equivalent thereof.

(c) Nothing in this chapter shall be construed to prohibit the employment of physician assistants in a hospital or other health care facility where such physician assistants function under the direction of a supervising physician.

(d) Nothing in this chapter shall be construed to prohibit a licensed physician assistant who is part of the Connecticut Disaster Medical Assistance Team or the Medical Reserve Corps, under the auspices of the Department of Public Health, or the Connecticut Urban Search and Rescue Team, under the auspices of the Department of Public Safety, and is engaged in officially authorized civil preparedness duty or civil preparedness training conducted by such team or corps, from providing patient services under the supervision, control, responsibility and direction of a licensed physician.

History:

(P.A. 90-211, S. 5, 23; P.A. 94-210, S. 22, 30; P.A. 95-74, S. 4, 9; 95-271, S. 3, 40; P.A. 96-12, S. 2; P.A. 97-213, S. 12; P.A. 99-102, S. 8; P.A. 05-259, S. 2; P.A. 06-110, S. 2; P.A. 07-119, S. 4.)

Conn. Gen. Stat. § 20-12d. Medical functions performed by physician assistants. Prescriptive authority.

(a) A physician assistant who has complied with the provisions of sections 20-12b and 20-12c may perform medical functions delegated by a supervising physician when: (1) The supervising physician is satisfied as to the ability and competency of the physician assistant; (2) such delegation is consistent with the health and welfare of the patient and in keeping with sound medical practice; and (3) such functions are performed under the oversight, control and direction of the supervising physician. The functions that may be performed under such delegation are those that are within the scope of the supervising physician's license, within the scope of such physician's competence as evidenced by such physician's postgraduate education, training and experience and within the normal scope of such physician's actual practice. Delegated functions shall be implemented in accordance with written protocols established by the supervising physician. All orders written by physician assistants shall be followed by the signature of the physician assistant and the printed name of the supervising physician. A physician assistant may, as delegated by the supervising physician within the scope of such physician's license, (A) prescribe and administer drugs, including controlled substances in schedule IV or V in all settings, (B) renew prescriptions for controlled substances in schedule II, III, IV or V in all settings, and (C) prescribe and administer controlled substances in schedule II or III in all settings, provided in all cases where the physician assistant prescribes a controlled substance in schedule II or III, the physician under whose supervision the physician assistant is prescribing shall document such physician's approval of the order in the patient's medical record not later than one calendar day thereafter. The physician assistant may, as delegated by the supervising

physician within the scope of such physician's license, request, sign for, receive and dispense drugs to patients, in the form of professional samples, as defined in section 20-14c, or when dispensing in an outpatient clinic as defined in the regulations of Connecticut state agencies and licensed pursuant to subsection (a) of section 19a-491 that operates on a not-for-profit basis, or when dispensing in a clinic operated by a state agency or municipality. Nothing in this subsection shall be construed to allow the physician assistant to request, sign for, receive or dispense any drug the physician assistant is not authorized under this subsection to prescribe.

(b) All prescription forms used by physician assistants shall contain the printed name, license number, address and telephone number of the physician under whose supervision the physician assistant is prescribing, in addition to the signature, name, address and license number of the physician assistant.

(c) No physician assistant may: (1) Engage in the independent practice of medicine; (2) claim to be or allow being represented as a physician licensed pursuant to this chapter; (3) use the title of doctor; or (4) associate by name or allow association by name with any term that would suggest qualification to engage in the independent practice of medicine. The physician assistant shall be clearly identified by appropriate identification as a physician assistant to ensure that the physician assistant is not mistaken for a physician licensed pursuant to this chapter.

(d) A physician assistant licensed under this chapter may make the actual determination and pronouncement of death of a patient, provided: (1) The death is an anticipated death; (2) the physician assistant attests to such pronouncement on the certificate of death; and (3) the physician assistant or a physician licensed by the state of Connecticut certifies the death and signs the certificate of death no later than twenty-four hours after the pronouncement.

History:

(P.A. 90-211, S. 6, 23; P.A. 95-271, S. 4, 40; P.A. 96-12, S. 1; P.A. 99-102, S. 9; P.A. 00-205, S. 2; P.A. 04-221, S. 21; 04-255, S. 21; P.A. 05-219, S. 1; P.A. 06-196, S. 247.)

2008 Ct. ALS 184, 13:
Sec. 13. **Subsection (a) of section 20-12d** of the general statutes is repealed and the following is substituted in lieu thereof (Effective October 1, 2008):

(a) A physician assistant who has complied with the provisions of sections 20-12b **[A>** OF THE 2008 SUPPLEMENT TO THE GENERAL STATUTES **<A]** and 20-12c **[A>** OF THE 2008 SUPPLEMENT TO THE GENERAL STATUTES **<A]** may perform medical functions delegated by a supervising physician when: (1) The supervising physician is satisfied as to the ability and competency of the physician assistant; (2) such delegation is consistent with the health and welfare of the patient and in keeping with sound medical practice; and (3) such functions are performed under the oversight, control and direction of the supervising physician. The functions that may be performed under such delegation are those that are within the scope of the supervising physician's license, within the scope of such physician's competence as evidenced by such physician's postgraduate education, training and experience and within the

normal scope of such physician's actual practice. Delegated functions shall be implemented in accordance with written protocols established by the supervising physician. All orders written by physician assistants shall be followed by the signature of the physician assistant and the printed name of the supervising physician. A physician assistant may, as delegated by the supervising physician within the scope of such physician's license, (A) prescribe and administer drugs, including controlled substances in schedule IV or V in all settings, (B) renew prescriptions for controlled substances in schedule II, III, IV or V in all settings, **[D>** and **<D]** (C) prescribe and administer controlled substances in schedule II or III in all settings, provided in all cases where the physician assistant prescribes a controlled substance in schedule II or III, the physician under whose supervision the physician assistant is prescribing shall document such physician's approval of the order in the patient's medical record not later than one calendar day thereafter **[A>** , AND (D) PRESCRIBE AND APPROVE THE USE OF DURABLE MEDICAL EQUIPMENT **<A]** . The physician assistant may, as delegated by the supervising physician within the scope of such physician's license, request, sign for, receive and dispense drugs to patients, in the form of professional samples, as defined in section 20-14c, or when dispensing in an outpatient clinic as defined in the regulations of Connecticut state agencies and licensed pursuant to subsection (a) of section 19a-491 that operates on a not-for-profit basis, or when dispensing in a clinic operated by a state agency or municipality. Nothing in this subsection shall be construed to allow the physician assistant to request, sign for, receive or dispense any drug the physician assistant is not authorized under this subsection to prescribe.

Conn. Gen. Stat. § 20-12e. Petition concerning ability to practice of physician assistant. Notification to department of termination or restriction of privileges of physician assistant.

(a) The state or county medical or osteopathic medical society or any state professional organization of physician assistants or any physician, physician assistant or holder of a permit issued pursuant to section 20-12h or subsection (d) of section 20-12b or any hospital shall within thirty days, and the board or any individual may, file a petition when such society, organization, practitioner, hospital, board or individual has any information that appears to show that a physician assistant is or may be unable to practice as a physician assistant with reasonable skill or safety for any of the reasons listed in section 20-12f. Petitions shall be filed with the department.

(b) Any health care facility licensed pursuant to subsection (a) of section 19a-491 which terminates or restricts the staff membership or privileges of any physician assistant or holder of a permit issued pursuant to section 20-12h or subsection (b) of section 20-12b shall, not later than fifteen days after the effective date of such action, notify the department of such action.

History:

(P.A. 90-211, S. 7, 23; P.A. 95-74, S. 5, 9; 95-271, S. 5, 40; P.A. 99-102, S. 10.)

Conn. Gen. Stat. § 20-12f. Disciplinary action concerning physician assistants.

The board shall have jurisdiction to hear all charges of conduct which fails to conform to the

accepted standards of the physician assistant profession brought against persons licensed to practice as a physician assistant or holding any permit issued pursuant to section 20-12h or subsection (b) of section 20-12b. The board may take any action set forth in section 19a-17 if it finds that a person licensed as a physician assistant or holding a permit issued pursuant to section 20-12h or subsection (b) of section 20-12b fails to conform to the accepted standards of the physician assistant profession. Conduct which fails to conform to the accepted standards of the physician assistant profession includes, but is not limited to, the following: Conviction of a felony; fraud or deceit in professional practice; illegal conduct; negligent, incompetent or wrongful conduct in professional activities; emotional disorder or mental illness; physical illness including, but not limited to, deterioration through the aging process; abuse or excessive use of drugs, including alcohol, narcotics or chemicals; wilful falsification of entries into any patient record; possession, use, prescription for use, or distribution of controlled substances or legend drugs, except for therapeutic or other medically proper purposes; misrepresentation or concealment of a material fact in the obtaining or reinstatement of a physician assistant license or permit; or violation of any provisions of this chapter and section 21a-252. The commissioner may order a license or permit holder to submit to a reasonable physical or mental examination if his physical or mental capacity to practice safely is the subject of an investigation. The commissioner may petition the superior court for the judicial district of Hartford to enforce such order or any action taken pursuant to section 19a-17. Notice of any contemplated action under said section, the cause of the action and the date of a hearing on the action shall be given and an opportunity for hearing afforded in accordance with the provisions of chapter 54.

History:

(P.A. 88-230, S. 1, 12; 90-98, S. 1, 2; 90-211, S. 8, 23; P.A. 93-142, S. 4, 7, 8; P.A. 95-74, S. 6, 9; 95-220, S. 4-6; 95-271, S. 7, 40.)

Conn. Gen. Stat. § 20-12g. Regulations concerning physician assistants.

The department may, with the advice and assistance of the board, promulgate such regulations as may be necessary for the implementation of sections 20-12a to 20-12f, inclusive.

History:

(P.A. 90-211, S. 9, 23.)

Conn. Gen. Stat. § 20-12h. Resident physician assistant program. License, temporary or training permit requirements.

No person shall participate in a resident physician assistant program until he has received a license or temporary permit issued pursuant to section 20-12b or a training permit issued by the department. The training permit shall be issued solely for purposes of participation in postgraduate education as a resident physician assistant in a short-term hospital, as defined in the regulations of Connecticut state agencies and licensed pursuant to subsection (a) of section 19a-491, that provides a postgraduate medical education program accredited by the Accreditation

Council for Graduate Medical Education. No person shall receive a training permit until a statement has been filed with the department on his behalf by the hospital administrator certifying that such person is to be appointed a resident physician assistant in such hospital and that he has satisfied the requirements of subdivisions (1), (2) and (5) of subsection (a) of section 20-12b. Such training permit shall authorize the holder to participate in clinical educational activities only when the supervising physician is physically present on the premises and is immediately available to the physician assistant when needed, but shall not authorize the holder to prescribe or dispense drugs.

History:

(P.A. 95-74, S. 2, 9; 95-271, S. 6, 40.)

Conn. Gen. Stat. § 20-12n. Homeopathic physicians.

(a) As used in this section, "homeopathic physician" means a physician who prescribes the single remedy in the minimum dose in potentized form, selected from the law of similars.

(b) Subject to the provisions of this section, no person shall practice as a homeopathic physician until such person has obtained a license to practice medicine and **surgery** from the Department of Public Health in accordance with this chapter. No license as a homeopathic physician shall be required of a graduate of any school or institution giving instruction in the healing arts who is completing a post-graduate medical training in homeopathy pursuant to subsection (c) of this section.

(c) Applicants for licensure as a homeopathic physician shall, in addition to meeting the requirements of section 20-10, have successfully completed not less than one hundred twenty hours of post-graduate medical training in homeopathy offered by an institution approved by the Connecticut Homeopathic Medical Examining Board or the American Institute of Homeopathy, or one hundred twenty hours of post-graduate medical training in homeopathy under the direct supervision of a licensed homeopathic physician, which shall consist of thirty hours of theory and ninety hours of clinical practice. The Connecticut Homeopathic Medical Examining Board shall approve any training completed under the direction of a licensed homeopathic physician.

History:

(P.A. 03-252, S. 6.)

Conn. Gen. Stat. § 20-13. Issuance of license.

Any person who has complied with the provisions of section 20-10 or section 20-12, and who files the proof thereof with the Department of Public Health, shall receive from the department a license, which shall include a statement that the person named therein is qualified to practice medicine and **surgery**.

History:

(1949 Rev., S. 4364(e); 1953, 1955, S. 2192d(e); 1959, P.A. 616, S. 4; P.A. 77-614, S. 323, 610; P.A. 81-471, S. 6, 71; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58.)

Conn. Gen. Stat. § 20-13a. Definitions.

As used in sections 20-13a to 20-13i, inclusive, unless the context otherwise requires:

(1) "Board" means the Connecticut Medical Examining Board, as provided for in section 20-8a;

(2) "Commissioner" means the Commissioner of Public Health;

(3) "County society" means a county medical association affiliated with the Connecticut State Medical Society;

(4) "Department" means the Department of Public Health;

(5) "License" means any license or permit issued pursuant to section 20-10, 20-11a or 20-12;

(6) "Physician" means a person holding a license issued pursuant to this chapter, except a homeopathic physician; and

(7) "State society" means the Connecticut State Medical Society or the Connecticut Osteopathic Medical Society.

History:

(P.A. 76-276, S. 1, 22; P.A. 77-614, S. 323, 610; P.A. 82-472, S. 74, 183; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58; 95-271, S. 8, 40; P.A. 99-102, S. 11.)

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Sec. 7. **Section 20-13a** of the general statutes is repealed and the following is substituted in lieu thereof (Effective October 1, 2008):

As used in sections 20-13a to [D> 20-13i 20-13E AS AMENDED BY THIS ACT,

(1) "Board" means the Connecticut Medical Examining Board, as provided for in section 20-8a [A> OF THE 2008 SUPPLEMENT TO THE GENERAL STATUTES

(2) "Commissioner" means the Commissioner of Public Health;

(3) "County society" means a county medical association affiliated with the Connecticut State

Medical Society;

(4) "Department" means the Department of Public Health;

(5) "License" means any license or permit issued pursuant to section 20-10, 20-11a or 20-12;

(6) "Physician" means a person holding a license issued pursuant to this chapter, except a homeopathic physician; and

(7) "State society" means the Connecticut State Medical Society or the Connecticut Osteopathic Medical Society.

Conn. Gen. Stat. § 20-13b. Guidelines for reviewing complaints against physicians.

The Commissioner of Public Health, with advice and assistance from the board, shall establish guidelines as may be necessary to carry out the provisions of sections 20-13a to 20-13i, inclusive. Not later than January 1, 2006, such guidelines shall include, but need not be limited to: (1) Guidelines for screening complaints received to determine which complaints will be investigated; (2) guidelines to provide a basis for prioritizing the order in which complaints will be investigated; (3) a system for conducting investigations to ensure prompt action when it appears necessary; (4) guidelines to determine when an investigation should be broadened beyond the scope of the initial complaint to include, but not be limited to, sampling patient records to identify patterns of care, reviewing office practices and procedures, and reviewing performance and discharge data from hospitals; and (5) guidelines to protect and ensure the confidentiality of patient and provider identifiable information when an investigation is broadened beyond the scope of the initial complaint. Such guidelines shall not be considered regulations, as defined in section 4-166.

History:

(P.A. 76-276, S. 2, 22; P.A. 77-614, S. 353, 610; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58; P.A. 05-275, S. 20.)

2008 Ct. ALS 184, 8

Sec. 8. **Section 20-13b** of the general statutes is repealed and the following is substituted in lieu thereof (Effective October 1, 2008):

The Commissioner of Public Health, with advice and assistance from the board, shall establish guidelines as may be necessary to carry out the provisions of sections 20-13a to **[D>** 20-13i **<D]** **[A>** 20-13E **<A]** , inclusive **[A>** , AS AMENDED BY THIS ACT **<A]** . Not later than January 1, 2006, such guidelines shall include, but need not be limited to: (1) Guidelines for screening complaints received to determine which complaints will be investigated; (2) guidelines to provide a basis for prioritizing the order in which complaints will be investigated; (3) a system for conducting investigations to ensure prompt action when it appears necessary; (4) guidelines

to determine when an investigation should be broadened beyond the scope of the initial complaint to include, but not be limited to, sampling patient records to identify patterns of care, reviewing office practices and procedures, and reviewing performance and discharge data from hospitals; and (5) guidelines to protect and ensure the confidentiality of patient and provider identifiable information when an investigation is broadened beyond the scope of the initial complaint. Such guidelines shall not be considered regulations, as defined in section 4-166.

Conn. Gen. Stat. § 20-13c. Restriction, suspension or revocation of physician's right to practice. Grounds.

The board is authorized to restrict, suspend or revoke the license or limit the right to practice of a physician or take any other action in accordance with section 19a-17, for any of the following reasons: (1) Physical illness or loss of motor skill, including, but not limited to, deterioration through the aging process; (2) emotional disorder or mental illness; (3) abuse or excessive use of drugs, including alcohol, narcotics or chemicals; (4) illegal, incompetent or negligent conduct in the practice of medicine; (5) possession, use, prescription for use, or distribution of controlled substances or legend drugs, except for therapeutic or other medically proper purposes; (6) misrepresentation or concealment of a material fact in the obtaining or reinstatement of a license to practice medicine; (7) failure to adequately supervise a physician assistant; (8) failure to fulfill any obligation resulting from participation in the National Health Service Corps; (9) failure to maintain professional liability insurance or other indemnity against liability for professional malpractice as provided in subsection (a) of section 20-11b; (10) failure to provide information requested by the department for purposes of completing a health care provider profile, as required by section 20-13j; (11) engaging in any activity for which accreditation is required under section 19a-690 or 19a-691 without the appropriate accreditation required by section 19a-690 or 19a-691; (12) failure to provide evidence of accreditation required under section 19a-690 or 19a-691 as requested by the department pursuant to section 19a-690 or 19a-691; (13) failure to comply with the continuing medical education requirements set forth in section 20-10b; or (14) violation of any provision of this chapter or any regulation established hereunder. In each case, the board shall consider whether the physician poses a threat, in the practice of medicine, to the health and safety of any person. If the board finds that the physician poses such a threat, the board shall include such finding in its final decision and act to suspend or revoke the license of said physician.

History:

(P.A. 76-276, S. 3, 22; P.A. 77-614, S. 354, 610; P.A. 80-484, S. 15, 176; P.A. 81-471, S. 7, 71; P.A. 90-211, S. 10, 23; P.A. 91-105, S. 3, 4; P.A. 92-40; P.A. 94-71, S. 7; P.A. 99-284, S. 34; P.A. 01-50, S. 3, 4; P.A. 05-275, S. 21.)

Conn. Gen. Stat. § 20-13d. Complaints required and permitted. Department to be notified of termination or restriction of physician's privileges. Facilities to be notified of suspension, revocation or restriction of physician's license. Notice of disciplinary action taken in other state.

(a) The state society or any county society or any physician or hospital shall within thirty days, and the board or any individual may, file a petition when such society, physician or hospital or said board or individual has any information which appears to show that a physician is or may be unable to practice medicine with reasonable skill or safety for any of the reasons listed in section 20-13c. Petitions shall be filed with the Department of Public Health on forms supplied by the department, shall be signed and sworn and shall set forth in detail the matters complained of.

(b) Any health care facility licensed under section 19a-493 which terminates or restricts the staff membership or privileges of any physician shall, not later than fifteen days after the effective date of such action, notify the department of such action.

(c) The department shall notify any health care facility licensed under section 19a-493 if the board suspends, revokes or otherwise restricts the license of any physician. The commissioner shall adopt regulations in accordance with chapter 54 to implement a system of notification in accordance with the provisions of this subsection.

(d) A physician shall report to the department any disciplinary action similar to an action specified in subsection (a) of section 19a-17 taken against him by a duly authorized professional disciplinary agency of any other state, the District of Columbia, a United States possession or territory, or a foreign jurisdiction, within thirty days of such action. Failure to so report may constitute a ground for disciplinary action under section 20-13c.

History:

(P.A. 76-276, S. 4, 22; P.A. 77-614, S. 355, 610; P.A. 84-148, S. 1, 4; P.A. 90-13, S. 8; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58.)

Conn. Gen. Stat. § 20-13e. Investigation of petition. Examination of physician. Hearing. Enforcement.

(a) The department shall investigate each petition filed pursuant to section 20-13d, in accordance with the provisions of subdivision (10) of subsection (a) of section 19a-14, to determine if probable cause exists to issue a statement of charges and to institute proceedings against the physician under subsection (d) of this section. Such investigation shall be concluded not later than eighteen months from the date the petition is filed with the department and, unless otherwise specified by this subsection, the record of such investigation shall be deemed a public record, in accordance with section 1-210, at the conclusion of such eighteen-month period. Any such investigation shall be confidential and no person shall disclose his knowledge of such investigation to a third party unless the physician requests that such investigation and disclosure be open. If the department determines that probable cause exists to issue a statement of charges, the entire record of such proceeding shall be public unless the department determines that the physician is an appropriate candidate for participation in a rehabilitation program in accordance with the provisions of sections 19a-12a and 19a-12b. The petition and all records of any physician determined to be eligible for participation in a rehabilitation program prior to June 11, 2007, shall remain confidential during the physician's participation and upon successful

completion of the rehabilitation program, in accordance with the terms and conditions agreed upon by the physician and the department. If at any time subsequent to the filing of a petition and during the eighteen-month period, the department makes a finding of no probable cause, the petition and the entire record of such investigation shall remain confidential unless the physician requests that such petition and record be open.

(b) As part of an investigation of a petition filed pursuant to subsection (a) of section 20-13d, the Department of Public Health may order the physician to submit to a physical or mental examination, to be performed by a physician chosen from a list approved by the department. The department may seek the advice of established medical organizations or licensed health professionals in determining the nature and scope of any diagnostic examinations to be used as part of any such physical or mental examination. The examining physician shall make a written statement of his or her findings.

(c) If the physician fails to obey a department order to submit to examination or attend a hearing, the department may petition the superior court for the judicial district of Hartford to order such examination or attendance, and said court or any judge assigned to said court shall have jurisdiction to issue such order.

(d) Subject to the provisions of section 4-182, no license shall be restricted, suspended or revoked by the board, and no physician's right to practice shall be limited by the board, until the physician has been given notice and opportunity for hearing in accordance with the regulations established by the commissioner.

History:

(P.A. 76-276, S. 5, 22; P.A. 77-614, S. 356, 610; P.A. 80-483, S. 160, 186; P.A. 81-471, S. 8, 71; P.A. 84-148, S. 2, 4; P.A. 88-230, S. 1, 12; P.A. 90-98, S. 1, 2; P.A. 91-105, S. 2, 4; P.A. 93-142, S. 4, 7, 8; 93-381, S. 9, 39; P.A. 95-220, S. 4-6; 95-257, S. 12, 21, 58; P.A. 05-288, S. 80; P.A. 07-103, S. 3.)

Conn. Gen. Stat. § 20-13i. Annual report by department.

The department shall file with the Governor and the joint standing committee on public health of the General Assembly on or before January 1, 1986, and thereafter on or before January first of each succeeding year, a report of the activities of the department and the board conducted pursuant to sections 20-13d and 20-13e. Each such report shall include, but shall not be limited to, the following information: The number of petitions received; the number of hearings held on such petitions; and, without identifying the particular physician concerned, a brief description of the impairment alleged in each such petition and the actions taken with regard to each such petition by the department and the board.

History:

(P.A. 76-276, S. 9, 22; P.A. 80-484, S. 147, 176; P.A. 84-148, S. 3, 4.)

2008 Ct. ALS 184, 63
Sec. 63. (Effective October 1, 2008) Sections 19a-7g, 19a-181e, 19a-197, 20-13i and 25-39a of the general statutes are repealed.

Conn. Gen. Stat. § 20-13j. Physician profiles. Establishment. Public availability.

(a) For purposes of this section: "Department" means the Department of Public Health, and "physician" means a physician licensed pursuant to this chapter.

(b) The department, after consultation with the Connecticut Medical Examining Board and the Connecticut State Medical Society, shall collect the following information to create an individual profile on each physician for dissemination to the public:

(1) The name of the medical school attended by the physician and the date of graduation;

(2) The site, training, discipline and inclusive dates of the physician's postgraduate medical education required pursuant to the applicable licensure section of the general statutes;

(3) The area of the physician's practice specialty;

(4) The address of the physician's primary practice location or primary practice locations, if more than one;

(5) A list of languages, other than English, spoken at the physician's primary practice locations;

(6) An indication of any disciplinary action taken against the physician by the department, the state board or any professional licensing or disciplinary body in another jurisdiction;

(7) Any current certifications issued to the physician by a specialty board of the American Board of Medical Specialties;

(8) The hospitals and nursing homes at which the physician has admitting privileges;

(9) Any appointments of the physician to Connecticut medical school faculties and an indication as to whether the physician has current responsibility for graduate medical education;

(10) A listing of the physician's publications in peer reviewed literature;

(11) A listing of the physician's professional services, activities and awards;

(12) Any hospital disciplinary actions against the physician that resulted, within the past ten years, in the termination or revocation of the physician's hospital privileges for a medical disciplinary cause or reason, or the resignation from, or nonrenewal of, medical staff membership or the restriction of privileges at a hospital taken in lieu of or in settlement of a

pending disciplinary case related to medical competence in such hospital;

(13) A description of any criminal conviction of the physician for a felony within the last ten years. For the purposes of this subdivision, a physician shall be deemed to be convicted of a felony if the physician pleaded guilty or was found or adjudged guilty by a court of competent jurisdiction or has been convicted of a felony by the entry of a plea of nolo contendere;

(14) To the extent available, and consistent with the provisions of subsection (c) of this section, all medical malpractice court judgments and all medical malpractice arbitration awards against the physician in which a payment was awarded to a complaining party during the last ten years, and all settlements of medical malpractice claims against the physician in which a payment was made to a complaining party within the last ten years;

(15) An indication as to whether the physician is actively involved in patient care; and

(16) The name of the physician's professional liability insurance carrier.

(c) Any report of a medical malpractice judgment or award against a physician made under subdivision (14) of subsection (b) of this section shall comply with the following: (1) Dispositions of paid claims shall be reported in a minimum of three graduated categories indicating the level of significance of the award or settlement; (2) information concerning paid medical malpractice claims shall be placed in context by comparing an individual physician's medical malpractice judgments, awards and settlements to the experience of other physicians licensed in Connecticut who perform procedures and treat patients with a similar degree of risk; (3) all judgment award and settlement information reported shall be limited to amounts actually paid by or on behalf of the physician; and (4) comparisons of malpractice payment data shall be accompanied by (A) an explanation of the fact that physicians treating certain patients and performing certain procedures are more likely to be the subject of litigation than others and that the comparison given is for physicians who perform procedures and treat patients with a similar degree of risk; (B) a statement that the report reflects data for the last ten years and the recipient should take into account the number of years the physician has been in practice when considering the data; (C) an explanation that an incident giving rise to a malpractice claim may have occurred years before any payment was made due to the time lawsuits take to move through the legal system; (D) an explanation of the effect of treating high-risk patients on a physician's malpractice history; and (E) an explanation that malpractice cases may be settled for reasons other than liability and that settlements are sometimes made by the insurer without the physician's consent. Information concerning all settlements shall be accompanied by the following statement: "Settlement of a claim may occur for a variety of reasons that do not necessarily reflect negatively on the professional competence or conduct of the physician. A payment in settlement of a medical malpractice action or claim should not be construed as creating a presumption that medical malpractice has occurred."

(d) Pending malpractice claims against a physician and actual amounts paid by or on behalf of a physician in connection with a malpractice judgment, award or settlement shall not be disclosed by the department to the public. This subsection shall not be construed to prevent the department

from investigating and disciplining a physician on the basis of medical malpractice claims that are pending.

(e) Prior to the initial release of a physician's profile to the public, the department shall provide the physician with a copy of the physician's profile. Additionally, any amendments or modifications to the profile that were not supplied by the physician or not generated by the department itself shall be provided to the physician for review prior to release to the public. A physician shall have sixty days from the date the department mails or delivers the prepublication copy to dispute the accuracy of any information that the department proposes to include in such profile and to submit a written statement setting forth the basis for such dispute. If a physician does not notify the department that the physician disputes the accuracy of such information within such sixty-day period, the department shall make the profile available to the public and the physician shall be deemed to have approved the profile and all information contained therein. If a physician notifies the department that the physician disputes the accuracy of such information in accordance with this subsection, the physician's profile shall be released to the public without the disputed information, but with a statement to the effect that information in the identified category is currently the subject of a dispute and is therefore not currently available. Not later than thirty days after the department's receipt of notice of a dispute, the department shall review any information submitted by the physician in support of such dispute and determine whether to amend the information contained in the profile. In the event that the department determines not to amend the disputed information, the disputed information shall be included in the profile with a statement that such information is disputed by the physician.

(f) A physician may elect to have the physician's profile omit information provided pursuant to subdivisions (9) to (11), inclusive, of subsection (b) of this section. In collecting information for such profiles and in the dissemination of such profiles, the department shall inform physicians that they may choose not to provide the information described in said subdivisions (9) to (11), inclusive.

(g) Each profile created pursuant to this section shall include the following statement: "This profile contains information that may be used as a starting point in evaluating the physician. This profile should not, however, be your sole basis for selecting a physician."

(h) The department shall maintain a web site on the Internet for use by the public in obtaining profiles of physicians.

(i) No state law that would otherwise prohibit, limit or penalize disclosure of information about a physician shall apply to disclosure of information required by this section.

(j) All information provided by a physician pursuant to this section shall be subject to the penalties of false statement, pursuant to section 53a-157b.

(k) Except for the information in subdivisions (1), (2), (10) and (11) of subsection (b) of this section, a physician shall notify the department of any changes to the information required in said subsection (b) not later than sixty days after such change.

History:

(P.A. 99-284, S. 33; P.A. 05-275, S. 22, 23.)

2008 Ct. ALS 109, 1
Section 1. **Section 20-13j** of the general statutes is repealed and the following is substituted in lieu thereof (Effective January 1, 2010):

(a) For **[A>** THE **<A]** purposes of this section:

[A> (1) **<A]** "Department" means the Department of Public Health **[A>** ; **<A]** **[D>** , **<D]** and **[D>** "physician" means a physician licensed pursuant to this chapter **<D]**

[A> (2) "HEALTH CARE PROVIDER" MEANS: (A) A PHYSICIAN LICENSED UNDER THIS CHAPTER; (B) A DENTIST LICENSED UNDER CHAPTER 379; (C) A CHIROPRACTOR LICENSED UNDER CHAPTER 372; (D) AN OPTOMETRIST LICENSED UNDER CHAPTER 380; (E) A PODIATRIST LICENSED UNDER CHAPTER 375; (F) A NATUREOPATH LICENSED UNDER CHAPTER 373; (G) A DENTAL HYGIENIST LICENSED UNDER CHAPTER 379A; (H) AN ADVANCED PRACTICE REGISTERED NURSE LICENSED UNDER CHAPTER 378; OR (I) A PHYSICAL THERAPIST LICENSED UNDER CHAPTER 376 **<A]** .

(b) The department, after consultation with the Connecticut Medical Examining Board **[A>** , **<A]** **[D>** and **<D]** the Connecticut State Medical Society, **[A>** OR ANY OTHER APPROPRIATE STATE BOARD, **<A]** shall **[A>** , WITHIN AVAILABLE APPROPRIATIONS, **<A]** collect the following information to create an individual profile on each **[D>** physician **<D]** **[A>** HEALTH CARE PROVIDER **<A]** for dissemination to the public:

(1) The name of the medical **[A>** OR DENTAL **<A]** school **[A>** , CHIROPRACTIC COLLEGE, SCHOOL OR COLLEGE OF OPTOMETRY, SCHOOL OR COLLEGE OF CHIROPODY OR PODIATRY, SCHOOL OR COLLEGE OF NATUREOPATHY, SCHOOL OF DENTAL HYGIENE, SCHOOL OF PHYSICAL THERAPY OR OTHER SCHOOL OR INSTITUTION GIVING INSTRUCTION IN THE HEALING ARTS **<A]** attended by the **[D>** physician **<D]** **[A>** HEALTH CARE PROVIDER **<A]** and the date of graduation;

(2) The site, training, discipline and inclusive dates of **[D>** the physician's **<D]** **[A>** ANY COMPLETED **<A]** postgraduate **[D>** medical **<D]** education **[A>** OR OTHER PROFESSIONAL EDUCATION **<A]** required pursuant to the applicable licensure section of the general statutes;

(3) The area of the **[D>** physician's **<D]** **[A>** HEALTH CARE PROVIDER'S **<A]** practice specialty;

(4) The address of the **[D>** physician's **<D]** **[A>** HEALTH CARE PROVIDER'S **<A]** primary

practice location or primary practice locations, if more than one;

(5) A list of languages, other than English, spoken at the [D> physician's <D] [A> HEALTH CARE PROVIDER'S <A] primary practice locations;

(6) An indication of any disciplinary action taken against the [D> physician <D] [A> HEALTH CARE PROVIDER <A] by the department, the [A> APPROPRIATE <A] state board or any professional licensing or disciplinary body in another jurisdiction;

(7) Any current certifications issued to the [D> physician <D] [A> HEALTH CARE PROVIDER <A] by a specialty board of the [D> American Board of Medical Specialties <D] [A> PROFESSION <A] ;

(8) The hospitals and nursing homes at which the [D> physician has admitting <D] [A> HEALTH CARE PROVIDER HAS BEEN GRANTED <A] privileges;

(9) Any appointments of the [D> physician <D] [A> HEALTH CARE PROVIDER <A] to [A> A <A] Connecticut medical school [D> faculties <D] [A> FACULTY <A] and an indication as to whether the [D> physician <D] [A> HEALTH CARE PROVIDER <A] has current responsibility for graduate medical education;

(10) A listing of the [D> physician's <D] [A> HEALTH CARE PROVIDER'S <A] publications in peer reviewed literature;

(11) A listing of the [D> physician's <D] [A> HEALTH CARE PROVIDER'S <A] professional services, activities aud awards;

(12) Any hospital disciplinary actions against the [D> physician <D] [A> HEALTH CARE PROVIDER <A] that resulted, within the past ten years, in the termination or revocation of the [D> physician's <D] [A> HEALTH CARE PROVIDER'S <A] hospital privileges for a [D> medical <D] [A> PROFESSIONAL <A] disciplinary cause or reason, or the resignation from, or nonrenewal of, [D> medical <D] [A> PROFESSIONAL <A] staff membership or the restriction of privileges at a hospital taken in lieu of or in settlement of a pending disciplinary case related to [D> medical <D] [A> PROFESSIONAL <A] competence in such hospital;

(13) A description of any criminal conviction of the [D> physician <D] [A> HEALTH CARE PROVIDER <A] for a felony within the last ten years. For the purposes of this subdivision, a [D> physician <D] [A> HEALTH CARE PROVIDER <A] shall be deemed to be convicted of a felony if the [D> physician <D] [A> HEALTH CARE PROVIDER <A] pleaded guilty or was found or adjudged guilty by a court of competent jurisdiction or has been convicted of a felony by the entry of a plea of nolo contendere;

(14) To the extent available, and consistent with the provisions of subsection (c) of this section, all [D> medical <D] [A> PROFESSIONAL <A] malpractice court judgments and all [D> medical <D] [A> PROFESSIONAL <A] malpractice arbitration awards against the [D>

physician <D] [A> HEALTH CARE PROVIDER <A] in which a payment was awarded to a complaining party during the last ten years, and all settlements of [D> medical <D] [A> PROFESSIONAL <A] malpractice claims against the [D> physician <D] [A> HEALTH CARE PROVIDER <A] in which a payment was made to a complaining party within the last ten years;

(15) An indication as to whether the [D> physician <D] [A> HEALTH CARE PROVIDER <A] is actively involved in patient care; and

(16) The name of the [D> physician's <D] [A> HEALTH CARE PROVIDER'S <A] professional liability insurance carrier.

(c) Any report of a [D> medical <D] [A> PROFESSIONAL <A] malpractice judgment or award against a [D> physician <D] [A> HEALTH CARE PROVIDER <A] made under subdivision (14) of subsection (b) of this section shall comply with the following: (1) Dispositions of paid claims shall be reported in a minimum of three graduated categories indicating the level of significance of the award or settlement; (2) information concerning paid [D> medical <D] [A> PROFESSIONAL <A] malpractice claims shall be placed in context by comparing an individual [D> physician's medical <D] [A> HEALTH CARE PROVIDER'S PROFESSIONAL <A] malpractice judgments, awards and settlements to the experience of other [D> physicians <D] [A> HEALTH CARE PROVIDERS <A] licensed in Connecticut who perfonn procedures and treat patients with a similar degree of risk; (3) all judgment award and settlement information reported shall be limited to amounts actually paid by or on behalf of the [D> physician <D] [A> HEALTH CARE PROVIDER <A] ; and (4) comparisons of [A> PROFESSIONAL <A] malpractice payment data shall be accompanied by (A) an explanation of the fact that [D> physicians <D] [A> HEALTH CARE PROVIDERS <A] treating certain patients and performing certain procedures are more likely to be the subject of litigation than others and that the comparison given is for [D> physicians <D] [A> HEALTH CARE PROVIDERS <A] who perform procedures and treat patients with a similar degree of risk; (B) a statement that the report reflects data for the last ten years and the recipient should take into account the number of years the [D> physician <D] [A> HEALTH CARE PROVIDER <A] has been in practice when considering the data; (C) an explanation that an incident giving rise to a [A> PROFESSIONAL <A] malpractice claim may have occurred years before any payment was made due to the time lawsuits take to move through the legal system; (D) an explanation of the effect of treating high-risk patients on a [D> physician's <D] [A> HEALTH CARE PROVIDER'S PROFESSIONAL <A] malpractice history; and (E) an explanation that [A> PROFESSIONAL <A] malpractice cases may be settled for reasons other than liability and that settlements are sometimes made by the insurer without the [D> physician's <D] [A> HEALTH CARE PROVIDER'S <A] consent. Information concerning all settlements shall be accompanied by the following statement: "Settlement of a claim may occur for a variety of reasons that do not necessarily reflect negatively on the professional competence or conduct of the [D> physician <D] [A> HEALTH CARE PROVIDER <A] . A payment in settlement of a [D> medical <D] [A> PROFESSIONAL <A] malpractice action or claim should not be construed as creating a presumption that [D> medical <D] [A> PROFESSIONAL <A] malpractice has occurred."

(d) Pending [A> PROFESSIONAL <A] malpractice claims against a [D> physician <D] [A>

HEALTH CARE PROVIDER <A] and actual amounts paid by or on behalf of a [D> physician <D] [A> HEALTH CARE PROVIDER <A] in connection with a [A> PROFESSIONAL <A] malpractice judgment, award or settlement shall not be disclosed by the department to the public. This subsection shall not be construed to prevent the department from investigating and disciplining a [D> physician <D] [A> HEALTH CARE PROVIDER <A] on the basis of [D> medical <D] [A> PROFESSIONAL <A] malpractice claims that are pending.

(e) Prior to the initial release of a [D> physician's <D] [A> HEALTH CARE PROVIDER'S <A] profile to the public, the department shall provide the [D> physician <D] [A> HEALTH CARE PROVIDER <A] with a copy of the [D> physician's <D] [A> HEALTH CARE PROVIDER'S <A] profile. Additionally, any amendments or modifications to the profile that were not supplied by the [D> physician <D] [A> HEALTH CARE PROVIDER <A] or not generated by the department itself shall be provided to the [D> physician <D] [A> HEALTH CARE PROVIDER <A] for review prior to release to the public. A [D> physician <D] [A> HEALTH CARE PROVIDER <A] shall have sixty days from the date the department mails or delivers the prepublication copy to dispute the accuracy of any information that the department proposes to include in such profile and to submit a written statement setting forth the basis for such dispute. If a [D> physician <D] [A> HEALTH CARE PROVIDER <A] does not notify the department that the [D> physician <D] [A> HEALTH CARE PROVIDER <A] disputes the accuracy of such information within such sixty-day period, the department shall make the profile available to the public and the [D> physician <D] [A> HEALTH CARE PROVIDER <A] shall be deemed to have approved the profile and all information contained [D> therein <D] [A> IN THE PROFILE <A] . If a [D> physician <D] [A> HEALTH CARE PROVIDER <A] notifies the department that the [D> physician <D] [A> HEALTH CARE PROVIDER <A] disputes the accuracy of such information in accordance with this subsection, the [D> physician's <D] [A> HEALTH CARE PROVIDER'S <A] profile shall be released to the public without the disputed information, but with a statement to the effect that information in the identified category is currently the subject of a dispute and is therefore not currently available. Not later than thirty days after the department's receipt of notice of a dispute, the department shall review any information submitted by the [D> physician <D] [A> HEALTH CARE PROVIDER <A] in support of such dispute and determine whether to amend the information contained in the profile. In the event that the department determines not to amend the disputed information, the disputed information shall be included in the profile with a statement that such information is disputed by the [D> physician <D] [A> HEALTH CARE PROVIDER <A] .

(f) A [D> physician <D] [A> HEALTH CARE PROVIDER <A] may elect to have the [D> physician's <D] [A> HEALTH CARE PROVIDER'S <A] profile omit information provided pursuant to subdivisions (9) to (11), inclusive, of subsection (b) of this section. In collecting information for such profiles and in the dissemination of such profiles, the department shall inform [D> physicians <D] [A> HEALTH CARE PROVIDERS <A] that they may choose not to provide the information described in said subdivisions (9) to (11), inclusive.

(g) Each profile created pursuant to this section shall include the following statement: "This profile contains information that may be used as a starting point in evaluating [D> the physician <D] [A> A HEALTH CARE PROVIDER <A] . This profile should not, however, be your sole

basis for selecting a [D> physician <D] [A> HEALTH CARE PROVIDER <A] ."

(h) The department shall maintain a web site on the Internet for use by the public in obtaining profiles of [D> physicians <D] [A> HEALTH CARE PROVIDERS <A] .

(i) No state law that would otherwise prohibit, limit or penalize disclosure of information about a [D> physician <D] [A> HEALTH CARE PROVIDER <A] shall apply to disclosure of information required by this section.

(j) All information provided by a [D> physician <D] [A> HEALTH CARE PROVIDER <A] pursuant to this section shall be subject to the [D> penalties of <D] [A> PENALTY FOR <A] false statement [D> , pursuant to <D] [A> UNDER <A] section 53a-157b.

(k) Except for the information in subdivisions (1), (2), (10) and (11) of subsection (b) of this section, a [D> physician <D] [A> HEALTH CARE PROVIDER <A] shall notify the department of any changes to the information required in [D> said <D] subsection (b) [A> OF THIS SECTION <A] not later than sixty days after such change.

§ 20-13k. Guidelines for disciplinary action.

Not later than January 1, 2006, the Department of Public Health, with the advice and assistance of the Connecticut Medical Examining Board and relevant medical professional associations, shall establish guidelines for use in the disciplinary process. Such guidelines shall include, but need not be limited to: (1) Identification of each type of violation; (2) a range of penalties for each type of violation; (3) additional optional conditions that may be imposed by the board for each violation; (4) identification of factors the board shall consider in determining what penalty should apply; (5) conditions, such as mitigating factors or other facts, that may be considered in allowing deviations from the guidelines; and (6) a provision that when a deviation from the guidelines occurs, the reason for the deviation shall be identified. Such guidelines shall not be considered regulations, as defined in section 4-166.

History:

(P.A. 05-275, S. 17.)

Conn. Gen. Stat. § 20-13l. Notification of criminal charges against physicians. Investigation.

The Office of the Chief State's Attorney shall notify the Department of Public Health immediately, in writing, when criminal charges are brought against a physician licensed by the department for (1) reckless endangerment within the scope of the physician's medical practice, (2) manslaughter, or (3) murder. Upon such notification, the department may initiate an investigation of the physician to determine whether any disciplinary action should be taken against the physician, including possible suspension of his or her license, while such criminal

charges are pending against the physician.

History:

(P.A. 05-67, S. 1.)

Conn. Gen. Stat. § 20-14. Exceptions. Prescription in English. Penalties.

No provision of this section, sections 20-8, 20-9 to 20-13, inclusive, or 20-14a shall be construed to repeal or affect any of the provisions of any private charter, or to apply to licensed pharmacists. All physicians or surgeons and all physician assistants practicing under the provisions of this chapter shall, when requested, write a duplicate of their prescriptions in the English language. Any person who violates any provision of this section regarding prescriptions shall be fined ten dollars for each offense. Any person who violates any provision of section 20-9 shall be fined not more than five hundred dollars or be imprisoned not more than five years or be both fined and imprisoned. For the purposes of this section, each instance of patient contact or consultation which is in violation of any provision of section 20-9 shall constitute a separate offense. Failure to renew a license in a timely manner shall not constitute a violation for the purposes of this section. Any person who swears to any falsehood in any statement required by section 20-10, 20-12, 20-12b or 20-12c to be filed with the Department of Public Health shall be guilty of false statement.

History:

(1949 Rev., S. 4368; 1969, P.A. 117; 1971, P.A. 871, S. 97; P.A. 77-614, S. 323, 610; P.A. 84-526, S. 1; P.A. 90-211, S. 11, 23; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58.)

Conn. Gen. Stat. § 20-14a. Prescription of drugs by generic name. Disclosure to patient. Labeling.

(a) For the purposes of this section, "brand name" means the name the manufacturer places upon a drug or pharmaceutical or on its container, label, or wrapping at the time of packaging; and "generic name" means the chemical name or formula or the established name designated in the official United States Pharmacopoeia, official Homeopathic Pharmacopoeia of the United States, or official National Formulary, or any supplement to any of them.

(b) Any physician, surgeon or other person authorized to prescribe drugs within this state, who prescribes a drug, shall in each such prescription, oral or written, include the generic name thereof, if any, unless such physician, surgeon or other person authorized to prescribe drugs, in the exercise of his professional judgment, prescribes a specific brand name drug. The physician, surgeon or other person so authorized shall state to the patient for whom a drug is being prescribed, or to his parent or guardian, the name of the drug or medicine being prescribed, either orally or in writing, and all licensed pharmacists dispensing prescriptions and all health care institutions or facility pharmacies shall label the container containing said medication or prescription with the name as provided by the physician, surgeon or other person so authorized,

the strength of each dose prescribed and the date of refill if said prescription is a refill, except if the physician, surgeon or other person so authorized expressly forbids the placing of said drug or medicine name on the prescription label or package. On all prescriptions, whether or not a generic name is stated, the physician, surgeon or other person so authorized shall, if the patient is over the age of sixty-five, include a notation to that effect.

(c) It is declared to be the public policy of this state that generic name of drugs be used in prescriptions wherever feasible.

History:

(1972, P.A. 15, S. 1-3; June, 1972, P.A. 1, S. 1; P.A. 73-242.)

Conn. Gen. Stat. § 20-14b. Renewal of licenses.

Licenses issued under this chapter shall be renewed annually, on and after January 1, 1981, in accordance with the provisions of section 19a-88.

History:

(P.A. 80-484, S. 14, 176.)

Conn. Gen. Stat. § 20-14c. Dispensing and labeling of drugs. Definitions.

As used in this section and sections 20-14d to 20-14g, inclusive, and section 20-12d:

(1) "Dispense" has the same meaning as provided in section 20-571.

(2) "Drug" means a legend drug, as defined in section 20-571, or a controlled drug, as defined in section 21a-240.

(3) "Prescribing practitioner" means a physician, dentist, podiatrist, optometrist, physician assistant, advanced practice registered nurse, nurse-midwife or veterinarian licensed by the state of Connecticut and authorized to prescribe medication within the scope of such person's practice.

(4) "Professional samples" means complimentary starter dose drugs packaged in accordance with federal and state statutes and regulations that are provided to a prescribing practitioner free of charge by a manufacturer or distributor and distributed free of charge by the prescribing practitioner to such prescribing practitioner's patients.

History:

(P.A. 85-545, S. 1, 6; P.A. 89-389, S. 13, 22; P.A. 90-211, S. 12, 23; P.A. 92-88, S. 2; P.A. 95-264, S. 49; P.A. 99-102, S. 20; 99-175, S. 1.)

Conn. Gen. Stat. § 20-14d. Dispensing of drugs by licensed practitioners to be in accordance with sections 20-14c to 20-14g, inclusive.

Notwithstanding any provision of the general statutes, no drug may be dispensed by a prescribing practitioner except in accordance with the provisions of this section and sections 20-14c, 20-14f and 20-14g.

History:

(P.A. 85-545, S. 2, 6; P.A. 95-264, S. 65; P.A. 99-175, S. 2.)

Conn. Gen. Stat. § 20-14e. Dispensing of drugs.

(a) A drug dispensed by a prescribing practitioner shall be personally dispensed by the prescribing practitioner and the dispensing of such drug shall not be delegated except that, in emergency departments of acute care hospitals licensed under chapter 368v, the tasks related to dispensing such drug may be carried out by a nurse licensed pursuant to chapter 378 under the supervision of the prescribing practitioner.

(b) A patient's medical record shall include a complete record of any drug dispensed by the prescribing practitioner.

(c) A prescribing practitioner dispensing a drug shall package the drug in containers approved by the federal Consumer Product Safety Commission, unless requested otherwise by the patient, and shall label the container with the following information: (1) The full name of the patient; (2) the prescribing practitioner's full name and address; (3) the date of dispensing; (4) instructions for use; and (5) any cautionary statements as may be required by law.

(d) Professional samples dispensed by a prescribing practitioner shall be exempt from the requirements of subsection (c) of this section.

History:

(P.A. 85-545, S. 3, 6; P.A. 95-264, S. 50; P.A. 99-80, S. 2; 99-175, S. 3.)

Conn. Gen. Stat. § 20-14f. Report to commissioner of intent to continue to dispense drugs other than professional samples.

A prescribing practitioner who, as part of his practice, dispenses any drug other than professional samples shall notify the Commissioner of Consumer Protection that he is engaged in the dispensing of drugs and shall, biennially, upon the date of renewal of the controlled substance registration required by section 21a-317, inform the commissioner of his intent to continue to dispense drugs to his patients.

History:

(P.A. 85-545, S. 4; P.A. 95-264, S. 66; June 30 Sp. Sess. P.A. 03-6, S. 146(c); P.A. 04-189, S. 1.)

Conn. Gen. Stat. § 20-14g. Regulations.

The Commissioner of Consumer Protection, with the advice and assistance of the Commission of Pharmacy, may adopt regulations, in accordance with chapter 54, to carry out the provisions of sections 20-14c to 20-14f, inclusive.

History:

(P.A. 85-545, S. 5, 6; P.A. 99-175, S. 4; June 30 Sp. Sess. P.A. 03-6, S. 146(c); P.A. 04-189, S. 1.)

Conn. Gen. Stat. § 20-14h. Definitions.

As used in sections 20-14h to 20-14j, inclusive:

(1) "Administration" means the direct application of a medication by means other than injection to the body of a person.

(2) "Day programs", "residential facilities" and "individual and family support" include only those programs, facilities and support services designated in the regulations adopted pursuant to section 20-14j.

(3) "Juvenile detention centers" include only those centers operated under the jurisdiction of the Judicial Department.

(4) "Medication" means any medicinal preparation, and includes any controlled substances specifically designated in the regulations or policies adopted pursuant to section 20-14j.

(5) "Trained person" means a person who has successfully completed training prescribed by the regulations or policies adopted pursuant to section 20-14j.

History:

(P.A. 87-433, S. 1, 4; P.A. 90-70, S. 1, 4; P.A. 05-150, S. 1.)

Conn. Gen. Stat. § 20-14i. Administration of medication by trained persons.

Any provisions to the contrary notwithstanding, chapter 378 shall not prohibit the administration of medication to persons attending day programs, residing in residential facilities or receiving individual and family support, under the jurisdiction of the Departments of Children and Families, Correction, Developmental Services and Mental Health and Addiction Services, or being detained in juvenile detention centers or residing in residential facilities dually licensed by

the Department of Children and Families and the Department of Public Health, when such medication is administered by trained persons, pursuant to the written order of a physician licensed under this chapter, a dentist licensed under chapter 379, an advanced practice registered nurse licensed to prescribe in accordance with section 20-94a or a physician assistant licensed to prescribe in accordance with section 20-12d, authorized to prescribe such medication. The provisions of this section shall not apply to institutions, facilities or programs licensed pursuant to chapter 368v.

History:

(P.A. 87-433, S. 2, 4; P.A. 90-70, S. 2, 4; P.A. 93-91, S. 1, 2; P.A. 96-19, S. 2; P.A. 04-257, S. 103; P.A. 05-150, S. 2; 05-246, S. 14; P.A. 07-73, S. 2(a).)

Conn. Gen. Stat. § 20-14j. Regulations. Advisory task force. Training programs and policies re administration of medication at juvenile detention centers.

(a) The commissioners of the departments which license the residential facilities, day programs or individual and family support services in which the administration of medication in accordance with section 20-14i is appropriate shall adopt regulations, in accordance with the provisions of chapter 54, to carry out the provisions of sections 20-14h and 20-14i. If licensing is not required, the regulations shall be adopted by the commissioners of the departments having authority over the persons served in such facilities or programs, or receiving individual and family support. Such regulations shall be adopted by each affected department in consultation with an advisory task force which shall include the Commissioner of Public Health, the Commissioner of Mental Health and Addiction Services, the Commissioner of Developmental Services, the Commissioner of Correction and the Commissioner of Children and Families, or their designees. The task force shall submit a report to the joint standing committee of the General Assembly having cognizance of matters relating to public health by November 1, 1988.

(b) The Chief Court Administrator shall (1) establish ongoing training programs for personnel who are to administer medications to detainees in juvenile detention centers, and (2) adopt policies to carry out the provisions of sections 20-14h and 20-14i concerning the administration of medication to detainees in juvenile detention centers.

History:

(P.A. 87-433, S. 3, 4; P.A. 90-70, S. 3, 4; P.A. 93-91, S. 1, 2; 93-381, S. 9, 39; P.A. 95-257, S. 11, 12, 21, 58; P.A. 05-150, S. 3; P.A. 07-73, S. 2(b).)

Conn. Gen. Stat. § 20-14k. Requirement for the posting of policy regarding Medicare assignment. Regulations.

Any physician licensed under this chapter shall post, in a conspicuous place, the policy regarding Medicare assignment and shall inform all eligible persons of such policy prior to the delivery of care and services. The Commissioner of Social Services shall adopt regulations in accordance

with the provisions of chapter 54 for purposes of this section.

History:

(P.A. 87-356, S. 1; P.A. 93-262, S. 1, 87; P.A. 99-102, S. 21.)

Conn. Gen. Stat. § 20-14ll. Delegation of ophthalmological services.

A physician licensed pursuant to this chapter, who specializes in ophthalmology, may delegate to an appropriately trained medical assistant the use or application of any ocular agent, provided such delegated service is performed only under the supervision, control and responsibility of the licensed physician. For purposes of this section, "appropriately trained medical assistant" means a medical assistant who has completed on-the-job training in the use and application of ocular agents under the supervision, control and responsibility of an employing, licensed physician, an affidavit in support of which shall be kept by the employing physician on the premises.

History:

(P.A. 05-36, S. 3.)

- **CHAPTER 371 OSTEOPATHY**

Conn. Gen. Stat. § 20-17 to 20-23. Licensure; qualifications for examination. Examination; qualifications to practice without examination. Permit for participation in intern or resident osteopathic physician program. Professional liability insurance required, when; amount of insurance; reporting requirements. List of approved colleges, schools and institutions. Grounds for disciplinary action. Osteopathy defined; osteopath authorized to practice medicine and surgery. Reports and certificates pertaining to public health. Penalty.

Sections 20-17 to 20-23, inclusive, are repealed, effective October 1, 1999.

History:

(1949 Rev., S. 4371-4377; 1955, S. 2194d; 1959, P.A. 616, S. 6, 7; 1961, P.A. 151; 1969, P.A. 125, S. 1, 2; June, 1971, P.A. 8, S. 42; 1972, P.A. 127, S. 38; 294, S. 23; P.A. 73-148; P.A. 75-268, S. 2; P.A. 76-113, S. 2, 3; P.A. 77-614, S. 360, 361, 610; P.A. 80-484, S. 18-20, 174, 176; P.A. 84-526, S. 2; P.A. 88-230, S. 1, 12; 88-362, S. 3-5; P.A. 89-251, S. 74, 203; P.A. 90-98, S. 1, 2; May Sp. Sess. P.A. 92-6, S. 19, 117; P.A. 93-142, S. 4, 7, 8; 93-381, S. 9, 39; P.A. 94-71, S. 2, 8; P.A. 95-220, S. 4-6; 95-257, S. 12, 21, 58; 95-271, S. 9-12, 40; P.A. 96-180, S. 65, 66, 166; P.A. 99-102, S. 51.)

Conn. Gen. Stat. § 20-28. Examination. Scope of practice.

(a) The examination provided for in section 20-27 shall consist of both a written and practical examination. The subjects of the written examination shall be as follows: Anatomy, physiology,

symptomatology, histology, vertebral palpation, principles of chiropractic and adjusting, chemistry, hygiene, pathology, dietetics and diagnosis. The national board tests of the National Board of Chiropractic Examiners may be accepted as the written examination provided it includes physiotherapy. The practical examination shall require the candidate to demonstrate clinical competency in basic chiropractic principles and procedures, including orthopedics, neurology, diagnosis, x-ray, vertebral palpation and adjustment.

(b) Any chiropractor who has complied with the provisions of this chapter may:

(1) Practice chiropractic as defined in section 20-24, but shall not prescribe for or administer to any person any medicine or drug included in materia medica, except vitamins, or perform any **surgery** or practice obstetrics or osteopathy;

(2) Examine, analyze and diagnose the human living body and its diseases, and use for diagnostic purposes the x-ray or any other general method of examination for diagnosis and analysis taught in any school or college of chiropractic which has been recognized and approved by the State Board of Chiropractic Examiners;

(3) Treat the human body by manual, mechanical, electrical or natural methods, including acupuncture, or by use of physical means, including light, heat, water or exercise in preparation for chiropractic adjustment or manipulation, and by the oral administration of foods, food concentrates, food extracts or vitamins;

(4) Administer first aid and, incidental to the care of the sick, advise and instruct patients in all matters pertaining to hygiene and sanitary measures as taught and approved by recognized chiropractic schools and colleges.

History:

(1949 Rev., S. 4381; P.A. 76-83, S. 2; P.A. 77-614, S. 323, 610; P.A. 81-471, S. 12, 71; P.A. 83-17, S. 2, 3; P.A. 96-225, S. 2, 4.)

- **CHAPTER 375 PODIATRY**

Conn. Gen. Stat. § 20-50a. Requirements for surgery.

Podiatric **surgery** requiring an anesthetic other than a local anesthetic shall be performed in a facility accredited by the Joint Commission on Accreditation of Healthcare Organizations or a free standing **surgery** center accredited by the Accreditation Association for Ambulatory Health Care, by a licensed podiatrist who is accredited by the credentials committee of the medical staff of such facility to perform podiatric **surgery** in conformance with rules promulgated by the chief of the surgical department of said facility taking into account the training, experience, demonstrated competence and judgment of each such licensed podiatrist, and such podiatrist shall comply with such rules. Podiatric **surgery** shall not include amputation of the leg or foot other than from the transmetatarsal level to the toes.

History:

(P.A. 91-113, S. 2; P.A. 97-213, S. 7.)

Conn. Gen. Stat. § 20-54. Qualifications for general practice, medical and nonsurgical treatment of the ankle and surgical treatment of the ankle. Permits. Exception for surgery under the direct supervision of a physician or surgeon. Regulations. Effect of permit on hospital privileges.

(a) No person other than those described in section 20-57 and those to whom a license has been reissued as provided by section 20-59 shall engage in the practice of podiatry in this state until such person has presented to the department satisfactory evidence that such person has received a diploma or other certificate of graduation from an accredited school or college of chiropody or podiatry approved by the Board of Examiners in Podiatry with the consent of the Commissioner of Public Health, nor shall any person so practice until such person has obtained a license from the Department of Public Health after meeting the requirements of this chapter. A graduate of an approved school of chiropody or podiatry subsequent to July 1, 1947, shall present satisfactory evidence that he or she has been a resident student through not less than four graded courses of not less than thirty-two weeks each in such approved school and has received the degree of D.S.C., Doctor of Surgical Chiropody, or Pod. D., Doctor of Podiatry, or other equivalent degree; and, if a graduate of an approved chiropody or podiatry school subsequent to July 1, 1951, that he or she has completed, before beginning the study of podiatry, a course of study of an academic year of not less than thirty-two weeks' duration in a college or scientific school approved by said board with the consent of the Commissioner of Public Health, which course included the study of chemistry and physics or biology; and if a graduate of an approved college of podiatry or podiatric medicine subsequent to July 1, 1971, that he or she has completed a course of study of two such prepodiatry college years, including the study of chemistry, physics or mathematics and biology, and that he or she received the degree of D.P.M., Doctor of Podiatric Medicine. No provision of this section shall be construed to prevent graduates of a podiatric college, approved by the Board of Examiners in Podiatry with the consent of the Commissioner of Public Health, from receiving practical training in podiatry in a residency program in an accredited hospital facility which program is accredited by the Council on Podiatric Education.

(b) A licensed podiatrist who is board qualified or certified by the American Board of Podiatric **Surgery** or the American Board of Podiatric Orthopedics and Primary Podiatric Medicine may engage in the medical and nonsurgical treatment of the ankle and the anatomical structures of the ankle, as well as the administration and prescription of drugs incidental thereto, and the nonsurgical treatment of manifestations of systemic diseases as they appear on the ankle. Such licensed podiatrist shall restrict treatment of displaced ankle fractures to the initial diagnosis and the initial attempt at closed reduction at the time of presentation and shall not treat tibial pilon fractures. For purposes of this section, "ankle" means the distal metaphysis and epiphysis of the tibia and fibula, the articular cartilage of the distal tibia and distal fibula, the ligaments that connect the distal metaphysis and epiphysis of the tibia and fibula and the talus, and the portions

of skin, subcutaneous tissue, fascia, muscles, tendons and nerves at or below the level of the myotendinous junction of the triceps surae.

(c) No licensed podiatrist may independently engage in the surgical treatment of the ankle, including the surgical treatment of the anatomical structures of the ankle, as well as the administration and prescription of drugs incidental thereto, and the surgical treatment of manifestations of systemic diseases as they appear on the ankle, until such licensed podiatrist has obtained a permit from the Department of Public Health after meeting the requirements set forth in subsection (d) or (e) of this section, as appropriate. No licensed podiatrist who applies for a permit to independently engage in the surgical treatment of the ankle shall be issued such permit unless (1) the commissioner is satisfied that the applicant is in compliance with all requirements set forth in subsection (d) or (e) of this section, as appropriate, and (2) the application includes payment of a fee in the amount of one hundred dollars. For purposes of this section, "surgical treatment of the ankle" does not include the performance of total ankle replacements or the treatment of tibial pilon fractures.

(d) The Department of Public Health may issue a permit to independently engage in standard ankle **surgery** procedures to any licensed podiatrist who: (1) (A) Graduated on or after June 1, 2006, from a three-year residency program in podiatric medicine and **surgery** that was accredited by the Council on Podiatric Medical Education, or its successor organization, at the time of graduation, and (B) holds and maintains current board certification in reconstructive rearfoot ankle **surgery** by the American Board of Podiatric **Surgery**, or its successor organization; (2) (A) graduated on or after June 1, 2006, from a three-year residency program in podiatric medicine and **surgery** that was accredited by the Council on Podiatric Medical Education, or its successor organization, at the time of graduation, (B) is board qualified, but not board certified, in reconstructive rearfoot ankle **surgery** by the American Board of Podiatric **Surgery**, or its successor organization, and (C) provides documentation satisfactory to the department that such licensed podiatrist has completed acceptable training and experience in standard or advanced midfoot, rearfoot and ankle procedures; or (3) (A) graduated before June 1, 2006, from a residency program in podiatric medicine and **surgery** that was at least two years in length and was accredited by the Council on Podiatric Medical Education at the time of graduation, (B) holds and maintains current board certification in reconstructive rearfoot ankle **surgery** by the American Board of Podiatric **Surgery**, or its successor organization, and (C) provides documentation satisfactory to the department that such licensed podiatrist has completed acceptable training and experience in standard or advanced midfoot, rearfoot and ankle procedures; except that a licensed podiatrist who meets the qualifications of subdivision (2) of this subsection may not perform tibial and fibular osteotomies until such licensed podiatrist holds and maintains current board certification in reconstructive rearfoot ankle **surgery** by the American Board of Podiatric Medicine, or its successor organization. For purposes of this subsection, "standard ankle **surgery** procedures" includes soft tissue and osseous procedures.

(e) The Department of Public Health may issue a permit to independently engage in advanced ankle **surgery** procedures to any licensed podiatrist who has obtained a permit under subsection (d) of this section, or who meets the qualifications necessary to obtain a permit under said

subsection (d), provided such licensed podiatrist: (1) (A) Graduated on or after June 1, 2006, from a three-year residency program in podiatric medicine and **surgery** that was accredited by the Council on Podiatric Medical Education, or its successor organization, at the time of graduation, (B) holds and maintains current board certification in reconstructive rearfoot ankle **surgery** by the American Board of Podiatric **Surgery**, or its successor organization, and (C) provides documentation satisfactory to the department that such licensed podiatrist has completed acceptable training and experience in advanced midfoot, rearfoot and ankle procedures; or (2) (A) graduated before June 1, 2006, from a residency program in podiatric medicine and **surgery** that was at least two years in duration and was accredited by the Council on Podiatric Medical Education at the time of graduation, (B) holds and maintains current board certification in reconstructive rearfoot ankle **surgery** by the American Board of Podiatric **Surgery**, or its successor organization, and (C) provides documentation satisfactory to the department that such licensed podiatrist has completed acceptable training and experience in advanced midfoot, rearfoot and ankle procedures. For purposes of this subsection, "advanced ankle **surgery** procedures" includes ankle fracture fixation, ankle fusion, ankle arthroscopy, insertion or removal of external fixation pins into or from the tibial diaphysis at or below the level of the myotendinous junction of the triceps surae, and insertion and removal of retrograde tibiotalocalcaneal intramedullary rods and locking screws up to the level of the myotendinous junction of the triceps surae, but does not include the surgical treatment of complications within the tibial diaphysis related to the use of such external fixation pins.

(f) A licensed podiatrist who (1) graduated from a residency program in podiatric medicine and **surgery** that was at least two years in duration and was accredited by the Council on Podiatric Medical Education, or its successor organization, at the time of graduation, and (2) (A) holds and maintains current board certification in reconstructive rearfoot ankle **surgery** by the American Board of Podiatric **Surgery**, or its successor organization, (B) is board qualified in reconstructive rearfoot ankle **surgery** by the American Board of Podiatric **Surgery**, or its successor organization, or (C) is board certified in foot and ankle **surgery** by the American Board of Podiatric **Surgery**, or its successor organization, may engage in the surgical treatment of the ankle, including standard and advanced ankle **surgery** procedures, without a permit issued by the department in accordance with subsection (d) or (e) of this section, provided such licensed podiatrist is performing such procedures under the direct supervision of a physician or surgeon licensed under chapter 370 who maintains hospital privileges to perform such procedures or under the direct supervision of a licensed podiatrist who has been issued a permit under the provisions of subsection (d) or (e) of this section, as appropriate, to independently engage in standard or advanced ankle **surgery** procedures.

(g) The Commissioner of Public Health shall appoint an advisory committee to assist and advise the commissioner in evaluating applicants' training and experience in midfoot, rearfoot and ankle procedures for purposes of determining whether such applicants should be permitted to independently engage in standard or advanced ankle **surgery** procedures pursuant to subsection (d) or (e) of this section. The advisory committee shall consist of four members, two of whom shall be podiatrists recommended by the Connecticut Podiatric Medical Association and two of whom shall be orthopedic surgeons recommended by the Connecticut Orthopedic Society.

(h) The Commissioner of Public Health shall adopt regulations, in accordance with chapter 54, to implement the provisions of subsections (c) to (f), inclusive, of this section. Such regulations shall include, but not be limited to, the number and types of procedures required for an applicant's training or experience to be deemed acceptable for purposes of issuing a permit under subsection (d) or (e) of this section. In identifying the required number and types of procedures, the commissioner shall seek the advice and assistance of the advisory committee appointed under subsection (g) of this section and shall consider nationally recognized standards for accredited residency programs in podiatric medicine and **surgery** for midfoot, rearfoot and ankle procedures. The commissioner may issue permits pursuant to subsections (c) to (e), inclusive, of this section prior to the effective date of any regulations adopted pursuant to this section.

(i) The Department of Public Health's issuance of a permit to a licensed podiatrist to independently engage in the surgical treatment of the ankle shall not be construed to obligate a hospital or outpatient surgical facility to grant such licensed podiatrist privileges to perform such procedures at the hospital or outpatient surgical facility.

History:

(1949 Rev., S. 4552, 4556; 1949, S. 2274d; 1955, S. 2273d; 1963, P.A. 247; 1971, P.A. 124; 1972, P.A. 232; P.A. 76-113, S. 4; P.A. 77-614, S. 323, 610; P.A. 80-484, S. 25, 176; P.A. 81-472, S. 133, 159; P.A. 91-113, S. 3; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58; P.A. 06-160, S. 1; P.A. 07-252, S. 25, 34.)

Conn. Gen. Stat. § 20-59. Disciplinary action by board; grounds.

The board may take any of the actions set forth in section 19a-17 for any of the following reasons: (1) Procurement of a license by fraud or material deception; (2) conviction in a court of competent jurisdiction, either within or without this state, of any crime in the practice of podiatry; (3) fraudulent or deceptive conduct in the course of professional services or activities; (4) illegal or incompetent or negligent conduct in the practice of podiatry; (5) habitual intemperance in the use of spirituous stimulants or addiction to the use of morphine, cocaine or other drugs having a similar effect; (6) aiding and abetting the practice of podiatry by an unlicensed person or a person whose license has been suspended or revoked; (7) mental illness or deficiency of the practitioner; (8) physical illness or loss of motor skill, including but not limited to, deterioration through the aging process, of the practitioner; (9) undertaking or engaging in any medical practice beyond the privileges and rights accorded to the practitioner of podiatry by the provisions of this chapter; (10) failure to maintain professional liability insurance or other indemnity against liability for professional malpractice as provided in subsection (a) of section 20-58a; (11) independently engaging in the performance of ankle **surgery** procedures without a permit, in violation of section 20-54; or (12) violation of any provision of this chapter or any regulation adopted hereunder. The Commissioner of Public Health may order a license holder to submit to a reasonable physical or mental examination if his physical or mental capacity to practice safely is the subject of an investigation. Said commissioner may petition the superior court for the judicial district of Hartford to enforce such order or any action taken pursuant to section 19a-17. The clerk of any court in this state in which a person practicing podiatry has been

convicted of any crime shall, upon such conviction, make written report, in duplicate, to the Department of Public Health of the name and residence of such person, the crime of which such person was convicted and the date of conviction; and said department shall forward one of such duplicate reports to the board.

History:

(1949 Rev., S. 4559; P.A. 77-614, S. 379, 610; P.A. 80-484, S. 28, 176; P.A. 81-471, S. 21, 71; P.A. 88-230, S. 1, 12; P.A. 90-98, S. 1, 2; P.A. 93-142, S. 4, 7, 8; 93-381, S. 9, 39; P.A. 94-71, S. 11; P.A. 95-220, S. 4-6; 95-257, S. 12, 21, 58; P.A. 07-252, S. 35.)

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Sec. 4. Section 20-59 of the 2008 supplement to the general statutes is repealed and the following is substituted in lieu thereof (Effective January 1, 2010):

The board may take any of the actions set forth in section 19a-17 **[A>** OF THE 2008 SUPPLEMENT TO THE GENERAL STATUTES **<A]** for any of the following reasons: (1) Procurement of a license by fraud or material deception; (2) conviction in a court of competent jurisdiction, either within or without this state, of any crime in the practice of podiatry; (3) fraudulent or deceptive conduct in the course of professional services or activities; (4) illegal or incompetent or negligent conduct in the practice of podiatry; (5) habitual intemperance in the use of spirituous stimulants or addiction to the use of morphine, cocaine or other drugs having a similar effect; (6) aiding and abetting the practice of podiatry by an unlicensed person or a person whose license has been suspended or revoked; (7) mental illness or deficiency of the practitioner; (8) physical illness or loss of motor skill, including **[A>** , **<A]** but not limited to, deterioration through the aging process, of the practitioner; (9) undertaking or engaging in any medical practice beyond the privileges and rights accorded to the practitioner of podiatry by the provisions of this chapter; (10) failure to maintain professional liability insurance or other indemnity against liability for professional malpractice as provided in subsection (a) of section 20-58a; (11) independently engaging in the performance of ankle **surgery** procedures without a permit, in violation of section 20-54 **[A>** OF THE 2008 SUPPLEMENT TO THE GENERAL STATUTES **<A]** ; **[D>** or **<D]** (12) violation of any provision of this chapter or any regulation adopted hereunder **[A>** ; OR (13) FAILURE TO PROVIDE INFORMATION TO THE DEPARTMENT OF PUBLIC HEALTH REQUIRED TO COMPLETE A HEALTH CARE PROVIDER PROFILE, AS SET FORTH IN SECTION 20-13J, AS AMENDED BY THIS ACT **<A]** . The Commissioner of Public Health may order a license holder to submit to a reasonable physical or mental examination if his physical or mental capacity to practice safely is the subject of an investigation. Said commissioner may petition the superior court for the judicial district of Hartford to enforce such order or any action taken pursuant to section 19a-17 **[A>** OF THE 2008 SUPPLEMENT TO THE GENERAL STATUTES **<A]** . The clerk of any court in this state in which a person practicing podiatry has been convicted of any crime shall, upon such conviction, make written report, in duplicate, to the Department of Public Health of the name and residence of such person, the crime of which such person was convicted and the date of conviction; and said department shall forward one of such duplicate reports to the board.

Conn. Gen. Stat. § 20-65. Penalty.

Any person, except a licensed podiatrist, a licensed natureopathic physician or a physician licensed to practice medicine or surgery, who practices or attempts to practice podiatry, or any person who buys, sells or fraudulently obtains any diploma or license to practice podiatry, or any person who uses the title "podiatrist" or any word or title to induce the belief that such person is engaged in the practice of podiatry, without complying with the provisions of this chapter, upon the first conviction shall be fined not more than five hundred dollars or imprisoned not more than five years or be both fined and imprisoned, except that nothing herein contained shall be construed to prohibit or restrict the sale or fitting of corrective, orthopedic or arch-supporting shoes or commercial foot appliances by retail merchants and no such retail merchant shall be permitted to practice podiatry without being licensed for such practice. For the purposes of this section, each instance of patient contact or consultation that is in violation of any provision of this chapter shall constitute a separate offense. Failure to renew a license in a timely manner shall not constitute a violation for the purposes of this section.

History:

(1949 Rev., S. 4567; P.A. 84-526, S. 5; P.A. 99-102, S. 23.)

- **CHAPTER 375a ATHLETIC TRAINING**

Conn. Gen. Stat. § 20-65f. Definitions.

As used in this chapter:

(1) "Athletic training" means the application or provision, with the consent and under the direction of a health care provider, of (A) principles, methods and procedures of evaluation, prevention, treatment and rehabilitation of athletic injuries sustained by athletes, (B) appropriate preventative and supportive devices, temporary splinting and bracing, physical modalities of heat, cold, light massage, water, electric stimulation, sound, exercise and exercise equipment, (C) the organization and administration of athletic training programs, and (D) education and counseling to athletes, coaches, medical personnel and athletic communities in the area of the prevention and care of athletic injuries. For purposes of this subdivision, "health care provider" means a person licensed to practice medicine or **surgery** under chapter 370, chiropractic under chapter 372, podiatry under chapter 375 or natureopathy under chapter 373;

(2) "Athletic injury" means any injury sustained by an athlete as a result of such athlete's participation in exercises, sports, games or recreation requiring strength, agility, flexibility, range of motion, speed or stamina, or any comparable injury that prevents such athlete from participating in any such activities;

(3) "Athlete" means any person who is a member of any professional, amateur, school or other sports team, or is a regular participant in sports or recreational activities, including, but not limited to, training and practice activities, that require strength, agility, flexibility, range of

motion, speed or stamina. For purposes of this subdivision, "regular" means not less than three times per week;

(4) "Standing orders" means written protocols, recommendations and guidelines for treatment and care, furnished and signed by a health care provider specified under subdivision (1) of this section, to be followed in the practice of athletic training that may include, but not be limited to, (A) appropriate treatments for specific athletic injuries, (B) athletic injuries or other conditions requiring immediate referral to a licensed health care provider, and (C) appropriate conditions for the immediate referral to a licensed health care provider of injured athletes of a specified age or age group;

(5) "Commissioner" means the Commissioner of Public Health.

History:

(P.A. 00-226, S. 1, 20.)

- **CHAPTER 376 PHYSICAL THERAPISTS**

Conn. Gen. Stat. § 20-66. Definitions.

As used in this chapter, unless the context otherwise requires:

(1) "Physical therapist" means a person licensed to practice physical therapy in this state;

(2) "Physical therapy" means the evaluation and treatment of any person by the employment of the effective properties of physical measures, the performance of tests and measurements as an aid to evaluation of function and the use of therapeutic exercises and rehabilitative procedures, with or without assistive devices, for the purpose of preventing, correcting or alleviating a physical or mental disability. "Physical therapy" includes the establishment and modification of physical therapy programs, treatment planning, instruction, wellness care, peer review and consultative services, but does not include **surgery**, the prescribing of drugs, the development of a medical diagnosis of disease, injury or illness, the use of cauterization or the use of Roentgen rays or radium for diagnostic or therapeutic purposes;

(3) "Physical therapist assistant" means a person licensed to assist in the practice of physical therapy in this state under the supervision of a physical therapist. For purposes of this subdivision and subdivision (2) of subsection (a) of section 20-73, "supervision" means the overseeing of or the participation in the work of a physical therapist assistant by a licensed physical therapist, including, but not limited to: (A) Continuous availability of direct communication between the physical therapist assistant and a licensed physical therapist; (B) availability of a licensed physical therapist on a regularly scheduled basis to (i) review the practice of the physical therapist assistant, and (ii) support the physical therapist assistant in the performance of the physical therapist assistant's services; and (C) a predetermined plan for

emergency situations, including the designation of an alternate licensed physical therapist in the absence of the regular licensed physical therapist;

(4) "Assist in the practice of physical therapy" means the treatment of any person by the employment of the effective properties of physical measures and the use of therapeutic exercises and rehabilitative procedures, with or without assistive devices, for the purpose of preventing, correcting or alleviating a physical or mental disability, but does not include the interpretation of referrals, initial or discharge evaluation or assessment, or determination or modification of treatment or discharge plans; and

(5) "Wellness care" means services related to conditioning, strength training, fitness, workplace ergonomics or injury prevention.

History:

(1949 Rev., S. 4398; 1953, S. 2201d; P.A. 73-579, S. 1; P.A. 80-336, S. 1; P.A. 82-472, S. 75, 183; P.A. 89-307, S. 1; P.A. 93-110, S. 4, 5; 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58; 95-299, S. 2; P.A. 96-174, S. 1, 3; P.A. 99-249, S. 6, 10; P.A. 00-226, S. 12, 20; P.A. 03-209, S. 1, 2; P.A. 06-125, S. 1.)

Conn. Gen. Stat. § 20-73. Licensure required for practice and use of title. Practice regulated. Fraud in obtaining licensure. Revocation of license.

(a)(1) No person may practice as a physical therapist unless licensed pursuant to this chapter. No person may use the term "Registered Physical Therapist", "Licensed Physical Therapist" or "Physical Therapist" or the letters "R.P.T.", "L.P.T." or any other letters, words or insignia indicating or implying licensure as a physical therapist in this state unless the person is so licensed.

(2) No person may practice as a physical therapist assistant unless such person is licensed pursuant to this chapter and is under the supervision of a physical therapist licensed pursuant to this chapter. No person may use the term "Registered Physical Therapist Assistant", "Licensed Physical Therapist Assistant" or "Physical Therapist Assistant", or the letters "P.T.A." to represent or imply the term "Physical Therapist Assistant", or any other letters, words or insignia indicating or implying licensure as a physical therapist assistant in this state unless the person is so licensed.

(b) (1) The treatment of human ailments by physical therapy shall only be performed by a person licensed under the provisions of this chapter as a physical therapist or physical therapist assistant. Except as otherwise provided in subdivisions (2) and (3) of this subsection, such treatment may be performed by a licensed physical therapist without an oral or written referral by a person licensed in this state to practice medicine and **surgery**, podiatry, naturopathy, chiropractic or dentistry, or an advanced practice registered nurse licensed to prescribe in accordance with section 20-94a or a physician assistant licensed to prescribe in accordance with section 20-12d, provided the licensed physical therapist (A) was admitted to a bachelor's degree program prior to

January 1, 1998, and has practiced physical therapy for at least four out of the most recent six years of his or her clinical practice, or earned a master's degree or higher in physical therapy from an accredited institution of higher education, (B) requires any person receiving such treatment to disclose or affirmatively confirm the identity of such person's primary care provider or health care provider of record upon each initial visit for treatment without an oral or written referral, (C) provides information to any person seeking such treatment regarding the need to consult with such person's primary care provider or health care provider of record regarding such person's underlying medical condition if the condition is prolonged, does not improve within a thirty-day period, or continues to require ongoing continuous treatment, and (D) refers any person receiving such treatment to an appropriate licensed practitioner of the healing arts if, upon examination or reexamination, the same condition for which the person sought physical therapy does not demonstrate objective, measurable, functional improvement in a period of thirty consecutive days or at the end of six visits, whichever is earlier.

(2) In any case in which a person seeking such treatment requires a Grade V spinal manipulation, such treatment shall only be performed (A) upon the oral or written referral of a person licensed in this state, or in a state having licensing requirements meeting the approval of the appropriate examining board in this state, to practice medicine and **surgery**, podiatry, natureopathy, chiropractic or dentistry, or an advanced practice registered nurse licensed to prescribe in accordance with section 20-94a or a physician assistant licensed to prescribe in accordance with section 20-12d, and (B) by a licensed physical therapist who (i) was admitted to a bachelor's degree program prior to January 1, 1998, and has practiced physical therapy for at least four out of the most recent six years of his or her clinical practice, or earned a master's degree or higher in physical therapy from an accredited institution of higher education, and (ii) holds a specialist certification in orthopedic physical therapy from the American Physical Therapy Association, or proof of completion of forty hours of course work in manual therapy, including Grade V spinal manipulation. Nothing in this section shall prevent a physical therapist from providing wellness care within the scope of physical therapy practice to asymptomatic persons without a referral. Nothing in this section shall require an employer or insurer to pay for such wellness care.

(3) In any case involving an injury, as described in section 31-275, such treatment shall only be performed upon the oral or written referral of a person licensed in this state or in a state having licensing requirements meeting the standards set by the Department of Public Health and the appropriate examining board in this state to practice medicine and **surgery**, podiatry, natureopathy, chiropractic or dentistry, or an advanced practice registered nurse licensed to prescribe in accordance with section 20-94a or a physician assistant licensed to prescribe in accordance with section 20-12d.

(c) Any person who violates the provisions of this section or who obtains or attempts to obtain licensure as a physical therapist or physical therapist assistant by any wilful misrepresentation or any fraudulent representation shall be fined not more than five hundred dollars or imprisoned not more than five years, or both. A physical therapist, physical therapist assistant or dentist who violates the provisions of this section shall be subject to licensure revocation in the same manner as is provided under section 19a-17, or in the case of a healing arts practitioner, section 20-45. For purposes of this section each instance of patient contact or consultation in violation of any

provision of this section shall constitute a separate offense. Failure to renew a license in a timely manner shall not constitute a violation for the purposes of this section.

(d) Nothing in this section shall prohibit or limit the ability of a person licensed or certified in a field other than physical therapy from providing wellness care that is within the scope of such person's practice.

History:

(1949 Rev., S. 4407, 4409; 1953, S. 2209d, 2210d; 1959, P.A. 575, S. 5; P.A. 73-579, S. 3; P.A. 76-276, S. 18, 22; P.A. 77-614, S. 323, 610; P.A. 80-336, S. 3; P.A. 81-473, S. 19, 43; P.A. 84-526, S. 6; P.A. 93-55, S. 2; 93-381, S. 9, 39; P.A. 94-213, S. 3; P.A. 95-257, S. 12, 21, 58; 95-299, S. 3; P.A. 99-102, S. 24; P.A. 00-226, S. 15, 20; P.A. 03-209, S. 3, 4; P.A. 06-125, S. 2; 06-195, S. 82.)

Conn. Gen. Stat. § 20-73a. Charges against licensee, verification, hearing. Grounds for disciplinary action. Appeal.

(a) The Board of Examiners for Physical Therapists shall have jurisdiction to hear all charges of conduct that fails to conform to the accepted standards of the practice of physical therapy brought against any person licensed as a physical therapist or physical therapist assistant and, after holding a hearing, written notice of which shall be given to the person complained of, the board, if it finds such person to be guilty, may revoke or suspend such person's license or take any of the actions set forth in section 19a-17. Any proceedings relative to such action may be begun by the filing of written charges with the Commissioner of Public Health. The causes for which such action may be taken are as follows: (1) Conviction in a court of competent jurisdiction, either within or without this state, of any crime in the practice of such person's profession; (2) illegal, incompetent or negligent conduct in the practice of physical therapy or in the supervision of a physical therapist assistant; (3) aiding or abetting the unlawful practice of physical therapy; (4) treating human ailments by physical therapy without the oral or written referral by a person licensed in this state or in a state having licensing requirements meeting the approval of the appropriate examining board in this state to practice medicine and **surgery**, podiatry, natureopathy, chiropractic or dentistry if such referral is required pursuant to section 20-73; (5) failure to register with the Department of Public Health as required by law; (6) fraud or deception in obtaining a license; (7) engaging in fraud or material deception in the course of professional services or activities; (8) failure to comply with the continuing education requirements of section 20-73b; or (9) violation of any provision of this chapter, or any regulation adopted under this chapter.

(b) The clerk of any court in this state in which a person practicing physical therapy has been convicted of any crime as described in this section shall, immediately after such conviction, transmit a certified copy, in duplicate, of the information and judgment, without charge, to the Department of Public Health, containing the name and address of the physical therapist or physical therapist assistant, the crime of which the physical therapist or physical therapist assistant has been convicted and the date of conviction. The hearing on such charges shall be

conducted in accordance with the regulations adopted by the Commissioner of Public Health in accordance with chapter 54. Any person aggrieved by a final decision of the board may appeal from the decision as provided in section 4-183. Such appeal shall have precedence over nonprivileged cases in respect to order of trial. The Attorney General shall act as attorney in the public interest in defending against such an appeal. The board may petition the superior court for the judicial district of Hartford to enforce any action taken pursuant to section 19a-17.

History:

(1959, P.A. 575, S. 7; 1971, P.A. 870, S. 57; P.A. 73-579, S. 4; P.A. 76-436, S. 419, 681; P.A. 77-603, S. 62, 125; 77-614, S. 386, 610; P.A. 78-280, S. 34, 127; P.A. 80-336, S. 4; P.A. 81-473, S. 20, 43; P.A. 88-230, S. 1, 12; P.A. 89-307, S. 2; P.A. 90-98, S. 1, 2; P.A. 93-142, S. 4, 7, 8; 93-381, S. 9, 39; P.A. 95-220, S. 4-6; 95-257, S. 12, 21, 58; P.A. 96-47, S. 3; P.A. 99-102, S. 25; P.A. 00-226, S. 16, 20; P.A. 06-125, S. 3.)

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Sec. 5. Subsection (a) of section 20-73a of the general statutes is repealed and the following is substituted in lieu thereof (Effective January 1, 2010):

(a) The Board of Examiners for Physical Therapists shall have jurisdiction to hear all charges of conduct that fails to conform to the accepted standards of the practice of physical therapy brought against any person licensed as a physical therapist or physical therapist assistant and, after holding a hearing, written notice of which shall be given to the person complained of, the board, if it finds such person to be guilty, may revoke or suspend such person's license or take any of the actions set forth in section 19a-17 **[A>** OF THE 2008 SUPPLEMENT TO THE GENERAL STATUTES **<A]** . Any proceedings relative to such action may be begun by the filing of written charges with the Commissioner of Public Health. The causes for which such action may be taken are as follows: (1) Conviction in a court of competent jurisdiction, either within or without this state, of any crime in the practice of such person's profession; (2) illegal, incompetent or negligent conduct in the practice of physical therapy or in the supervision of a physical therapist assistant; (3) aiding or abetting the unlawful practice of physical therapy; (4) treating human ailments by physical therapy without the oral or written referral by a person licensed in this state or in a state having licensing requirements meeting the approval of the appropriate examining board in this state to practice medicine and surgery, podiatry, natureopathy, chiropractic or dentistry if such referral is required pursuant to section 20-73; (5) failure to register with the Department of Public Health as required by law; (6) fraud or deception in obtaining a license; (7) engaging in fraud or material deception in the course of professional services or activities; (8) failure to comply with the continuing education requirements of section 20-73b **[A>** OF THE 2008 SUPPLEMENT TO THE GENERAL STATUTES **<A]** ; **[D>** or **<D]** (9) violation of any provision of this chapter, or any regulation adopted under this chapter **[A>** ; OR (10) FAILURE TO PROVIDE INFORMATION TO THE DEPARTMENT OF PUBLIC HEALTH REQUIRED TO COMPLETE A HEALTH CARE PROVIDER PROFILE, AS SET FORTH IN SECTION 20-13J, AS AMENDED BY THIS ACT **<A]** .

Conn. Gen. Stat. § 20-74. Construction. Administration by commissioner.

(a) No provision of this chapter shall confer any authority to practice medicine or **surgery**, nor shall this chapter prohibit the incidental care of the sick by domestic servants or by persons principally employed as housekeepers or as athletic trainers, nor prohibit any person from the domestic administration of family remedies or the furnishing of assistance in the case of emergency. It shall not prohibit persons registered under the provisions of chapter 372, 373, 375 or 378 from administering care to patients, nor shall it prohibit the care of the sick with or without compensation or personal profit in connection with the practice of the religious tenets of any church by adherents thereof, provided such persons shall not otherwise engage in the practice of physical therapy or assist in the practice of physical therapy within the meaning of this chapter. It shall not prohibit students who are enrolled in schools or courses of physical therapy or physical therapist assistant programs approved by the Board of Examiners for Physical Therapists with the consent of the Commissioner of Public Health from performing such work as is incidental to their respective courses of study; nor shall it prohibit any physical therapist from another state from doing such therapist's work or other physical therapy activities as is incidental to the person's course of study when taking or giving a postgraduate course or other courses of study in this state approved by said board. Any physical therapist who is a graduate from a school approved by the board with the consent of the Department of Public Health but not licensed in this state may, with the approval of the department and upon obtaining a temporary certificate from the department, practice physical therapy in this state on a temporary basis for a period of six months, which period may be extended upon request at the discretion of the department, provided (1) such physical therapist does not claim to be licensed to practice in this state, and (2) application for licensure by examination, reciprocity or endorsement is filed with the department within six months after starting such practice. Persons in the service of the federal government are excluded from the provisions of this chapter.

(b) The Commissioner of Public Health shall administer the provisions of this chapter with respect to the licensing of physical therapist assistants within available appropriations.

History:

(1949 Rev., S. 4408; 1953, S. 2212d; 1959, P.A. 575, S. 6; P.A. 73-579, S. 5; P.A. 80-336, S. 5; P.A. 81-473, S. 21, 43; P.A. 88-362, S. 10; P.A. 89-307, S. 3; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58; P.A. 96-174, S. 2, 3; P.A. 99-102, S. 26; P.A. 00-226, S. 17, 20.)

- **CHAPTER 376b (SUBSTANCE ABUSE COUNSELORS) ALCOHOL AND DRUG COUNSELORS**

Conn. Gen. Stat. § 20-74s. Licensure and certification of alcohol and drug counselors.

(a) Definitions. For purposes of this section and subdivision (18) of subsection (c) of section 19a-14:

(1) "Commissioner" means the Commissioner of Public Health;

(2) "Licensed alcohol and drug counselor" means a person licensed under the provisions of this section;

(3) "Certified alcohol and drug counselor" means a person certified under the provisions of this section;

(4) "Practice of alcohol and drug counseling" means the professional application of methods that assist an individual or group to develop an understanding of alcohol and drug dependency problems, define goals, and plan action reflecting the individual's or group's interest, abilities and needs as affected by alcohol and drug dependency problems;

(5) "Private practice of alcohol and drug counseling" means the independent practice of alcohol and drug counseling by a licensed or certified alcohol and drug counselor who is self-employed on a full-time or part-time basis and who is responsible for that independent practice;

(6) "Self-help group" means a voluntary group of persons who offer peer support to each other in recovering from an addiction; and

(7) "Supervision" means the regular on-site observation of the functions and activities of an alcohol and drug counselor in the performance of his or her duties and responsibilities to include a review of the records, reports, treatment plans or recommendations with respect to an individual or group.

(b) Eligibility for licensure and certification. Except as provided in subsections (s) to (x), inclusive, of this section, no person shall engage in the practice of alcohol and drug counseling unless licensed as a licensed alcohol and drug counselor pursuant to subsection (d) of this section or certified as a certified alcohol and drug counselor pursuant to subsection (e) of this section.

(c) Private practice restricted. Except as provided in subsections (s) to (x), inclusive, of this section, no person shall engage in the private practice of alcohol and drug counseling unless (1) licensed as a licensed alcohol and drug counselor pursuant to subsection (d) of this section, or (2) certified as a certified alcohol and drug counselor pursuant to subsection (e) of this section and practicing under the supervision of a licensed alcohol and drug counselor.

(d) Licensure eligibility requirements. To be eligible for licensure as a licensed alcohol and drug counselor, an applicant shall (1) have attained a master's degree from an accredited institution of higher education with a minimum of eighteen graduate semester hours in counseling or counseling-related subjects, except that applicants holding certified clinical supervisor status by the Connecticut Certification Board, Inc. as of October 1, 1998, may substitute such certification in lieu of the master's degree requirement, and (2) be certified or have met all the requirements for certification as a certified alcohol and drug counselor.

(e) Certification eligibility requirements. To be eligible for certification by the Department of Public Health as a certified alcohol and drug counselor, an applicant shall have (1) completed three hundred hours of supervised practical training in alcohol and drug counseling that the commissioner deems acceptable; (2) completed three years of supervised paid work experience or unpaid internship that the commissioner deems acceptable that entailed working directly with alcohol and drug clients, except that a master's degree may be substituted for one year of such experience; (3) completed three hundred sixty hours of commissioner-approved education, at least two hundred forty hours of which relates to the knowledge and skill base associated with the practice of alcohol and drug counseling; and (4) successfully completed a department prescribed examination.

(f) Alternative certification eligibility requirements prior to October 1, 1998. For individuals applying for certification as an alcohol and drug counselor by the Department of Public Health prior to October 1, 1998, current certification by the Department of Mental Health and Addiction Services may be substituted for the certification requirements of subsection (e) of this section.

(g) Application for licensure. Fee. The commissioner shall grant a license as an alcohol and drug counselor to any applicant who furnishes satisfactory evidence that he has met the requirements of subsections (d) or (o) of this section. The commissioner shall develop and provide application forms. The application fee shall be one hundred fifty dollars.

(h) Renewal of license. Fee. A license as an alcohol and drug counselor shall be renewed in accordance with the provisions of section 19a-88 for a fee of one hundred fifty dollars.

(i) Application for certification. Fee. The commissioner shall grant certification as a certified alcohol and drug counselor to any applicant who furnishes satisfactory evidence that he has met the requirements of subsections (e) or (o) of this section. The commissioner shall develop and provide application forms. The application fee shall be one hundred fifty dollars.

(j) Renewal of certification. Fee. A certificate as an alcohol and drug counselor may be renewed in accordance with the provisions of section 19a-88 for a fee of one hundred fifty dollars.

(k) Commissioner may contract out credential verification. The commissioner may contract with a qualified private organization for services that include (1) providing verification that applicants for licensure or certification have met the education, training and work experience requirements under this section; and (2) any other services that the commissioner may deem necessary.

(l) Grandfathering of licensed alcohol and drug counselors based on master's degree and former substance abuse certification; license renewal. Fee. Any person who has attained a master's level degree and is certified by the Connecticut Certification Board as a substance abuse counselor on or before July 1, 2000, shall be deemed a licensed alcohol and drug counselor. Any person so deemed shall renew his license pursuant to section 19a-88 for a fee of one hundred fifty dollars.

(m) Grandfathering of certified alcohol and drug counselors based on former substance abuse certification without a master's degree; certification renewal. Fee. Any person who has not

attained a master's level degree and is certified by the Connecticut Certification Board as a substance abuse counselor on or before July 1, 2000, shall be deemed a certified alcohol and drug counselor. Any person so deemed shall renew his certification pursuant to section 19a-88 for a fee of one hundred fifty dollars.

(n) Grandfathering of certified alcohol and drug counselors based on work experience and examination; certification renewal. Fee. Any person who is not certified by the Connecticut Certification Board as a substance abuse counselor on or before July 1, 2000, who (1) documents to the department that he has a minimum of five years full-time or eight years part-time paid work experience, under supervision, as an alcohol and drug counselor, and (2) successfully passes a commissioner-approved examination no later than July 1, 2000, shall be deemed a certified alcohol and drug counselor. Any person so deemed shall renew his certification pursuant to section 19a-88 for a fee of one hundred fifty dollars.

(o) Licensure and certification by endorsement. The commissioner may license or certify without examination any applicant who, at the time of application, is licensed or certified by a governmental agency or private organization located in another state, territory or jurisdiction whose standards, in the opinion of the commissioner, are substantially similar to, or higher than, those of this state.

(p) Title protection. No person shall assume, represent himself as, or use the title or designation "alcoholism counselor", "alcohol counselor", "alcohol and drug counselor", "alcoholism and drug counselor", "licensed clinical alcohol and drug counselor", "licensed alcohol and drug counselor", "licensed associate alcohol and drug counselor", "certified alcohol and drug counselor", "chemical dependency counselor", "chemical dependency supervisor" or any of the abbreviations for such titles, unless licensed or certified under subsections (g) to (n), inclusive, of this section and unless the title or designation corresponds to the license or certification held.

(q) Regulations. The commissioner shall adopt regulations, in accordance with chapter 54, to implement provisions of this section.

(r) Disciplinary action: Grounds and penalties. The commissioner may suspend, revoke or refuse to issue a license in circumstances that have endangered or are likely to endanger the health, welfare or safety of the public.

(s) Exceptions to licensure and certification. Religion. Nothing in this section shall be construed to apply to the activities and services of a rabbi, priest, minister, Christian Science practitioner or clergyman of any religious denomination or sect, when engaging in activities that are within the scope of the performance of the person's regular or specialized ministerial duties and for which no separate charge is made, or when these activities are performed, with or without charge, for or under the auspices or sponsorship, individually or in conjunction with others, of an established and legally cognizable church, denomination or sect, and when the person rendering services remains accountable to the established authority thereof.

(t) Exception to licensure and certification. Other health care providers. Nothing in this section

shall be construed to apply to the activities and services of a person licensed in this state to practice medicine and **surgery**, psychology, marital and family therapy, clinical social work, professional counseling, advanced practice registered nursing or registered nursing, when such person is acting within the scope of the person's license and doing work of a nature consistent with that person's license, provided the person does not hold himself or herself out to the public as possessing a license or certification issued pursuant to this section.

(u) Exceptions to licensure and certification. Students. Nothing in this section shall be construed to apply to the activities and services of a student intern or trainee in alcohol and drug counseling who is pursuing a course of study in an accredited institution of higher education or training course, provided these activities are performed under supervision and constitute a part of an accredited course of study, and provided further the person is designated as an intern or trainee or other such title indicating the training status appropriate to his level of training.

(v) Exception to licensure and certification. State-employed substance abuse counselors. Exception for Department of Correction. Nothing in this section shall be construed to apply to any alcohol and drug counselor or substance abuse counselor employed by the state, except that this section shall apply to alcohol and drug counselors employed by the Department of Correction pursuant to subsection (x) of this section.

(w) Exception to licensure and certification. Supervised employees and self-help groups. Nothing in this section shall be construed to apply to the activities and services of paid alcohol and drug counselors who are working under supervision or uncompensated alcohol and drug abuse self-help groups, including, but not limited to, Alcoholics Anonymous and Narcotics Anonymous.

(x) Applicability to employees of Department of Correction. The provisions of this section shall apply to employees of the Department of Correction, other than trainees or student interns covered under subsection (u) of this section and persons completing supervised paid work experience in order to satisfy mandated clinical supervision requirements for certification under subsection (e) of this section, as follows: (1) Any person hired by the Department of Correction on or after October 1, 2002, for a position as a substance abuse counselor or supervisor of substance abuse counselors shall be a licensed or certified alcohol and drug counselor; (2) any person employed by the Department of Correction prior to October 1, 2002, as a substance abuse counselor or supervisor of substance abuse counselors shall become licensed or certified as an alcohol and drug counselor by October 1, 2007; and (3) any person employed by the Department of Correction on or after October 1, 2007, as a substance abuse counselor or supervisor of substance abuse counselors shall be a licensed or certified alcohol and drug counselor.

History:

(P.A. 97-186, S. 1-9; P.A. 98-247, S. 1-9; P.A. 99-249, S. 3, 10; P.A. 02-75, S. 1-4; P.A. 03-195, S. 1; P.A. 07-252, S. 23, 24.)

- **CHAPTER 378 NURSING**

Conn. Gen. Stat. § 20-87a. Definitions. Scope of practice.

(a) The practice of nursing by a registered nurse is defined as the process of diagnosing human responses to actual or potential health problems, providing supportive and restorative care, health counseling and teaching, case finding and referral, collaborating in the implementation of the total health care regimen, and executing the medical regimen under the direction of a licensed physician, dentist or advanced practice registered nurse.

(b) Advanced nursing practice is defined as the performance of advanced level nursing practice activities that, by virtue of postbasic specialized education and experience, are appropriate to and may be performed by an advanced practice registered nurse. The advanced practice registered nurse performs acts of diagnosis and treatment of alterations in health status, as described in subsection (a) of this section, and shall collaborate with a physician licensed to practice medicine in this state. In all settings, the advanced practice registered nurse may, in collaboration with a physician licensed to practice medicine in this state, prescribe, dispense and administer medical therapeutics and corrective measures and may request, sign for, receive and dispense drugs in the form of professional samples in accordance with sections 20-14c to 20-14e, inclusive, except that an advanced practice registered nurse licensed pursuant to section 20-94a and maintaining current certification from the American Association of Nurse Anesthetists who is prescribing and administrating medical therapeutics during **surgery** may only do so if the physician who is medically directing the prescriptive activity is physically present in the institution, clinic or other setting where the **surgery** is being performed. For purposes of this subsection, "collaboration" means a mutually agreed upon relationship between an advanced practice registered nurse and a physician who is educated, trained or has relevant experience that is related to the work of such advanced practice registered nurse. The collaboration shall address a reasonable and appropriate level of consultation and referral, coverage for the patient in the absence of the advanced practice registered nurse, a method to review patient outcomes and a method of disclosure of the relationship to the patient. Relative to the exercise of prescriptive authority, the collaboration between an advanced practice registered nurse and a physician shall be in writing and shall address the level of schedule II and III controlled substances that the advanced practice registered nurse may prescribe and provide a method to review patient outcomes, including, but not limited to, the review of medical therapeutics, corrective measures, laboratory tests and other diagnostic procedures that the advanced practice registered nurse may prescribe, dispense and administer. An advanced practice registered nurse licensed under the provisions of this chapter may make the determination and pronouncement of death of a patient, provided the advanced practice registered nurse attests to such pronouncement on the certificate of death and signs the certificate of death no later than twenty-four hours after the pronouncement.

(c) The practice of nursing by a licensed practical nurse is defined as the performing of selected tasks and sharing of responsibility under the direction of a registered nurse or an advanced practice registered nurse and within the framework of supportive and restorative care, health counseling and teaching, case finding and referral, collaborating in the implementation of the total health care regimen and executing the medical regimen under the direction of a licensed physician or dentist.

(d) In the case of a registered or licensed practical nurse employed by a home health care agency, the practice of nursing includes, but is not limited to, executing the medical regimen under the direction of a physician licensed in a state that borders Connecticut.

History:

(P.A. 75-166, S. 1, 6; P.A. 89-107, S. 1; 89-389, S. 1, 22; P.A. 94-213, S. 4; P.A. 97-112, S. 2; P.A. 99-168, S. 1; P.A. 03-8, S. 1; P.A. 04-221, S. 34; 04-255, S. 22; May Sp. Sess. P.A. 04-2, S. 108; P.A. 06-169, S. 1.)

Conn. Gen. Stat. § 20-101. Construction of chapter. Permitted practices. Temporary practice.

No provision of this chapter shall confer any authority to practice medicine or **surgery** nor shall this chapter prohibit any person from the domestic administration of family remedies or the furnishing of assistance in the case of an emergency; nor shall it be construed as prohibiting persons employed in state hospitals and state sanatoriums and subsidiary workers in general hospitals from assisting in the nursing care of patients if adequate medical and nursing supervision is provided; nor shall it be construed to prohibit the administration of medications by dialysis patient care technicians in accordance with section 19a-269a; nor shall it be construed as prohibiting students who are enrolled in schools of nursing approved pursuant to section 20-90, and students who are enrolled in schools for licensed practical nurses approved pursuant to section 20-90, from performing such work as is incidental to their respective courses of study; nor shall it prohibit a registered nurse who holds a master's degree in nursing or in a related field recognized for certification as either a nurse practitioner, a clinical nurse specialist, or a nurse anesthetist by one of the certifying bodies identified in section 20-94a from practicing for a period not to exceed one hundred twenty days after the date of graduation, provided such graduate advanced practice registered nurse is working in a hospital or other organization under the supervision of a licensed physician or a licensed advanced practice registered nurse, such hospital or other organization has verified that the graduate advanced practice registered nurse has applied to sit for the national certification examination and the graduate advanced practice registered nurse is not authorized to prescribe or dispense drugs; nor shall it prohibit graduates of schools of nursing or schools for licensed practical nurses approved pursuant to section 20-90, from nursing the sick for a period not to exceed ninety calendar days after the date of graduation, provided such graduate nurses are working in hospitals or organizations where adequate supervision is provided, and such hospital or other organization has verified that the graduate nurse has successfully completed a nursing program. Upon notification that the graduate nurse has failed the licensure examination or that the graduate advanced practice registered nurse has failed the certification examination, all privileges under this section shall automatically cease. No provision of this chapter shall prohibit any registered nurse who has been issued a temporary permit by the department, pursuant to subsection (b) of section 20-94, from caring for the sick pending the issuance of a license without examination; nor shall it prohibit any licensed practical nurse who has been issued a temporary permit by the department, pursuant to subsection (b) of

section 20-97, from caring for the sick pending the issuance of a license without examination; nor shall it prohibit any qualified registered nurse or any qualified licensed practical nurse of another state from caring for a patient temporarily in this state, provided such nurse has been granted a temporary permit from said department and provided such nurse shall not represent or hold himself or herself out as a nurse licensed to practice in this state; nor shall it prohibit registered nurses or licensed practical nurses from other states from doing such nursing as is incident to their course of study when taking postgraduate courses in this state; nor shall it prohibit nursing or care of the sick, with or without compensation or personal profit, in connection with the practice of the religious tenets of any church by adherents thereof, provided such persons shall not otherwise engage in the practice of nursing within the meaning of this chapter. This chapter shall not prohibit the care of persons in their homes by domestic servants, housekeepers, nursemaids, companions, attendants or household aides of any type, whether employed regularly or because of an emergency of illness, if such persons are not initially employed in a nursing capacity.

History:

(1949 Rev., S. 4437; 1953, S. 2226d; 1957, P.A. 280, S. 1; P.A. 76-315, S. 4, 6; P.A. 80-484, S. 37, 176; P.A. 81-471, S. 26, 71; P.A. 85-46, S. 1, 2; P.A. 88-207, S. 2; 88-362, S. 18, 22; P.A. 89-350, S. 20, 21; P.A. 90-13, S. 10; P.A. 04-221, S. 10; P.A. 05-66, S. 4; P.A. 06-195, S. 30.)

- **CHAPTER 379 DENTISTRY**

Conn. Gen. Stat. § 20-107. Application for license. Graduates of foreign dental schools.

(a) Each application for a license to practice dentistry shall be in writing and signed by the applicant and no license shall be issued to any person unless he or she presents a diploma or other certificate of graduation from some reputable dental college or from a department of dentistry of a medical college conferring a dental degree, or unless he or she is practicing as a legally qualified dentist in another state having requirements for admission determined by the department to be similar to or higher than the requirements of this state.

(b) The Dental Commission may, with the consent of the Commissioner of Public Health, determine the colleges which shall be considered reputable dental or medical colleges for the purposes of this chapter. The commission shall consult when possible with nationally recognized accrediting agencies when making such determinations.

(c) Notwithstanding the provisions of subsections (a) and (b) of this section, the department may issue a license to practice dentistry to any applicant holding a diploma from a foreign dental school, provided the applicant (1) is a graduate of a dental school located outside the United States and has received the degree of doctor of dental medicine or **surgery**, or its equivalent; (2) has passed the written and practical examinations required in section 20-108; (3) has successfully completed not less than two years of graduate dental training as a resident dentist in a program accredited by the Commission on Dental Accreditation; and (4) has successfully completed, at a

level greater than the second postgraduate year, not less than two years of a residency or fellowship training program accredited by the Commission on Dental Accreditation in a community or school-based health center affiliated with and under the supervision of a school of dentistry in this state, or has served as a full-time faculty member of a school of dentistry in this state pursuant to the provisions of section 20-120 for not less than three years.

History:

(1949 Rev., S. 4447; 1963, P.A. 642, S. 22; P.A. 79-70, S. 1; P.A. 80-484, S. 39, 176; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58; P.A. 05-213, S. 5.)

Conn. Gen. Stat. § 20-108. Examination of applicants. Alternative to practical examination.

(a) Except as provided in section 20-110 and subsection (b) of this section, each applicant for a license to practice dental medicine or dental **surgery** shall be examined by the Department of Public Health, under the supervision of the Dental Commission as to his or her professional knowledge and skill before such license is granted. Such examination shall be conducted in the English language. The Dental Commission may, with the consent of the Commissioner of Public Health, accept and approve, in lieu of the written examination required by this section, the results of an examination given by the Joint Commission on National Dental Examinations, subject to such conditions as the commission may prescribe, and the Dental Commission with the consent of the Commissioner of Public Health, may accept and approve, in lieu of the written and practical examination required by this section, the results of regional testing agencies as to written and practical examinations, subject to such conditions as the commission, with the consent of the Commissioner of Public Health, may prescribe. Passing scores shall be established by the department with the consent of the commission.

(b) In lieu of the practical examination required by subsection (a) of this section, an applicant for licensure may submit evidence of having successfully completed not less than one year of graduate dental training as a resident dentist in a program accredited by the Commission on Dental Accreditation, provided the director of the dental residency program at the facility in which the applicant completed the residency training provides documentation satisfactory to the Department of Public Health attesting to the resident dentist's competency in all areas tested on the practical examination required by subsection (a) of this section. Not later than December 1, 2005, the Dental Commission, in consultation with the Department of Public Health, shall develop a form upon which such documentation shall be provided.

History:

(1949 Rev., S. 4448; 1957, P.A. 185; 1969, P.A. 101; P.A. 77-614, S. 397, 610; P.A. 80-484, S. 40, 176; P.A. 87-114, S. 1; P.A. 93-381, S. 9, 39; 93-435, S. 6, 95; P.A. 95-257, S. 12, 21, 58; P.A. 05-213, S. 2; P.A. 07-252, S. 45.)

Conn. Gen. Stat. § 20-114. Disciplinary action by Dental Commission concerning dentists and dental hygienists.

(a) The Dental Commission may take any of the actions set forth in section 19a-17 for any of the following causes: (1) The presentation to the department of any diploma, license or certificate illegally or fraudulently obtained, or obtained from an institution that is not reputable or from an unrecognized or irregular institution or state board, or obtained by the practice of any fraud or deception; (2) proof that a practitioner has become unfit or incompetent or has been guilty of cruelty, incompetence, negligence or indecent conduct toward patients; (3) conviction of the violation of any of the provisions of this chapter by any court of criminal jurisdiction, provided no action shall be taken under section 19a-17 because of such conviction if any appeal to a higher court has been filed until the appeal has been determined by the higher court and the conviction sustained; (4) the employment of any unlicensed person for other than mechanical purposes in the practice of dental medicine or dental **surgery** subject to the provisions of section 20-122a; (5) the violation of any of the provisions of this chapter or of the regulations adopted hereunder or the refusal to comply with any of said provisions or regulations; (6) the aiding or abetting in the practice of dentistry, dental medicine or dental hygiene of a person not licensed to practice dentistry, dental medicine or dental hygiene in this state; (7) designating a limited practice, except as provided in section 20-106a; (8) engaging in fraud or material deception in the course of professional activities; (9) the effects of physical or mental illness, emotional disorder or loss of motor skill, including but not limited to, deterioration through the aging process, upon the license holder; (10) abuse or excessive use of drugs, including alcohol, narcotics or chemicals; (11) failure to comply with the continuing education requirements set forth in section 20-126c; or (12) failure of a holder of a dental anesthesia or conscious sedation permit to successfully complete an on-site evaluation conducted pursuant to subsection (c) of section 20-123b. A violation of any of the provisions of this chapter by any unlicensed employee in the practice of dentistry or dental hygiene, with the knowledge of the employer, shall be deemed a violation by the employer. The Commissioner of Public Health may order a license holder to submit to a reasonable physical or mental examination if his or her physical or mental capacity to practice safely is the subject of an investigation. Said commissioner may petition the superior court for the judicial district of Hartford to enforce such order or any action taken pursuant to section 19a-17.

(b) For purposes of subdivision (8) of subsection (a) of this section, fraud or material deception shall include, but not be limited to, the following practices: (1) Submission of a claim form to a third party intentionally reporting incorrect treatment dates for the purpose of assisting a patient in obtaining benefits under a dental plan, which benefits would otherwise be disallowed; (2) increasing a fee to a patient for a dental procedure or dental hygiene service in excess of the fee generally charged by the dentist for such procedure or service solely because the patient has dental insurance; (3) intentionally describing a dental procedure incorrectly on a third-party claim form in order to receive a greater payment or reimbursement or intentionally misrepresenting a dental procedure not otherwise eligible for payment or reimbursement on such claim form for the purpose of receiving payment or reimbursement; and (4) intentionally accepting payment from a third party as payment in full for patient services rendered when (A) the patient has been excused from payment of any applicable deductible by the license holder, and (B) such license holder fails to notify the third party of such action.

History:

(1949 Rev., S. 4450; 1951, 1953, S. 2232d; 1957, P.A. 544; 1959, P.A. 616, S. 38; 1963, P.A. 642, S. 25; 1967, P.A. 219; 289; P.A. 75-75, S. 2, 3; P.A. 77-614, S. 323, 400, 610; P.A. 80-484, S. 43, 176; P.A. 81-471, S. 31, 71; P.A. 83-205; P.A. 84-68; P.A. 88-230, S. 1, 12; P.A. 90-98, S. 1, 2; P.A. 92-23, S. 2; 92-35, S. 6; P.A. 93-142, S. 4, 7, 8; 93-381, S. 9, 39; P.A. 95-220, S. 4-6; 95-257, S. 12, 21, 58; P.A. 05-213, S. 9; 05-288, S. 82.)

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Sec. 7. Subsection (a) of section 20-114 of the general statutes is repealed and the following is substituted in lieu thereof (Effective January 1, 2010):

(a) The Board of Examiners for Physical Therapists shall have jurisdiction to hear all charges of conduct that fails to conform to the accepted standards of the practice of physical therapy brought against any person licensed as a physical therapist or physical therapist assistant and, after holding a hearing, written notice of which shall be given to the person complained of, the board, if it finds such person to be guilty, may revoke or suspend such person's license or take any of the actions set forth in section 19a-17 [A> OF THE 2008 SUPPLEMENT TO THE GENERAL STATUTES <A] . Any proceedings relative to such action may be begun by the filing of written charges with the Commissioner of Public Health. The causes for which such action may be taken are as follows: (1) Conviction in a court of competent jurisdiction, either within or without this state, of any crime in the practice of such person's profession; (2) illegal, incompetent or negligent conduct in the practice of physical therapy or in the supervision of a physical therapist assistant; (3) aiding or abetting the unlawful practice of physical therapy; (4) treating human ailments by physical therapy without the oral or written referral by a person licensed in this state or in a state having licensing requirements meeting the approval of the appropriate examining board in this state to practice medicine and **surgery**, podiatry, natureopathy, chiropractic or dentistry if such referral is required pursuant to section 20-73; (5) failure to register with the Department of Public Health as required by law; (6) fraud or deception in obtaining a license; (7) engaging in fraud or material deception in the course of professional services or activities; (8) failure to comply with the continuing education requirements of section 20-73b [A> OF THE 2008 SUPPLEMENT TO THE GENERAL STATUTES <A] ; [D> or <D] (9) violation of any provision of this chapter, or any regulation adopted under this chapter [A> ; OR (10) FAILURE TO PROVIDE INFORMATION TO THE DEPARTMENT OF PUBLIC HEALTH REQUIRED TO COMPLETE A HEALTH CARE PROVIDER PROFILE, AS SET FORTH IN SECTION 20-13J, AS AMENDED BY THIS ACT <A] .

Conn. Gen. Stat. § 20-122. Ownership and operation of offices by unlicensed persons or by corporations. Penalty. Exception.

(a) No person, except a licensed and registered dentist, and no corporation, except a professional service corporation organized and existing under chapter 594a for the purpose of rendering professional dental services, and no institution shall own or operate a dental office, or an office, laboratory or operation or consultation room in which dental medicine, dental **surgery** or dental

hygiene is carried on as a portion of its regular business; but the provisions of this section do not apply to hospitals, community health centers, public or parochial schools, or convalescent homes, or institutions under control of an agency of the state of Connecticut, or the state or municipal board of health, or a municipal board of education; or those educational institutions treating their students, or to industrial institutions or corporations rendering treatment to their employees on a nonprofit basis, provided permission for such treatment has been granted by the State Dental Commission. Such permission may be revoked for cause after hearing by said commission.

(b) Any licensed practitioner who provides dental services in a dental office or other location in violation of subsection (a) of this section shall be subject to disciplinary action under sections 19a-17 and 20-114.

(c) Notwithstanding the provisions of subsections (a) and (b) of this section or chapter 594a, a professional service corporation whose capital stock is held by or under the control of a personal representative or the estate of a deceased or incompetent dentist may operate a dental office or other location for the purpose of rendering professional dental services for a reasonable period of time, not to exceed eighteen months from the date of the dentist's death or the date the dentist is lawfully determined to be incompetent, whichever is applicable.

History:

(1949 Rev., S. 4444, 4445; P.A. 73-206, S. 1; P.A. 87-139, S. 2; P.A. 92-35, S. 7; P.A. 05-272, S. 20.)

Conn. Gen. Stat. § 20-123. Scope of practice of dentistry. Activities restricted to licensed dentists. Extended scope of practice for graduates of post-doctoral dental training programs. Penalties. Exceptions.

(a) No person shall engage in the practice of dentistry unless he or she is licensed pursuant to the provisions of this chapter. The practice of dentistry or dental medicine is defined as the diagnosis, evaluation, prevention or treatment by surgical or other means, of an injury, deformity, disease or condition of the oral cavity or its contents, or the jaws or the associated structures of the jaws. The practice of dentistry does not include: (1) The treatment of dermatologic diseases or disorders of the skin or face; (2) the performance of microvascular free tissue transfer; (3) the treatment of diseases or disorders of the eye; (4) ocular procedures; (5) the performance of cosmetic **surgery** or other cosmetic procedures other than those related to the oral cavity, its contents, or the jaws; or (6) nasal or sinus **surgery**, other than that related to the oral cavity, its contents or the jaws.

(b) No person other than a person licensed to practice dentistry under this chapter shall:

(1) Describe himself or herself by the word "Dentist" or letters "D.D.S." or "D.M.D.", or in other words, letters or title in connection with his or her name which in any way represents such person as engaged in the practice of dentistry;

(2) Own or carry on a dental practice or business;

(3) Replace lost teeth by artificial ones, or attempt to diagnose or correct malpositioned teeth;

(4) Directly or indirectly, by any means or method, furnish, supply, construct, reproduce or repair any prosthetic denture, bridge, appliance or any other structure to be worn in a person's mouth, except upon the written direction of a licensed dentist, or place such appliance or structure in a person's mouth or attempt to adjust such appliance or structure in a person's mouth, or deliver such appliance or structure to any person other than the dentist upon whose direction the work was performed;

(5) Sell or distribute materials, except to a licensed dentist, dental laboratory or dental supply house, with instructions for an individual to construct, repair, reproduce or duplicate any prosthetic denture, bridge, appliance or any other structure to be worn in a person's mouth;

(6) Advertise to the public, by any method, to furnish, supply, construct, reproduce or repair any prosthetic denture, bridge, appliance or other structure to be worn in a person's mouth;

(7) Give estimates of the cost of dental treatment; or

(8) Advertise or permit it to be advertised by sign, card, circular, handbill or newspaper, or otherwise indicate that such person, by contract with others or by himself or herself, will perform any of the functions specified in subdivisions (1) to (7), inclusive, of this subsection.

(c) Notwithstanding the provisions of subsection (a) of this section, a person who is licensed to practice dentistry under this chapter, who has successfully completed a postdoctoral training program that is accredited by the Commission on Dental Accreditation or its successor organization, in the specialty area of dentistry in which such person practices may: (1) Diagnose, evaluate, prevent or treat by surgical or other means, injuries, deformities, diseases or conditions of the hard and soft tissues of the oral and maxillofacial area, or its adjacent or associated structures; and (2) perform any of the following procedures, provided the dentist has been granted hospital privileges to perform such procedures: (A) Surgical treatment of sleep apnea involving the jaws; (B) salivary gland **surgery;** (C) the harvesting of donor tissue; (D) frontal and orbital **surgery** and nasoethmoidal procedures to the extent that such **surgery** or procedures are associated with trauma.

(d) Any person who, in practicing dentistry or dental medicine, as defined in this section, employs or permits any other person except a licensed dentist to so practice dentistry or dental medicine shall be subject to the penalties provided in section 20-126.

(e) The provisions of this section do not apply to:

(1) Any practicing physician or surgeon who is licensed in accordance with chapter 370;

(2) Any regularly enrolled student in a dental school approved as provided in this chapter or a medical school approved as provided in chapter 370 receiving practical training in dentistry under the supervision of a licensed dentist or physician in a dental or medical school in this state or in any hospital, infirmary, clinic or dispensary affiliated with such school;

(3) A person who holds the degree of doctor of dental medicine or doctor of dental **surgery** or its equivalent and who has been issued a permit in accordance with section 20-126b and who is receiving practical training under the supervision of a licensed dentist or physician in an advanced dental education program conducted by a dental or medical school in this state or by a hospital operated by the federal government or licensed pursuant to subsection (a) of section 19a-491;

(4) Any regularly enrolled student in or graduate of an accredited school of dental hygiene who is receiving practical training in dental hygiene in an approved school of dental hygiene in the state or in any hospital, infirmary, clinic or dispensary affiliated with such school, under the supervision of a dentist licensed pursuant to this chapter or a dental hygienist licensed pursuant to chapter 379a; or

(5) Controlled investigations or innovative training programs related to the delivery of dental health services within accredited dental schools or schools of dental hygiene, provided such programs are (A) under the supervision of a dentist licensed pursuant to this chapter or physician licensed pursuant to chapter 370, and (B) conducted within a program accredited by the Commission on Dental Accreditation or such other national professional accrediting body as may be recognized by the United States Department of Education.

History:

(1949 Rev., S. 4458; 1949, 1953, S. 2233d; 1963, P.A. 450, S. 1; 1967, P.A. 238; 1969, P.A. 102; 1971, P.A. 244; P.A. 73-183; P.A. 92-35, S. 8; P.A. 94-149, S. 22; P.A. 05-213, S. 3.)

Conn. Gen. Stat. § 20-126. Penalties.

Any person who violates any provision of this chapter shall be fined not more than five hundred dollars or imprisoned not more than five years or both. Any person who continues to practice dentistry, dental medicine or dental **surgery**, after his license, certificate, registration or authority to so do has been suspended or revoked and while such disability continues, shall be fined not more than five hundred dollars or imprisoned not more than five years or both. For purposes of this section each instance of patient contact or consultation which is in violation of any provision of this section shall constitute a separate offense. Failure to renew a license in a timely manner shall not constitute a violation for the purposes of this section.

History:

(1949 Rev., S. 4462; 1951, S. 2235d; 1967, P.A. 128; P.A. 76-436, S. 422, 681; P.A. 77-614, S.

407, 610; P.A. 84-526, S. 9; P.A. 94-149, S. 20.)

Conn. Gen. Stat. § 20-126b. Permit for advanced dental education.

No person shall participate in an advanced dental education program unless he has received a permit issued by the Department of Public Health. The permit shall be issued solely for purposes of participation in an advanced dental education program conducted by a dental or medical school or by a hospital operated by the federal government or licensed pursuant to subsection (a) of section 19a-491. No person shall receive a permit until a statement has been filed with the department on his behalf by the program administration certifying that he is to be enrolled in the program and that he has received the degree of doctor of dental medicine or doctor of dental **surgery** or its equivalent.

History:

(P.A. 94-149, S. 23; P.A. 95-257, S. 12, 21, 58.)

- **CHAPTER 379a DENTAL HYGIENISTS**

Conn. Gen. Stat. § 20-126i. Application for license. Application from foreign dental school graduate.

(a) Each application for a license to practice dental hygiene shall be in writing and signed by the applicant and accompanied by satisfactory proof that such person has received a diploma or certificate of graduation from a dental hygiene program with a minimum of two academic years of curriculum provided in a college or institution of higher education the program of which is accredited by the Commission on Dental Accreditation or such other national professional accrediting body as may be recognized by the United States Department of Education, and a fee of seventy-five dollars.

(b) Notwithstanding the provisions of subsection (a) of this section, each application for a license to practice dental hygiene from an applicant who holds a diploma from a foreign dental school shall be in writing and signed by the applicant and accompanied by satisfactory proof that such person has (1) graduated from a dental school located outside the United States and received the degree of doctor of dental medicine or **surgery**, or its equivalent; (2) passed the written and practical examinations required in section 20-126j; and (3) enrolled in a dental hygiene program in this state that is accredited by the Commission on Dental Accreditation or its successor organization and successfully completed not less than one year of clinical training in a community health center affiliated with and under the supervision of such dental hygiene program.

History:

(P.A. 94-149, S. 2; P.A. 05-213, S. 10.)

- **CHAPTER 380 OPTOMETRY**

Conn. Gen. Stat. § 20-127. Definitions. Scope of practice. License renewal forms.

(a) For the purposes of this chapter:

(1) The "practice of advanced optometric care" means any one or more of the following practices and procedures: (A) Measuring, examining, diagnosing, preventing, enhancing, managing or treating visual functions, defects of vision, muscular functions or anomalies, or other conditions or diseases of the visual system, the eye and ocular adnexae; (B) the prescribing, supplying, adjusting, fitting or adapting of ophthalmic devices and lenses, spectacles, prisms, orthoptic therapy, visual therapy, visual rehabilitation, oculomotor therapy, tinted lenses, filters, contact lenses, diagnosing, preventing, enhancing, managing, treating or relieving visual functions, defects of vision, muscular functions or anomalies, or diseases of the visual system, the eye and ocular adnexae; (C) the administration or prescription of any pharmaceutical agents related to the diagnosis and treatment of conditions and diseases of the eye and ocular adnexae, excluding nonemergency oral glaucoma agents but including controlled substances under schedules II, III, IV and V in accordance with section 21a-252, subject to the limitations of subsection (f) of this section relating to quantities dispensed, performance or ordering of procedures or laboratory tests related to the diagnosis and treatment of conditions and diseases of the eye and ocular adnexae; these procedures include, but are not limited to, removal of superficial foreign bodies of the cornea, ultrasound and topical, oral or injectable medication to counteract anaphylaxis or anaphylactic reaction; (D) the nonsurgical treatment of glaucoma consistent with subsection (k) of this section; or (E) the use of punctal plugs. The "practice of advanced optometric care" does not include surgical treatment of glaucoma, treatment of ocular cancer, treatment of infectious diseases of the retina, diagnosis and treatment of systemic diseases, use of therapeutic lasers, use of injectable medications other than to counteract anaphylaxis or anaphylactic reaction, surgical procedures other than noninvasive procedures, use of general anesthesia, use of intravenous injections, procedures that require the cutting or opening of the globe, enucleation of the eye, extraocular muscle **surgery** or any invasive procedure performed on the human body other than noninvasive procedures performed on the eye or ocular adnexae.

(2) "Optometrist" means an individual licensed pursuant to this chapter to engage in the practice of optometry.

(3) The "practice of optometry" means any one or more of the following practices and procedures: (A) The examination of the human eye and the eyelid for the purpose of diagnosis, treatment excluding the lacrimal drainage system and lacrimal gland or referral for consultation, as authorized by this section or, where appropriate, referral to an ophthalmologist; (B) the use of tests, instruments, devices, ocular agents-D, ocular agents-T and noninvasive procedures for the purpose of investigation, examination, diagnosis, treatment excluding the lacrimal drainage system and lacrimal gland, or correction, as authorized by this section, of visual defects, abnormal conditions or diseases of the human eye and eyelid; (C) the prescription and application of ophthalmic lenses, prisms, filters, devices containing lenses or prisms or filters or

any combination thereof, orthoptics, vision training, ocular agents-D for the purpose of diagnosing visual defects, abnormal conditions or diseases of the human eye and eyelid, ocular agents-T and noninvasive procedures for the purpose of correction, alleviation or treatment, as authorized by this section, of visual defects, abnormal conditions or diseases of the human eye and eyelid excluding the lacrimal drainage system, lacrimal gland and structures posterior to the iris but including the treatment of iritis; (D) the examination of the human eye for purposes of prescribing, fitting or insertion of contact lenses to the human eye. The practice of optometry shall not include the use of **surgery**, x-ray, photocoagulation or ionizing radiation, or the treatment of glaucoma. Nothing in this subdivision shall be construed to limit the scope of practice of opticians licensed pursuant to chapter 381 or the practice of physicians licensed pursuant to chapter 370.

(4) "Ocular agents-D" means: (A) Topically administered agents used for the purpose of diagnosing visual defects, abnormal conditions or the diseases of the human eye and eyelid known generally as cycloplegics not to exceed one per cent, mydriatics other than phenylephrine hydrochloride ten per cent and topical anesthetics, which are administered topically for the examination of the human eye and the analysis of ocular functions; (B) those vision training or optical devices which have been designated drugs for preclearance testing by the federal Food and Drug Administration or similar agency; and (C) fluorescein and similar dyes used in fitting contact lenses. The drugs described in subparagraph (A) of this subdivision may be acquired and used only for diagnostic purposes. Nothing in this subdivision shall be construed to allow an optometrist to acquire or use a controlled substance listed under section 21a-243.

(5) "Ocular agents-T" means: (A) Topically administered ophthalmic agents used for the purpose of treating or alleviating the effects of diseases or abnormal conditions of the human eye or eyelid excluding the lacrimal drainage system, lacrimal gland and structures posterior to the iris, but including the treatment of iritis, excluding allergens, alpha adrenergic agonists, antiparasitics, antifungal agents, antimetabolites, antineoplastics, beta adrenergic blocking agent, carbonic anhydrase inhibitors, collagen corneal shields, epinephrine preparations, miotics used for the treatment of glaucoma, temporary collagen implants and succus cineraria maritima; (B) orally administered antibiotics, antihistamines and antiviral agents used for the purpose of treating or alleviating the effects of diseases or abnormal conditions of the human eye or eyelid excluding the lacrimal drainage system, lacrimal gland and structures posterior to the iris, but including the treatment of iritis; and (C) orally administered analgesic agents used for the purpose of alleviating pain caused by diseases or abnormal conditions of the human eye or eyelid excluding the lacrimal drainage system, lacrimal gland and structures posterior to the iris, but including the treatment of iritis. "Ocular agent-T" does not include any controlled substance or drug administered by injection.

(6) "Noninvasive procedures" means procedures used to diagnose or treat a disease or abnormal condition of the human eye or eyelid excluding the lacrimal drainage system, lacrimal gland and structures posterior to the iris but including the removal of superficial foreign bodies of the cornea and the treatment of iritis, provided the procedures do not require an incision or use of a laser.

(b) Optometrists who were first licensed prior to April 1, 1985, shall be permitted to acquire and use ocular agents-D topically in the practice of optometry only after they have completed a course which (1) consists of a minimum of forty-five classroom hours and fifteen clinic hours, (2) is conducted by an institution accredited by a regional professional accreditation organization recognized or approved by the National Commission on Accrediting or the United States Commissioner of Education and (3) is approved by the Department of Public Health, and have passed an examination, prescribed by said department with the advice and consent of the board of examiners in optometry, in pharmacology as it applies to optometry, with a particular emphasis on the topical application of ocular agents-D to the eye for the purpose of examination of the human eye and the analysis of ocular functions. Optometrists licensed on and after April 1, 1985, shall not be required to take a course or pass an examination in order to acquire and use said agents topically in the practice of optometry.

(c) Optometrists who were first licensed in this state prior to January 1, 1991, shall be permitted to acquire, administer, dispense and prescribe ocular agents-T in the practice of optometry only after they have (1) successfully completed a minimum of ninety-six classroom hours and fourteen clinical hours in the didactic and clinical use of ocular agents-T for the purposes of treating deficiencies, deformities, diseases or abnormalities of the human eye, including the removal of foreign bodies from the eye and adnexae, conducted by a duly accredited school or college of optometry or medical school, and have passed an examination as administered by the accredited school or college of optometry or medical school which conducted the course of study and (2) successfully completed a course in cardiopulmonary resuscitation offered by an accredited hospital, the American Heart Association or a comparable institution or organization. Proof of successful completion of the courses required under subdivisions (1) and (2) of this subsection shall be reported to the Department of Consumer Protection. Optometrists licensed on and after January 1, 1991, and who have graduated from an accredited school or college of optometry on or after January 1, 1991, shall not be required to take either a course in the didactic and clinical use of ocular agents-T or a course in cardiopulmonary resuscitation or pass an examination in order to acquire, administer, dispense and prescribe such ocular agents-T.

(d) Optometrists shall be permitted to engage in the practice of advanced optometric care only after they have (1) successfully completed a minimum of seventy-five classroom hours and fifty-one clinical hours in the study of advanced optometric care that includes the treatment of deficiencies, deformities, diseases or abnormalities of the human eye, including anterior segment disease, lacrimology and glaucoma conducted by a duly accredited school or college of optometry or medical school, (2) passed an examination as administered by the accredited school or college of optometry or medical school that conducted the course of study and (3) met the requirements that permit them to acquire and use ocular agents-D and to acquire, administer, dispense and prescribe ocular agents-T pursuant to subsections (b) and (c) of this section.

(e) No licensed optometrist authorized pursuant to this section to acquire, administer, dispense and prescribe an ocular agent-T shall dispense such agent to any person unless no charge is imposed for such agent and the quantity dispensed does not exceed a seventy-two-hour supply, except if the minimum available quantity for said agent is greater than a seventy-two-hour supply, the optometrist may dispense the minimum available quantity.

(f) No licensed optometrist authorized pursuant to this section to practice advanced optometric care shall dispense controlled substances under schedules II, III, IV and V or under section 21a-252, to any person unless no charge is imposed for such substances and the quantity dispensed does not exceed a seventy-two-hour supply, except if the minimum available quantity for said agent is greater than a seventy-two-hour supply, the optometrist may dispense the minimum available quantity.

(g) (1) An optometrist may delegate to an optometric assistant, optometric technician or appropriately trained person the use or application of any ocular agent in accordance with section 20-138a, or an optometrist may cause the same to be self-administered by a patient under the care and direction of the optometrist.

(2) No optometrist shall delegate to any person the authority to prescribe any ocular agent.

(h) An optometrist shall refer any patient with iritis or a corneal ulcer to an ophthalmologist not later than seventy-two hours after commencement of initial treatment of such condition unless there is improvement of such condition within such time period.

(i) Notwithstanding the provisions of section 52-184c, each optometrist authorized by this section to practice advanced optometric care, or to use ocular agents-D or ocular agents-T or both, shall be held to the same standard of care as ophthalmologists with regard to such advanced optometric care, the use of such ocular agents-D or ocular agents-T or both and any other procedures authorized by this section.

(j) Each optometrist authorized pursuant to this section to practice advanced optometric care, or to use ocular agents-D or ocular agents-T or both, shall post in a conspicuous location in each office waiting room, a standardized notice stating that said optometrist is authorized to practice advanced optometric care, or to use ocular agents for diagnosis or treatment or both, within the scope of his practice.

(k) An optometrist engaged in the practice of advanced optometric care and the nonsurgical treatment of glaucoma shall refer to an ophthalmologist or other physician, for evaluation, any glaucoma patient who (1) presents with the presence of pediatric glaucoma or closed angle glaucoma, or (2) does not improve in response to treatment. Nothing in this subsection shall be construed to prohibit the emergency administration, prior to referral, of medication otherwise authorized under this section.

(l) Each optometrist authorized pursuant to this section to practice advanced optometric care shall notify the Department of Public Health of his intent to engage in such practice. The Commissioner of Public Health shall develop license renewal forms that indicate whether a person holds himself out as authorized to practice advanced optometric care.

(m) On and after January 1, 2005, no initial license to engage in optometry shall be issued unless the applicant meets the requirements of this section to practice advanced optometric care. The

foregoing provision shall not apply to optometrists licensed in this state prior to January 1, 2005.

History:

(1949 Rev., S. 4488; P.A. 73-343, S. 1, 2; P.A. 86-13, S. 2, 4; P.A. 87-129, S. 1; P.A. 92-88, S. 1; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58; P.A. 96-70, S. 1; June 30 Sp. Sess. P.A. 03-6, S. 146(d); P.A. 04-35, S. 1; 04-169, S. 17; 04-189, S. 1; P.A. 05-36, S. 1; P.A. 07-92, S. 1-4; 07-252, S. 79.)

- **CHAPTER 384 VETERINARY MEDICINE**

Conn. Gen. Stat. § 20-197. License required. Practice defined.

No person shall practice veterinary medicine, **surgery** or dentistry until he has obtained a license as provided in section 20-199. A person shall be construed to practice veterinary medicine, **surgery** or dentistry, within the meaning of this chapter, who holds himself out as being able to diagnose, administer biologics for, treat, operate or prescribe for any animal or bird disease, pain, injury, deformity or physical condition, or who either offers or undertakes, by any means or methods, to diagnose, administer biologics for, treat, operate or prescribe for any animal or bird disease, pain, injury, deformity or physical condition. The euthanizing of animals in accordance with applicable state and federal drug laws by the Connecticut Humane Society, the floating of teeth in horses by persons experienced in that practice and the performance of myofascial trigger point therapy by persons experienced in that practice shall not be deemed to be the practice of veterinary medicine. For the purposes of this section, "floating teeth" means using hand-held rasps to reduce or eliminate sharp or uneven edges on a horse's upper and lower molars to avoid injury to the tongue and cheeks and to improve chewing food, but does not include treating decay or tumors or extracting teeth. For the purposes of this section, "myofascial trigger point therapy" means the use of specific palpation, compression, stretching and corrective exercise for promoting optimum athleticism, and "persons experienced in that practice" means persons who, prior to October 1, 2003, have attended a minimum of two hundred hours of classroom, lecture and hands-on practice in myofascial trigger point therapy, including animal musculoskeletal anatomy and biomechanics, theory and application of animal myofascial trigger point techniques, factors that habituate a presenting condition and corrective exercise.

History:

(1949 Rev., S. 4600; 1957, P.A. 360, S. 2; P.A. 79-262, S. 1; P.A. 81-57, S. 1, 2; P.A. 86-123, S. 3; P.A. 98-94; P.A. 03-277, S. 1; P.A. 04-109, S. 3; P.A. 05-288, S. 83.)

Conn. Gen. Stat. § 20-198. Qualifications for examination. Approved schools. Denial of eligibility for licensure.

(a) No person shall be granted a license to practice veterinary medicine, **surgery** or dentistry until the department finds that such person (1) was graduated with the degree of doctor of

veterinary medicine, or its equivalent, from a school of veterinary medicine, **surgery** or dentistry which, at the time such person graduated, was accredited by the American Veterinary Medical Association, or (2) if graduated from a school located outside of the United States, its territories or Canada, graduated from a program acceptable to the American Veterinary Medical Association as required to receive certification by the Educational Commission for Foreign Veterinary Graduates. No person who was graduated from a school of veterinary medicine, **surgery** or dentistry that is not accredited by the American Veterinary Medical Association and that is located outside the United States, its territories or Canada shall be granted a license unless such person has also received certification from the Educational Commission for Foreign Veterinary Graduates or Program for the Assessment of Veterinary Education Equivalence.

(b) The department may, under such regulations as the Commissioner of Public Health may adopt, in accordance with chapter 54, with the advice and assistance of the board, deny eligibility for licensure to a graduate of a school that has been found to have provided fraudulent or inaccurate documentation regarding either the school's educational program or the academic credentials of graduates of the school's program or to have failed to meet educational standards prescribed in such regulations.

History:

(1949 Rev., S. 4601, 4602; P.A. 80-484, S. 76, 176; P.A. 86-123, S. 4; P.A. 89-115, S. 2, 7; P.A. 93-381, S. 9, 39; P.A. 94-210, S. 26, 30; P.A. 95-257, S. 12, 21, 58; P.A. 03-252, S. 13; P.A. 05-272, S. 8; P.A. 07-252, S. 48.)

Conn. Gen. Stat. § 20-202. Disciplinary action; grounds.

After notice and opportunity for hearing as provided in the regulations established by the Commissioner of Public Health, said board may take any of the actions set forth in section 19a-17 for any of the following causes: (1) The presentation to the board of any diploma, license or certificate illegally or fraudulently obtained; (2) proof that the holder of such license or certificate has become unfit or incompetent or has been guilty of cruelty, unskillfulness or negligence towards animals and birds; (3) conviction of the violation of any of the provisions of this chapter by any court of criminal jurisdiction, provided no license or registration shall be revoked or suspended because of such conviction if an appeal to a higher court has been filed until such appeal has been determined by the higher court and the conviction sustained; (4) the violation of any of the provisions of this chapter or the refusal to comply with any of said provisions; (5) the publication or circulation of any statement of a character tending to deceive or mislead the public; (6) the supplying of drugs, biologics, instruments or any substances or devices by which unqualified persons may practice veterinary medicine, **surgery** and dentistry, except that such drugs, biologics, instruments, substances or devices may be supplied to a farmer for his own animals or birds; (7) fraudulent issue or use of any health certificate, vaccination certificate, test chart or other blank form used in the practice of veterinary medicine relating to the dissemination of animal disease, transportation of diseased animals or the sale of inedible products of animal origin for human consumption; (8) knowingly having professional association with, or knowingly employing any person who is unlawfully practicing veterinary medicine; (9)

failure to keep veterinary premises and equipment in a clean and sanitary condition; (10) physical or mental illness, emotional disorder or loss of motor skill, including but not limited to, deterioration through the aging process; or (11) abuse or excessive use of drugs, including alcohol, narcotics or chemicals. A violation of any of the provisions of this chapter by any unlicensed employee in the practice of veterinary medicine, with the knowledge of his employer, shall be deemed a violation thereof by his employer. The Commissioner of Public Health may order a license holder to submit to a reasonable physical or mental examination if his physical or mental capacity to practice safely is the subject of an investigation. Said commissioner may petition the superior court for the judicial district of Hartford to enforce such order or any action taken pursuant to section 19a-17.

History:

(1949 Rev., S. 4604; 1957, P.A. 360, S. 4; P.A. 77-614, S. 266, 610; P.A. 79-262, S. 2; P.A. 80-484, S. 80, 176; P.A. 88-230, S. 1, 12; P.A. 90-98, S. 1, 2; P.A. 93-142, S. 4, 7, 8; 93-381, S. 9, 39; P.A. 95-220, S. 4-6; 95-257, S. 12, 21, 58; 95-271, S. 38, 40.)

Conn. Gen. Stat. § 20-206. Penalty.

(a) Any person who practices veterinary medicine, **surgery** or dentistry in violation of any of the provisions of this chapter shall be subject to the disciplinary actions specified in section 19a-17.

(b) Any person not licensed as provided in this chapter who represents himself as a veterinarian or, having had his license suspended or revoked continues to represent himself as a veterinarian or carries on veterinary medicine, **surgery** or dentistry as defined in section 20-197, shall be fined not more than three hundred dollars or imprisoned not more than six months or both. Failure to renew a license in a timely manner shall not constitute a violation for the purposes of this subsection. Any such person shall be enjoined from such practice by the Superior Court upon application by the Connecticut Board of Veterinary Medicine. The Department of Public Health may, on its own initiative or at the request of the board, investigate any alleged violation of this chapter or any regulations adopted thereunder.

History:

(1949 Rev., S. 4608; P.A. 85-314; P.A. 86-123, S. 9; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58; P.A. 98-166, S. 2, 9.)

- **CHAPTER 388 ELECTROLOGISTS**

Conn. Gen. Stat. § 20-268. Board of examiners.

There shall be in the department a Board of Examiners of Electrologists, composed of five members, one of whom shall be a doctor of medicine licensed to practice medicine and **surgery** in the state and a diplomate of the American Board of Dermatology, two of whom shall be public

members and two of whom shall be practicing electrologists who are residents of this state. The Governor shall appoint the members of the board, subject to the provisions of section 4-9a. The board shall meet at least once during each calendar quarter and at such other times as the chairperson deems necessary. Special meetings shall be held on the request of a majority of the board after notice in accordance with the provisions of section 1-225. A majority of the members of the board shall constitute a quorum. Members shall not be compensated for their services. Any member who fails to attend three consecutive meetings or who fails to attend fifty per cent of all meetings held during any calendar year shall be deemed to have resigned from office. Minutes of all meetings shall be recorded by the board. No member shall participate in the affairs of the board during the pendency of any disciplinary proceedings by the board against such member. No professional member shall be an elected or appointed officer of a professional society of electrologists or have been such an officer during the year immediately preceding such professional member's appointment. The board shall (1) hear and decide matters concerning suspension or revocation of licensure, (2) adjudicate complaints against practitioners, and (3) impose sanctions where appropriate.

History:

(1951, S. 2317d; P.A. 77-614, S. 454, 610; P.A. 80-484, S. 171, 174, 176; P.A. 81-471, S. 61, 71; June Sp. Sess. P.A. 91-12, S. 27, 55; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58; P.A. 98-143, S. 16, 24; P.A. 01-109, S. 5.)

Conn. Gen. Stat. § 20-277. Scope of chapter.

No provision of this chapter shall be construed to confer any authority to practice medicine or surgery; nor shall this chapter prohibit the practice of electrology by a person licensed to practice the healing arts or a person employed in a hospital or in the office of a licensed physician under such physician's immediate direction; nor shall this chapter prohibit the use of nonelectrical cosmetic devices or the use of wax or other proprietary depilatories used for the temporary removal of superfluous hair from the surface of the skin.

History:

(1951, S. 2326d; 1963, P.A. 330, S. 7; P.A. 01-109, S. 11.)

TITLE 21a CONSUMER PROTECTION

- **CHAPTER 420b DEPENDENCY-PRODUCING DRUGS**

Conn. Gen. Stat. § 21a-240. Definitions.

The following words and phrases, as used in this chapter, shall have the following meanings, unless the context otherwise requires:

(1) "Abuse of drugs" means the use of controlled substances solely for their stimulant, depressant or hallucinogenic effect upon the higher functions of the central nervous system and not as a therapeutic agent prescribed in the course of medical treatment or in a program of research operated under the direction of a physician or pharmacologist;

(2) "Administer" means the direct application of a controlled substance, whether by injection, inhalation, ingestion or any other means, to the body of a patient or research subject by: (A) A practitioner, or, in his presence, by his authorized agent, or (B) the patient or research subject at the direction and in the presence of the practitioner, or (C) a nurse or intern under the direction and supervision of a practitioner;

(3) "Agent" means an authorized person who acts on behalf of or at the direction of a manufacturer, distributor or dispenser. It does not include a common or contract carrier, public warehouseman, or employee of the carrier or warehouseman;

(4) "Amphetamine-type substances" include amphetamine, optical isomers thereof, salts of amphetamine and its isomers, and chemical compounds which are similar thereto in chemical structure or which are similar thereto in physiological effect, and which show a like potential for abuse, which are controlled substances under this chapter unless modified;

(5) "Barbiturate-type drugs" include barbituric acid and its salts, derivatives thereof and chemical compounds which are similar thereto in chemical structure or which are similar thereto in physiological effect, and which show a like potential for abuse, which are controlled substances under this chapter unless modified;

(6) "Bureau" means the Bureau of Narcotics and Dangerous Drugs, United States Department of Justice, or its successor agency;

(7) "Cannabis-type substances" include all parts of any plant, or species of the genus cannabis or any infra specific taxon thereof whether growing or not; the seeds thereof; the resin extracted from any part of such a plant; and every compound, manufacture, salt, derivative, mixture or preparation of such plant, its seeds or resin; but shall not include the mature stalks of such plant, fiber produced from such stalks, oil or cake made from the seeds of such plant, any other compound, manufacture, salt, derivative, mixture or preparation of such mature stalks, except the resin extracted therefrom, fiber, oil or cake, or the sterilized seed of such plant which is incapable of germination. Included are cannabinon, cannabinol, cannabidiol and chemical compounds which are similar to cannabinon, cannabinol or cannabidiol in chemical structure or which are similar thereto in physiological effect, and which show a like potential for abuse, which are controlled substances under this chapter unless modified;

(8) "Controlled drugs" are those drugs which contain any quantity of a substance which has been designated as subject to the federal Controlled Substances Act, or which has been designated as a depressant or stimulant drug pursuant to federal food and drug laws, or which has been designated by the Commissioner of Consumer Protection pursuant to section 21a-243, as having a stimulant, depressant or hallucinogenic effect upon the higher functions of the central nervous

system and as having a tendency to promote abuse or psychological or physiological dependence, or both. Such controlled drugs are classifiable as amphetamine-type, barbiturate-type, cannabis-type, cocaine-type, hallucinogenic, morphine-type and other stimulant and depressant drugs. Specifically excluded from controlled drugs and controlled substances are alcohol, nicotine and caffeine;

(9) "Controlled substance" means a drug, substance, or immediate precursor in schedules I to V, inclusive, of the Connecticut controlled substance scheduling regulations adopted pursuant to section 21a-243;

(10) "Counterfeit substance" means a controlled substance which, or the container or labeling of which, without authorization, bears the trademark, trade name or other identifying mark, imprint, number or device, or any likeness thereof, of a manufacturer, distributor or dispenser other than the person who in fact manufactured, distributed or dispensed the substance;

(11) "Deliver or delivery" means the actual, constructive or attempted transfer from one person to another of a controlled substance, whether or not there is an agency relationship;

(12) "Dentist" means a person authorized by law to practice dentistry in this state;

(13) "Dispense" means to deliver a controlled substance to an ultimate user or research subject by or pursuant to the lawful order of a practitioner, including the prescribing, administering, packaging, labeling or compounding necessary to prepare the substance for the delivery;

(14) "Dispenser" means a practitioner who dispenses;

(15) "Distribute" means to deliver other than by administering or dispensing a controlled substance;

(16) "Distributor" means a person who distributes and includes a wholesaler who is a person supplying or distributing controlled drugs which he himself has not produced or prepared to hospitals, clinics, practitioners, pharmacies, other wholesalers, manufacturers and federal, state and municipal agencies;

(17) "Drug" means (A) substances recognized as drugs in the official United States Pharmacopoeia, official Homeopathic Pharmacopoeia of the United States, or official National Formulary, or any supplement to any of them; (B) substances intended for use in the diagnosis, cure, mitigation, treatment or prevention of disease in man or animals; (C) substances, other than food, intended to affect the structure or any function of the body of man or animals; and (D) substances intended for use as a component of any article specified in subparagraph (A), (B) or (C) of this subdivision. It does not include devices or their components, parts or accessories;

(18) "Drug dependence" means a psychoactive substance dependence on drugs as that condition is defined in the most recent edition of the "Diagnostic and Statistical Manual of Mental Disorders" of the American Psychiatric Association;

(19) "Drug-dependent person" means a person who has a psychoactive substance dependence on drugs as that condition is defined in the most recent edition of the "Diagnostic and Statistical Manual of Mental Disorders" of the American Psychiatric Association;

(20) (A) "Drug paraphernalia" refers to equipment, products and materials of any kind which are used, intended for use or designed for use in planting, propagating, cultivating, growing, harvesting, manufacturing, compounding, converting, producing, processing, preparing, testing, analyzing, packaging, repackaging, storing, containing or concealing, or ingesting, inhaling or otherwise introducing into the human body, any controlled substance contrary to the provisions of this chapter including, but not limited to: (i) Kits intended for use or designed for use in planting, propagating, cultivating, growing or harvesting of any species of plant which is a controlled substance or from which a controlled substance can be derived; (ii) kits used, intended for use or designed for use in manufacturing, compounding, converting, producing, processing or preparing controlled substances; (iii) isomerization devices used, intended for use in increasing the potency of any species of plant which is a controlled substance; (iv) testing equipment used, intended for use or designed for use in identifying or analyzing the strength, effectiveness or purity of controlled substances; (v) dilutents and adulterants, such as quinine hydrochloride, mannitol, mannite, dextrose and lactose used, intended for use or designed for use in cutting controlled substances; (vi) separation gins and sifters used, intended for use or designed for use in removing twigs and seeds from, or in otherwise cleaning or refining, marijuana; (vii) capsules and other containers used, intended for use or designed for use in packaging small quantities of controlled substances; (viii) containers and other objects used, intended for use or designed for use in storing or concealing controlled substances; (ix) objects used, intended for use or designed for use in ingesting, inhaling, or otherwise introducing marijuana, cocaine, hashish, or hashish oil into the human body, such as: Metal, wooden, acrylic, glass, stone, plastic or ceramic pipes with screens, permanent screens, hashish heads or punctured metal bowls; water pipes; carburetion tubes and devices; smoking and carburetion masks; roach clips: Meaning objects used to hold burning material, such as a marijuana cigarette, that has become too small or too short to be held in the hand; miniature cocaine spoons, and cocaine vials; chamber pipes; carburetor pipes; electric pipes; air-driven pipes; chillums; bongs or ice pipes or chillers;

(B) "Factory" means any place used for the manufacturing, mixing, compounding, refining, processing, packaging, distributing, storing, keeping, holding, administering or assembling illegal substances contrary to the provisions of this chapter, or any building, rooms or location which contains equipment or paraphernalia used for this purpose;

(21) "Federal Controlled Substances Act, 21 USC 801 et seq." means Public Law 91-513, the Comprehensive Drug Abuse Prevention and Control Act of 1970;

(22) "Federal food and drug laws" means the federal Food, Drug and Cosmetic Act, as amended, Title 21 USC 301 et seq.;

(23) "Hallucinogenic substances" are psychodysleptic substances which assert a confusional or disorganizing effect upon mental processes or behavior and mimic acute psychotic disturbances.

Exemplary of such drugs are mescaline, peyote, psilocyn and d-lysergic acid diethylamide, which are controlled substances under this chapter unless modified;

(24) "Hospital", as used in sections 21a-243 to 21a-283, inclusive, means an institution for the care and treatment of the sick and injured, approved by the Department of Public Health or the Department of Mental Health and Addiction Services as proper to be entrusted with the custody of controlled drugs and substances and professional use of controlled drugs and substances under the direction of a licensed practitioner;

(25) "Intern" means a person who holds a degree of doctor of medicine or doctor of dental **surgery** or medicine and whose period of service has been recorded with the Department of Public Health and who has been accepted and is participating in training by a hospital or institution in this state. Doctors meeting the foregoing requirements and commonly designated as "residents" and "fellows" shall be regarded as interns for purposes of this chapter;

(26) "Immediate precursor" means a substance which the Commissioner of Consumer Protection has found to be, and by regulation designates as being, the principal compound commonly used or produced primarily for use, and which is an immediate chemical intermediary used or likely to be used, in the manufacture of a controlled substance, the control of which is necessary to prevent, curtail or limit manufacture;

(27) "Laboratory" means a laboratory approved by the Department of Consumer Protection as proper to be entrusted with the custody of controlled substances and the use of controlled substances for scientific and medical purposes and for purposes of instruction, research or analysis;

(28) "Manufacture" means the production, preparation, cultivation, growing, propagation, compounding, conversion or processing of a controlled substance, either directly or indirectly by extraction from substances of natural origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis, and includes any packaging or repackaging of the substance or labeling or relabeling of its container, except that this term does not include the preparation or compounding of a controlled substance by an individual for his own use or the preparation, compounding, packaging or labeling of a controlled substance: (A) By a practitioner as an incident to his administering or dispensing of a controlled substance in the course of his professional practice, or (B) by a practitioner, or by his authorized agent under his supervision, for the purpose of, or as an incident to, research, teaching or chemical analysis and not for sale;

(29) "Marijuana" means all parts of any plant, or species of the genus cannabis or any infra specific taxon thereof, whether growing or not; the seeds thereof; the resin extracted from any part of the plant; and every compound, manufacture, salt, derivative, mixture, or preparation of such plant, its seeds or resin. It does not include the mature stalks of such plant, fiber produced from such stalks, oil or cake made from the seeds of such plant, any other compound, manufacture, salt, derivative, mixture or preparation of such mature stalks, except the resin extracted therefrom, fiber, oil, or cake, or the sterilized seed of such plant which is incapable of

germination. Included are cannabinon, cannabinol or cannabidiol and chemical compounds which are similar to cannabinon, cannabinol or cannabidiol in chemical structure or which are similar thereto in physiological effect, and which show a like potential for abuse, which are controlled substances under this chapter unless modified;

(30) "Narcotic substance" means any of the following, whether produced directly or indirectly by extraction from substances of vegetable origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis: (A) Morphine-type: (i) Opium and opiate, and any salt, compound, derivative, or preparation of opium or opiate which are similar thereto in chemical structure or which are similar thereto in physiological effect and which show a like potential for abuse, which are controlled substances under this chapter unless modified; (ii) any salt, compound, isomer, derivative, or preparation thereof which is chemically equivalent or identical with any of the substances referred to in clause (i), but not including the isoquinoline alkaloids of opium; (iii) opium poppy and poppy straw; (B) cocaine-type, coca leaves and any salt, compound, derivative or preparation of coca leaves, and any salt, compound, isomer, derivatives or preparation thereof which is chemically equivalent or identical with any of these substances or which are similar thereto in physiological effect and which show a like potential for abuse, but not including decocainized coca leaves or extractions of coca leaves which do not contain cocaine or ecgonine;

(31) "Nurse" means a person performing nursing as defined in section 20-87a;

(32) "Official written order" means an order for controlled substances written on a form provided by the bureau for that purpose under the federal Controlled Substances Act;

(33) "Opiate" means any substance having an addiction-forming or addiction-sustaining liability similar to morphine or being capable of conversion into a drug having addiction-forming or addiction-sustaining liability; it does not include, unless specifically designated as controlled under this chapter, the dextrorotatory isomer of 3-methoxy-n-methylmorfinan and its salts (dextro-methorphan) but shall include its racemic and levorotatory forms;

(34) "Opium poppy" means the plant of the species papaver somniferum l., except its seed;

(35) Repealed by P.A. 99-102, S. 51;

(36) "Other stimulant and depressant drugs" means controlled substances other than amphetamine-type, barbiturate-type, cannabis-type, cocaine-type, hallucinogenics and morphine-type which are found to exert a stimulant and depressant effect upon the higher functions of the central nervous system and which are found to have a potential for abuse and are controlled substances under this chapter;

(37) "Person" includes any corporation, limited liability company, association or partnership, or one or more individuals, government or governmental subdivisions or agency, business trust, estate, trust, or any other legal entity. Words importing the plural number may include the singular; words importing the masculine gender may be applied to females;

(38) "Pharmacist" means a person authorized by law to practice pharmacy pursuant to section 20-590, 20-591, 20-592 or 20-593;

(39) "Pharmacy" means an establishment licensed pursuant to section 20-594;

(40) "Physician" means a person authorized by law to practice medicine in this state pursuant to section 20-9;

(41) "Podiatrist" means a person authorized by law to practice podiatry in this state;

(42) "Poppy straw" means all parts, except the seeds, of the opium poppy, after mowing;

(43) "Practitioner" means: (A) A physician, dentist, veterinarian, podiatrist, scientific investigator or other person licensed, registered or otherwise permitted to distribute, dispense, conduct research with respect to or to administer a controlled substance in the course of professional practice or research in this state; (B) a pharmacy, hospital or other institution licensed, registered or otherwise permitted to distribute, dispense, conduct research with respect to or to administer a controlled substance in the course of professional practice or research in this state;

(44) "Prescribe" means order or designate a remedy or any preparation containing controlled substances;

(45) "Prescription" means a written or oral order for any controlled substance or preparation from a licensed practitioner to a pharmacist for a patient;

(46) "Production" includes the manufacture, planting, cultivation, growing or harvesting of a controlled substance;

(47) "Registrant" means any person licensed by this state and assigned a current federal Bureau of Narcotics and Dangerous Drug Registry Number as provided under the federal Controlled Substances Act;

(48) "Registry number" means the alphabetical or numerical designation of identification assigned to a person by the federal Drug Enforcement Administration, or other federal agency, which is commonly known as the federal registry number;

(49) "Restricted drugs or substances" are the following substances without limitation and for all purposes: Datura stramonium; hyoscyamus niger; atropa belladonna, or the alkaloids atropine; hyoscyamine; belladonnine; apatropine; or any mixture of these alkaloids such as daturine, or the synthetic homatropine or any salts of these alkaloids, except that any drug or preparation containing any of the above-mentioned substances which is permitted by federal food and drug laws to be sold or dispensed without a prescription or written order shall not be a controlled substance; amyl nitrite; the following volatile substances to the extent that said chemical

substances or compounds containing said chemical substances are sold, prescribed, dispensed, compounded, possessed or controlled or delivered or administered to another person with the purpose that said chemical substances shall be breathed, inhaled, sniffed or drunk to induce a stimulant, depressant or hallucinogenic effect upon the higher functions of the central nervous system: Acetone; benzene; butyl alcohol; butyl nitrate and its salts, isomers, esters, ethers or their salts; cyclohexanone; dichlorodifluoromethane; ether; ethyl acetate; formaldehyde; hexane; isopropanol; methanol; methyl cellosolve acetate; methyl ethyl ketone; methyl isobutyl ketone; nitrous oxide; pentochlorophenol; toluene; toluol; trichloroethane; trichloroethylene; 1,4 butanediol;

(50) "Sale" is any form of delivery which includes barter, exchange or gift, or offer therefor, and each such transaction made by any person whether as principal, proprietor, agent, servant or employee;

(51) "State", when applied to a part of the United States, includes any state, district, commonwealth, territory or insular possession thereof, and any area subject to the legal authority of the United States of America;

(52) "State food, drug and cosmetic laws" means the Uniform Food, Drug and Cosmetic Act, section 21a-91 et seq.;

(53) "Ultimate user" means a person who lawfully possesses a controlled substance for his own use or for the use of a member of his household or for administering to an animal owned by him or by a member of his household;

(54) "Veterinarian" means a person authorized by law to practice veterinary medicine in this state;

(55) "Wholesaler" means a distributor or a person who supplies controlled substances that he himself has not produced or prepared to registrants as defined in subsection (47) of this section;

(56) "Reasonable times" means the time or times any office, care-giving institution, pharmacy, clinic, wholesaler, manufacturer, laboratory, warehouse, establishment, store or place of business, vehicle or other place is open for the normal affairs or business or the practice activities usually conducted by the registrant;

(57) "Unit dose drug distribution system" means a drug distribution system used in a hospital or chronic and convalescent nursing home in which drugs are supplied in individually labeled unit of use packages, each patient's supply of drugs is exchanged between the hospital pharmacy and the drug administration area or, in the case of a chronic and convalescent nursing home between a pharmacy and the drug administration area, at least once each twenty-four hours and each patient's medication supply for this period is stored within a patient-specific container, all of which is conducted under the direction of a pharmacist licensed in Connecticut and, in the case of a hospital, directly involved in the provision and supervision of pharmaceutical services at such hospital at least thirty-five hours each week;

(58) "Cocaine in a free-base form" means any substance which contains cocaine, or any compound, isomer, derivative or preparation thereof, in a nonsalt form.

History:

(1967, P.A. 555, S. 1; 1969, P.A. 391, S. 1; 578, S. 1; 753, S. 1, 2, 38; 1972, P.A. 278, S. 1; 294, S. 42; P.A. 73-137, S. 11-14; 73-291, S. 3; 73-616, S. 61; 73-681, S. 1, 29; P.A. 74-332, S. 4-6; 74-338, S. 36, 94; P.A. 75-176, S. 1; P.A. 77-101, S. 1; 77-614, S. 323, 610; P.A. 80-224, S. 1; P.A. 81-363, S. 1; 81-472, S. 53, 159; P.A. 82-355, S. 1; P.A. 85-613, S. 81, 154; P.A. 87-129, S. 2; 87-373, S. 1; P.A. 90-209, S. 26; P.A. 92-185, S. 2, 6; May Sp. Sess. P.A. 92-11, S. 66, 70; P.A. 93-381, S. 9, 39; P.A. 95-72, S. 2; 95-79, S. 79, 189; 95-257, S. 11, 12, 21, 58; 95-264, S. 57; P.A. 97-248, S. 5, 12; P.A. 99-102, S. 32, 51; June Sp. Sess. P.A. 99-2, S. 5, 72; P.A. 00-182, S. 1; P.A. 03-278, S. 78, 79; June 30 Sp. Sess. P.A. 03-6, S. 146(c), (d); P.A. 04-169, S. 17; 04-189, S. 1; P.A. 06-195, S. 15.)

TITLE 22 AGRICULTURE. DOMESTIC ANIMALS

- **CHAPTER 435 DOGS AND OTHER COMPANION ANIMALS. KENNELS AND PET SHOPS**

Conn. Gen. Stat. § 22-332. Impoundment and disposition of roaming, injured or mistreated animals. Authority to spay or neuter unclaimed dog.

(a) The Chief Animal Control Officer, any animal control officer or any municipal animal control officer shall be responsible for the enforcement of this chapter and shall make diligent search and inquiry for any violation of any of its provisions. Any such officer may take into custody (1) any dog found roaming in violation of the provisions of section 22-364, (2) any dog not having a tag or plate on a collar about its neck or on a harness on its body as provided by law or which is not confined or controlled in accordance with the provisions of any order or regulation relating to rabies issued by the commissioner in accordance with the provisions of this chapter, or (3) any dog found injured on any highway, neglected, abandoned or cruelly treated. The officer shall impound such dog at the pound serving the town where the dog is taken unless, in the opinion of a licensed veterinarian, the dog is so injured or diseased that it should be destroyed immediately, in which case the municipal animal control officer of such town may cause the dog to be mercifully killed by a licensed veterinarian or disposed of as the State Veterinarian may direct. The municipal animal control officer shall immediately notify the owner or keeper of any dog so taken, if known, of its impoundment. Such officer shall immediately notify the owner or keeper of any other animal which is taken into custody, if such owner or keeper is known. If the owner or keeper of any such dog or other animal is unknown, the officer shall immediately tag or employ such other suitable means of identification of the dog or other animal as may be approved by the Chief Animal Control Officer and shall promptly cause a description of such dog or other animal to be published once in the lost and found column of a newspaper having a circulation in such town.

(b) If such dog or other animal is not claimed by and released to the owner within seven days after the date of publication, the municipal animal control officer, upon finding such dog or other animal to be in satisfactory health, may have a licensed veterinarian spay or neuter such dog and sell such dog or other animal to any person who satisfies such officer that he is purchasing it as a pet and that he can give it a good home and proper care. The municipal animal control officer may retain possession of such dog or other animal for such additional period of time as he may deem advisable in order to place such dog or other animal as a pet and may have a licensed veterinarian spay or neuter such dog. If, within such period, any dog or other animal is not claimed by and released to the owner or keeper or purchased as a pet, the officer shall cause such dog or other animal to be mercifully killed by a licensed veterinarian or disposed of as the State Veterinarian may direct. Any veterinarian who so destroys a dog shall be paid from the dog fund account. No person who so destroys a dog or other animal shall be held criminally or civilly liable therefor nor shall any licensed veterinarian who spays or neuters a dog pursuant to this section be held civilly liable, including, but not limited to, liability for reconstructive neutical implantation **surgery**.

(c) The town treasurer or other fiscal officer shall pay from the dog fund account the advertising expense incurred under the provisions of this section upon receipt of an itemized statement together with a copy of the advertisement as published. Any person who purchases a dog as a pet shall pay a fee of five dollars and procure a license and tag for such dog from the town clerk, in accordance with the provisions of section 22-338.

History:

(1949 Rev., S. 3379; 1951, S. 710b; 1953, 1955, S. 1817d; 1961, P.A. 517, S. 21; 1963, P.A. 14, S. 3; 613, S. 35; 1969, P.A. 81, S. 4; 1971, P.A. 76; P.A. 74-183, S. 246, 291; P.A. 76-436, S. 212, 681; P.A. 78-280, S. 1, 127; P.A. 80-315, S. 1; P.A. 86-45, S. 1; P.A. 91-59, S. 6; P.A. 93-435, S. 34, 95; P.A. 96-243, S. 15, 16; P.A. 98-12, S. 8, 22; P.A. 03-137, S. 1.)

Conn. Gen. Stat. § 22-332d. Impoundment and disposition of certain cats. Authority to spay or neuter unclaimed cat.

(a) Any animal control officer for a municipality which has adopted an ordinance under subsection (b) of section 22-339d may take into custody any cat found to be damaging property other than property of its owner or keeper or causing an unsanitary, dangerous or unreasonably offensive condition unless such cat can be identified as under the care of its owner or a registered keeper of feral cats. The officer shall impound such cat at the pound serving the town where the cat is taken unless, in the opinion of a licensed veterinarian, the cat is so injured or diseased that it should be destroyed immediately, in which case the municipal animal control officer of such town may cause the cat to be mercifully killed by a licensed veterinarian or disposed of as the State Veterinarian may direct. The municipal animal control officer shall immediately notify the owner or keeper of any cat so taken, if known, of its impoundment. If the owner or keeper of any such cat is unknown, the officer shall immediately tag or employ such other suitable means of

identification of the cat as may be approved by the Chief Animal Control Officer and shall promptly cause a description of such cat to be published once in the lost and found column of a newspaper having a circulation in such town.

(b) If such cat is not claimed by and released to the owner within seven days after the date of publication, the municipal animal control officer, upon finding such cat to be in satisfactory health, may have a licensed veterinarian spay or neuter any such cat and sell such cat to any person who satisfies such officer that he is purchasing it as a pet and that he can give it a good home and proper care. The municipal animal control officer may retain possession of such cat for such additional period of time as he may deem advisable in order to place such cat as a pet and may have a licensed veterinarian spay or neuter such cat. If, within such period, any cat is not claimed by and released to the owner or keeper or purchased as a pet, the officer shall cause such cat to be mercifully killed by a licensed veterinarian or disposed of as the State Veterinarian may direct. No person who so destroys a cat shall be held criminally or civilly liable therefor nor shall any licensed veterinarian who spays or neuters a cat pursuant to this section be held civilly liable, including, but not limited to, liability for reconstructive neutical implantation **surgery**.

(c) Any cat captured or impounded under the provisions of subsection (a) of this section shall be redeemed by the owner or keeper thereof, or the agent of such owner or keeper, upon proper identification, and presentation to the municipal animal control officer of a license, tag or other means of identification for such cat, and upon the payment by such owner or keeper or his agent of (1) the redemption fee established by the municipality, which shall not exceed fifteen dollars, and (2) the cost of advertising incurred under the provisions of subsection (a) of this section. When the owner or keeper of any such impounded cat fails to redeem such cat within twenty-four hours after receiving notification to do so, or, where the owner was unknown, within twenty-four hours after notification was effected by means of publication in a newspaper, such owner or keeper shall pay, in addition to such redemption fee and the cost of advertising, the amount determined by the municipality to be the full cost of detention and care of such impounded cat. In addition, any owner or keeper of any such impounded cat who fails to redeem such cat within one hundred twenty hours after receiving notification to do so shall have committed an infraction. The legislative body of the municipality shall set any fees imposed by the municipality under this section.

History:

(P.A. 96-243, S. 2; P.A. 98-12, S. 10, 22; P.A. 03-137, S. 2.)

- **CHAPTER 436a ANIMAL POPULATION CONTROL**

Conn. Gen. Stat. § 22-380f. Payment for adoption of unspayed or unneutered dog or cat. Connecticut Humane Society exemption. Report. Termination of exemption.

(a) No pound shall sell or give away any unspayed or unneutered dog or cat to any person unless

such pound receives forty-five dollars from the person buying or adopting such dog or cat. Funds received pursuant to this section shall be paid quarterly by the municipality into the animal population control account established under section 22-380g. At the time of receipt of such payment, the pound shall provide a voucher, for the purpose of sterilization and vaccination benefits, as provided in section 22-380i, to the person buying or adopting such dog or cat. Such voucher shall be on a form provided by the commissioner and signed by the eligible owner. Such voucher shall become void after sixty days from the date of adoption unless a participating veterinarian certifies that the dog or cat is medically unfit for **surgery**. Such certification shall be on a form provided by the commissioner and specify a date by which such dog or cat may be fit for sterilization. If the **surgery** is performed more than thirty days after such specified date, the voucher shall become void. In the case of a dog or cat that has been previously sterilized or is permanently medically unfit for sterilization, as determined by a participating veterinarian, the voucher shall be void and the eligible owner may apply to the commissioner for a refund in the amount of forty-five dollars.

(b) Notwithstanding the provisions of subsection (a) of this section, no pound shall receive forty-five dollars from the Connecticut Humane Society for any unsterilized cat or dog that is given by such pound to the Connecticut Humane Society, provided such cat or dog is sterilized prior to the adoption of such animal from the Connecticut Humane Society. Such sterilization shall not be required if a licensed veterinarian certifies, in writing, that the animal is medically unfit for sterilization **surgery.**

(c) The Connecticut Humane Society shall submit a biannual report to the Commissioner of Agriculture that shall include, but not be limited to, the municipal facility from which any animal described in subsection (b) of this section was taken, the impound number of such animal, the species and gender of such animal, the date that the Connecticut Humane Society received the animal and the date of sterilization for such animal.

(d) Upon a finding that the Connecticut Humane Society has failed to comply with any provision of subsection (b) or (c) of this section, the Commissioner of Agriculture may terminate the Connecticut Humane Society's exemption from the payment of the forty-five-dollar fee required pursuant to subsection (a) of this section.

History:

(P.A. 92-187, S. 2, 10; P.A. 97-162, S. 4; 97-187, S. 1, 4; P.A. 01-87, S. 2; P.A. 03-198, S. 1; June 30 Sp. Sess. P.A. 03-6, S. 146(h); P.A. 04-189, S. 1; P.A. 07-105, S. 3.)

TITLE 22a ENVIRONMENTAL PROTECTION

- **CHAPTER 446a RADIATION AND RADIOACTIVE MATERIALS**

Conn. Gen. Stat. § 22a-150. Registration of x-ray devices.

The Commissioner of Environmental Protection shall, by regulation, require registration of

devices emitting x-rays used for diagnostic or therapeutic purposes by or under the supervision of a person or persons licensed to practice medicine, **surgery**, chiropractic, natureopathy, dentistry, podiatry or veterinary medicine and **surgery**, as authorized by law. The commissioner shall charge a registration fee of one hundred fifty dollars biennially for each such device, except that hospitals operated by the state or a municipality shall be exempt from payment of the fee.

History:

(1963, P.A. 623; 1971, P.A. 872, S. 414; P.A. 78-239, S. 2, 8; P.A. 80-123, S. 1, 2; P.A. 81-309, S. 1, 2; P.A. 89-201, S. 2; P.A. 90-231, S. 2, 28; P.A. 91-369, S. 24, 36; P.A. 99-102, S. 40; June 30 Sp. Sess. P.A. 03-6, S. 123.)

- **CHAPTER 446d SOLID WASTE MANAGEMENT**

Conn. Gen. Stat. § 22a-209b. Biomedical waste. Definitions.

As used in this section and section 22a-209c:

(1) "Biomedical waste treatment" means to render biomedical waste noninfectious by decontamination, autoclaving, incineration or by other techniques approved by the commissioner;

(2) "Human blood and blood products" means items containing free-flowing liquid waste blood, serum, plasma and other blood products or containers filled with such discarded fluids, except that blood in a glass vial shall be considered a sharp provided intravenous bags which did not contain blood or blood products shall not be considered a blood product;

(3) "Free-flowing liquid blood" means blood that is not contained by the disposable item or is visibly dripping;

(4) "Body fluid" means blood or any substance which contains visible blood, semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, peritoneal fluid and pericardial fluid;

(5) "Infectious body fluids" means only waste cerebrospinal, pleural and peritoneal fluids. Dialysates shall not be considered blood or body fluids;

(6) "Chemotherapy waste" means waste that has come in contact with an antineoplastic agent during the preparation, handling or administration of such an agent. A container which is or has been used to contain such an agent shall be deemed chemotherapy waste even if such container is empty;

(7) "Decontaminate" means to substantially reduce or eliminate, by disinfection or other means, any biological hazard that is or may be associated with biomedical waste;

(8) "Hypodermic needle and syringe" means needles, syringes and any other types of intravascular device including, but not limited to, in-dwelling catheters and introducers;

(9) "Infectious agent" means any organism, such as a virus or bacterium, that is capable of being communicated by invasion and multiplication in body tissue and capable of causing disease or adverse health impacts in humans;

(10) "Infectious waste" means types of waste listed in subparagraphs (A) to (G), inclusive, of this subdivision which are capable of causing infectious diseases because there is reason to believe that such waste has been contaminated by an organism that is known or suspected to be pathogenic to humans and such organism may be present in sufficient virulence to transmit disease. The following shall be considered infectious waste:

(A) Cultures and stocks of agents infectious to humans and associated biologicals including cultures from medical, clinical, hospital, public health, research and industrial laboratories; wastes from the production of biologicals; discarded live and attenuated vaccines; and culture dishes and devices used to transfer, inoculate, or mix cultures;

(B) Human blood, blood products and infectious body fluids;

(C) Sharps;

(D) Research animal waste which includes contaminated animal carcasses, animal body parts and bedding or animals that were intentionally exposed to infectious agents during research or special laboratory testing, including research in veterinary hospital, production of biologicals, or testing of pharmaceuticals;

(E) Isolation wastes;

(F) Any material collected during or resulting from the cleanup of a spill of infectious or chemotherapy waste; or

(G) Any waste which is mixed with infectious waste and which is neither a hazardous waste, as defined in section 22a-115, nor a radioactive material subject to section 22a-118;

(11) "Isolation waste" means biological waste and discarded material contaminated with body fluids from (A) humans who are isolated to protect others from a highly communicable disease, or (B) animals which are isolated because they are known to be infected with a highly communicable disease. A highly communicable disease is one listed in biosafety level 4 of the Centers for Disease Control/National Institutes of Health Guidelines entitled "Biosafety in Microbiological and Biomedical Laboratories" and dated May, 1988. These agents include fifteen arboviruses, arenaviruses and filoviruses: Junin, Marburg, Congo-Crimean, hemorrhagic fever, Lassa, Machepo, Ebola, Guanarito and the tick-borne encephalitis virus complex Absettarov, Hanzalova, Hypr, Kumlinge, Kyasanur Forest disease, Omsk hemorrhagic fever, and Russian spring-summer encephalitis;

(12) "Pathological waste" means any human tissue, organ or body part, except teeth and the contiguous structures of bone and gum, removed during **surgery**, autopsy or other medical procedure. Pathological waste does not include formaldehyde or other preservative agent, or a human corpse or part thereof regulated pursuant to section 7-64 or chapter 368i, 368j or 368k;

(13) "Sharps" mean discarded sharps that have been used in animal or human patient care or treatment or in medical, research or industrial laboratories, including hypodermic needles; syringes, with or without attached needle; scalpel blades; glass blood vials; suture needles; needles with attached tubing; glass culture dishes and pasteur pipettes, provided such glassware is known to have been in contact with an infectious agent; anaesthetic carpules used in dental offices; and unused, discarded hypodermic needles, suture needles, syringes and scalpel blades; and

(14) "Commissioner" means the Commissioner of Environmental Protection.

History:

(P.A. 94-182, S. 2, 4.)

NOTES:
P.A. 94-182 effective July 1, 1994; (Revisor's note: In 1997 various misspellings of virus types listed in Subdiv. (11) were corrected editorially by the Revisors).

TITLE 26 FISHERIES AND GAME

- **CHAPTER 490 FISHERIES AND GAME**

Conn. Gen. Stat. § 26-29a Free lifetime fishing licenses for persons with mental retardation.

No fee shall be charged for any sport fishing license issued under this chapter to any person with mental retardation, and such license shall be a lifetime license not subject to the expiration provisions of section 26-35. Proof of mental retardation shall consist of a certificate to that effect issued by any person licensed to practice medicine and **surgery** in this state.

History:

(1963, P.A. 77; P.A. 07-133, S. 4.)

TITLE 31 LABOR

- **CHAPTER 557 EMPLOYMENT REGULATION**

Conn. Gen. Stat. § 31-51kk. Family and medical leave: Definitions.

As used in sections 31-51kk to 31-51qq, inclusive:

(1) "Eligible employee" means an employee who has been employed (A) for at least twelve months by the employer with respect to whom leave is requested; and (B) for at least one thousand hours of service with such employer during the twelve-month period preceding the first day of the leave;

(2) "Employ" includes to allow or permit to work;

(3) "Employee" means any person engaged in service to an employer in the business of the employer;

(4) "Employer" means a person engaged in any activity, enterprise or business who employs seventy-five or more employees, and includes any person who acts, directly or indirectly, in the interest of an employer to any of the employees of such employer and any successor in interest of an employer, but shall not include the state, a municipality, a local or regional board of education, or a private or parochial elementary or secondary school. The number of employees of an employer shall be determined on October first annually;

(5) "Employment benefits" means all benefits provided or made available to employees by an employer, including group life insurance, health insurance, disability insurance, sick leave, annual leave, educational benefits and pensions, regardless of whether such benefits are provided by practice or written policy of an employer or through an "employee benefit plan", as defined in Section 1002(3) of Title 29 of the United States Code;

(6) "Health care provider" means (A) a doctor of medicine or osteopathy who is authorized to practice medicine or **surgery** by the state in which the doctor practices; (B) a podiatrist, dentist, psychologist, optometrist or chiropractor authorized to practice by the state in which such person practices and performs within the scope of the authorized practice; (C) an advanced practice registered nurse, nurse practitioner, nurse midwife or clinical social worker authorized to practice by the state in which such person practices and performs within the scope of the authorized practice; (D) Christian Science practitioners listed with the First Church of Christ, Scientist in Boston, Massachusetts; (E) any health care provider from whom an employer or a group health plan's benefits manager will accept certification of the existence of a serious health condition to substantiate a claim for benefits; (F) a health care provider as defined in subparagraphs (A) to (E), inclusive, of this subdivision who practices in a country other than the United States, who is licensed to practice in accordance with the laws and regulations of that country; or (G) such other health care provider as the Labor Commissioner determines, performing within the scope of the authorized practice. The commissioner may utilize any determinations made pursuant to chapter 568;

(7) "Parent" means a biological parent, foster parent, adoptive parent, stepparent or legal guardian of an eligible employee or an eligible employee's spouse, or an individual who stood in

loco parentis to an employee when the employee was a son or daughter;

(8) "Person" means one or more individuals, partnerships, associations, corporations, business trusts, legal representatives or organized groups of persons;

(9) "Reduced leave schedule" means a leave schedule that reduces the usual number of hours per workweek, or hours per workday, of an employee;

(10) "Serious health condition" means an illness, injury, impairment, or physical or mental condition that involves (A) inpatient care in a hospital, hospice, nursing home or residential medical care facility; or (B) continuing treatment, including outpatient treatment, by a health care provider;

(11) "Son or daughter" means a biological, adopted or foster child, stepchild, legal ward, or, in the alternative, a child of a person standing in loco parentis, who is (A) under eighteen years of age; or (B) eighteen years of age or older and incapable of self-care because of a mental or physical disability; and

(12) "Spouse" means a husband or wife, as the case may be.

History:

(P.A. 96-140, S. 1, 10; P.A. 06-102, S. 12.)

- **CHAPTER 568 WORKERS' COMPENSATION ACT**

Conn. Gen. Stat. § 31-308. Compensation for partial incapacity.

(a) If any injury for which compensation is provided under the provisions of this chapter results in partial incapacity, the injured employee shall be paid a weekly compensation equal to seventy-five per cent of the difference between the wages currently earned by an employee in a position comparable to the position held by the injured employee before his injury, after such wages have been reduced by any deduction for federal or state taxes, or both, and for the federal Insurance Contributions Act in accordance with section 31-310, and the amount he is able to earn after the injury, after such amount has been reduced by any deduction for federal or state taxes, or both, and for the federal Insurance Contributions Act in accordance with section 31-310, except that when (1) the physician attending an injured employee certifies that the employee is unable to perform his usual work but is able to perform other work, (2) the employee is ready and willing to perform other work in the same locality and (3) no other work is available, the employee shall be paid his full weekly compensation subject to the provisions of this section. Compensation paid under this subsection shall not be more than one hundred per cent, raised to the next even dollar, of the average weekly earnings of production and related workers in manufacturing in the state, as determined in accordance with the provisions of section 31-309, and shall continue during the period of partial incapacity, but no longer than five hundred twenty weeks. If the employer procures employment for an injured employee that is suitable to his capacity, the

wages offered in such employment shall be taken as the earning capacity of the injured employee during the period of the employment.

(b) With respect to the following injuries, the compensation, in addition to the usual compensation for total incapacity but in lieu of all other payments for compensation, shall be seventy-five per cent of the average weekly earnings of the injured employee, calculated pursuant to section 31-310, after such earnings have been reduced by any deduction for federal or state taxes, or both, and for the federal Insurance Contributions Act made from such employee's total wages received during the period of calculation of the employee's average weekly wage pursuant to said section 31-310, but in no case more than one hundred per cent, raised to the next even dollar, of the average weekly earnings of production and related workers in manufacturing in the state, as determined in accordance with the provisions of section 31-309, or less than fifty dollars weekly. All of the following injuries include the loss of the member or organ and the complete and permanent loss of use of the member or organ referred to: MEMBERINJURYWEEKS OF COMPENSATIONArm Master armLoss at or above elbow208 Other armLoss at or above elbow194Hand Master handLoss at or above wrist168 Other handLoss at or above wrist155One legLoss at or above knee155One footLoss at or above ankle125HearingBoth ears104One ear35One eyeComplete and permanentloss of sight in, orreduction of sight toone-tenth or less ofnormal vision157Thumb*On master hand63On other hand54Fingers**First finger36Second finger29Third finger21Fourth finger17Toes***Great toe28Other toes9BackNumber of weeks whichthe proportion ofincapacity representsto a maximum of 374wecksHeart520Brain520Carotid artery520Pancreas416Liver347Stomach260Loss of bladder233Speech163Lung117Cervical spine117Kidney117Rib cageBilateral69Ovary35Testis35Mammary35NoseSense and respiratoryfunction35JawMastication35Uterus35-104Vagina35-104Penis35-104CoccyxActual removal35Sense of smell17Sense of taste17SpleenIn addition to scar13Gall bladder13ToothMinimum1Loss of drainage duct ofeye (If corrected byprosthesis)17 for eachLoss of drainage duct ofeye (If uncorrected byprosthesis)33 for eachPelvispercentage of back

*The loss or loss of use of one phalanx of a thumb shall be construed as seventy-five per cent of the loss of the thumb.

**The loss or loss of use of one phalanx of a finger shall be construed as fifty per cent of the loss of the finger. The loss of or loss of use of two phalanges of a finger shall be construed as ninety per cent of the loss of the finger.

***The loss or loss of use of one phalanx of a great toe shall be construed as sixty-six and two-thirds per cent of the loss of the great toe. The loss of the greater part of any phalanx shall be construed as the loss of a phalanx and shall be compensated accordingly.

If the injury consists of the loss of a substantial part of a member resulting in a permanent partial loss of the use of a member, or if the injury results in a permanent partial loss of function, the commissioner may, in the commissioner's discretion, in lieu of other compensation, award to the injured employee the proportion of the sum provided in this subsection for the total loss of, or the

loss of the use of, the member or for incapacity or both that represents the proportion of total loss or loss of use found to exist, and any voluntary agreement submitted in which the basis of settlement is such proportionate payment may, if otherwise conformable to the provisions of this chapter, be approved by the commissioner in the commissioner's discretion. Notwithstanding the provisions of this subsection, the complete loss or loss of use of an organ which results in the death of an employee shall be compensable pursuant only to section 31-306.

(c) In addition to compensation for total or partial incapacity or for a specific loss of a member or use of the function of a member of the body, the commissioner, not earlier than one year from the date of the injury and not later than two years from the date of the injury or the **surgery** date of the injury, may award compensation equal to seventy-five per cent of the average weekly earnings of the injured employee, calculated pursuant to section 31-310, after such earnings have been reduced by any deduction for federal or state taxes, or both, and for the federal Insurance Contributions Act made from such employee's total wages received during the period of calculation of the employee's average weekly wage pursuant to said section 31-310, but not more than one hundred per cent, raised to the next even dollar, of the average weekly earnings of production and related workers in manufacturing in the state, as determined in accordance with the provisions of section 31-309, for up to two hundred eight weeks, for any permanent significant disfigurement of, or permanent significant scar on, (A) the face, head or neck, or (B) on any other area of the body which handicaps the employee in obtaining or continuing to work. The commissioner may not award compensation under this subsection when the disfigurement was caused solely by the loss of or the loss of use of a member of the body for which compensation is provided under subsection (b) of this section or for any scar resulting from an inguinal hernia operation or any spinal **surgery**. In making any award under this subsection, the commissioner shall consider (1) the location of the scar or disfigurement, (2) the size of the scar or disfigurement, (3) the visibility of the scar or disfigurement due to hyperpigmentation or depigmentation, whether hypertrophic or keloidal, (4) whether the scar or disfigurement causes a tonal or textural skin change, causes loss of symmetry of the affected area or results in noticeable bumps or depressions in the affected area, and (5) other relevant factors. Notwithstanding the provisions of this subsection, no compensation shall be awarded for any scar or disfigurement which is not located on (A) the face, head or neck, or (B) any other area of the body which handicaps the employee in obtaining or continuing to work. In addition to the requirements contained in section 31-297, the commissioner shall provide written notice to the employer prior to any hearing held by the commissioner to consider an award for any scar or disfigurement under this subsection.

(d) Any award or agreement for compensation made pursuant to this section shall be paid to the employee, or in the event of the employee's death, whether or not a formal award has been made prior to the death, to his surviving spouse or, if he has no surviving spouse, to his dependents in equal shares or, if he has no surviving spouse or dependents, to his children, in equal shares, regardless of their age.

History:

(1949 Rev., S. 7431; 1949, 1951, 1953, S. 3044d; 1957, P.A. 463, S. 3; 1958 Rev., S. 31-162;

1959, P.A. 580, S. 7; 1961, P.A. 491, S. 31; 1967, P.A. 842, S. 15; P.A. 75-48; P.A. 79-376, S. 75; P.A. 89-36; 89-346; P.A. 91-32, S. 26, 41; 91-339, S. 28; P.A. 93-228, S. 19, 35; P.A. 00-8.)

TITLE 34 LIMITED PARTNERSHIPS, PARTNERSHIPS, PROFESSIONAL ASSOCIATIONS, LIMITED LIABILITY COMPANIES AND STATUTORY TRUSTS

- CHAPTER 613 LIMITED LIABILITY COMPANIES

Conn. Gen. Stat. § 34-119. Restrictions on purposes and powers of limited liability companies.

(a) A limited liability company may be formed under sections 34-100 to 34-242, inclusive, for the transaction of any business or the promotion of any purpose which may be lawfully carried on by a limited liability company except that of a state bank and trust company, savings bank, industrial bank or building and loan association.

(b) Except as otherwise provided in this subsection, a limited liability company may be formed to render professional services provided: (1) Each member of the limited liability company must be licensed or otherwise authorized by law in this state or any other jurisdiction to render such professional services; (2) the limited liability company will render only one specific type of professional services and services ancillary to them and may not engage in any business other than the rendering of professional services for which it was formed to render and services ancillary to them; and (3) the limited liability company may render its professional services in this state only through its members, managers, employees and agents who are licensed or otherwise legally authorized to render such professional services within this state. A limited liability company that will render professional services by licensed or certified alcohol and drug counselors may only be formed pursuant to subdivision (2) of subsection (c) of this section.

(c) A limited liability company may be formed to render professional services rendered by members of two or more of the following professions: (1) Psychology, marital and family therapy, social work, nursing and psychiatry; (2) medicine and **surgery**, occupational therapy, social work and alcohol and drug counseling; and (3) medicine and **surgery** and chiropractic; provided (A) each member of the limited liability company must be licensed or otherwise authorized by law in this state or any other jurisdiction to render any of the types of professional services specified in subdivision (1), (2) or (3) of this subsection, (B) the limited liability company will render only the types of professional services specified in subdivision (1), (2) or (3) of this subsection and services ancillary to them and may not engage in any business other than the rendering of professional services for which it was formed to render and services ancillary to them, and (C) the limited liability company may render its professional services in this state only through its members, managers, employees and agents who are licensed or otherwise legally authorized to render any of the types of professional services specified in subdivision (1), (2) or (3) of this subsection within this state.

(d) No limited liability company formed under sections 34-100 to 34-242, inclusive, shall have power to transact in this state the business of a telegraph company, gas, electric, electric

distribution or water company, or cemetery corporation, or of any company, except a telephone company, requiring the right to take and condemn lands or to occupy the public highways of this state.

(e) No limited liability company may be formed under sections 34-100 to 34-242, inclusive, for the purpose of transacting the business of an insurance company or a surety or indemnity company, unless (1) it is an affiliate of an insurance company chartered by, incorporated, organized or constituted within or under the laws of this state; and (2) at the time of the filing of its articles of organization, there is also filed a certificate issued by the Insurance Commissioner pursuant to section 33-646 authorizing the formation of the limited liability company. No limited liability company formed under sections 34-100 to 34-242, inclusive, shall have power to transact in this state the business of any insurance company or a surety or indemnity company until it has procured a license from the Insurance Commissioner in accordance with the provisions of section 38a-41.

(f) Nothing in sections 34-100 to 34-242, inclusive, shall be construed to authorize a limited liability company formed under said sections to transact any business except in compliance with any laws of this state regulating or otherwise applying to the same. The provisions of sections 34-100 to 34-242, inclusive, shall govern all limited liability companies, except that where by law special provisions are made in the case of a designated class or classes of limited liability companies governing the limited liability company procedure thereof in any respect, limiting or extending the powers thereof, conditioning action upon the approval of any agency of the state or otherwise prescribing the conduct of such limited liability companies, such procedure, power, action or conduct shall be governed by such special provisions whether or not such limited liability companies are formed under said sections.

(g) Nothing in this section shall prohibit the formation of a limited liability company under sections 34-100 to 34-242, inclusive, for the transaction of any business or for the promotion of any purpose in any other state if not prohibited by the laws thereof.

History:

(P.A. 93-267, S. 8; P.A. 94-217, S. 3, 40; P.A. 96-254, S. 6, 10; 96-271, S. 185, 254; P.A. 98-28, S. 111, 117; P.A. 04-175, S. 2; P.A. 05-216, S. 3.)

TITLE 38a INSURANCE

- **CHAPTER 700c HEALTH INSURANCE**

Conn. Gen. Stat. § 38a-490c. Coverage for craniofacial disorders.

Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery, amended, renewed or continued in this state on or after October 1, 2003, shall provide coverage for medically

necessary orthodontic processes and appliances for the treatment of craniofacial disorders for individuals eighteen years of age or younger if such processes and appliances are prescribed by a craniofacial team recognized by the American Cleft Palate-Craniofacial Association, except that no coverage shall be required for cosmetic **surgery**.

History:

(P.A. 03-37, S. 1.)

Conn. Gen. Stat. § 38a-492j. Mandatory coverage for ostomy-related supplies.

Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery, renewed or continued in this state on or after October 1, 2000, that provides coverage for ostomy **surgery** shall include coverage, up to one thousand dollars annually, for medically necessary appliances and supplies relating to an ostomy including, but not limited to, collection devices, irrigation equipment and supplies, skin barriers and skin protectors. As used in this section, "ostomy" includes colostomy, ileostomy and urostomy. Payments under this section shall not be applied to any policy maximums for durable medical equipment. Nothing in this section shall be deemed to decrease policy benefits in excess of the limits in this section.

History:

(P.A. 00-63, S. 1.)

Conn. Gen. Stat. § 38a-503d. Mandatory coverage for mastectomy care. Termination of provider contract prohibited.

(a) Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (10), (11) and (12) of section 38a-469 delivered, issued for delivery, amended, renewed or continued in this state on or after July 1, 1997, shall provide coverage for at least forty-eight hours of inpatient care following a mastectomy or lymph node dissection, and shall provide coverage for a longer period of inpatient care if such care is recommended by the patient's treating physician after conferring with the patient. No such insurance policy may require mastectomy **surgery** or lymph node dissection to be performed on an outpatient basis. Outpatient **surgery** or shorter inpatient care is allowable under this section if the patient's treating physician recommends such outpatient **surgery** or shorter inpatient care after conferring with the patient.

(b) No individual health insurance carrier may terminate the services of, require additional documentation from, require additional utilization review, reduce payments or otherwise penalize or provide financial disincentives to any attending health care provider on the basis that the provider orders care consistent with the provisions of this section.

History:

(P.A. 97-198, S. 1, 5.)

Conn. Gen. Stat. § 38a-504. Mandatory coverage for treatment of tumors and leukemia. Mandatory coverage for reconstructive surgery, prosthesis, chemotherapy and wigs. Mandatory coverage for breast reconstruction after mastectomy.

(a) Each insurance company, hospital service corporation, medical service corporation, health care center or fraternal benefit society which delivers or issues for delivery in this state individual health insurance policies providing coverage of the type specified in subdivisions (1), (2), (4), (10), (11) and (12) of section 38a-469, shall provide coverage under such policies for the surgical removal of tumors and treatment of leukemia, including outpatient chemotherapy, reconstructive **surgery**, cost of any nondental prosthesis including any maxillo-facial prosthesis used to replace anatomic structures lost during treatment for head and neck tumors or additional appliances essential for the support of such prosthesis, outpatient chemotherapy following surgical procedure in connection with the treatment of tumors, and a wig if prescribed by a licensed oncologist for a patient who suffers hair loss as a result of chemotherapy. Such benefits shall be subject to the same terms and conditions applicable to all other benefits under such policies.

(b) Except as provided in subsection (c) of this section, the coverage required by subsection (a) of this section shall provide at least a yearly benefit of five hundred dollars for the surgical removal of tumors, five hundred dollars for reconstructive **surgery**, five hundred dollars for outpatient chemotherapy, three hundred fifty dollars for a wig and three hundred dollars for prosthesis, except that for purposes of the surgical removal of breasts due to tumors the yearly benefit for prosthesis shall be at least three hundred dollars for each breast removed.

(c) The coverage required by subsection (a) of this section shall provide benefits for the reasonable costs of reconstructive **surgery** on each breast on which a mastectomy has been performed, and reconstructive **surgery** on a nondiseased breast to produce a symmetrical appearance. Such benefits shall be subject to the same terms and conditions applicable to all other benefits under such policies. For the purposes of this subsection, reconstructive **surgery** includes, but is not limited to, augmentation mammoplasty, reduction mammoplasty and mastopexy.

History:

(P.A. 79-327, S. 2; P.A. 86-54; P.A. 87-40; 87-275, S. 2; P.A. 90-243, S. 94; P.A. 97-198, S. 3, 5; P.A. 98-27, S. 17; P.A. 04-34, S. 1.)

Conn. Gen. Stat. § 38a-516c. Coverage for craniofacial disorders.

Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery, amended, renewed or continued in this state on or after October 1, 2003, shall provide coverage for medically

necessary orthodontic processes and appliances for the treatment of craniofacial disorders for individuals eighteen years of age or younger if such processes and appliances are prescribed by a craniofacial team recognized by the American Cleft Palate-Craniofacial Association, except that no coverage shall be required for cosmetic **surgery**.

History:

(P.A. 03-37, S. 2.)

Conn. Gen. Stat. § 38a-518j. Mandatory coverage for ostomy-related supplies.

Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery, renewed or continued in this state on or after October 1, 2000, that provides coverage for ostomy **surgery** shall include coverage, up to one thousand dollars annually, for medically necessary appliances and supplies relating to an ostomy including, but not limited to, collection devices, irrigation equipment and supplies, skin barriers and skin protectors. As used in this section, "ostomy" includes colostomy, ileostomy and urostomy. Payments under this section shall not be applied to any policy maximums for durable medical equipment. Nothing in this section shall be deemed to decrease policy benefits in excess of the limits in this section.

History:

(P.A. 00-63, S. 2.)

Conn. Gen. Stat. § 38a-530d. Mandatory coverage for mastectomy care. Termination of provider contract prohibited.

(a) Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (10), (11) and (12) of section 38a-469 delivered, issued for delivery, amended, renewed or continued in this state on or after July 1, 1997, shall provide coverage for at least forty-eight hours of inpatient care following a mastectomy or lymph node dissection, and shall provide coverage for a longer period of inpatient care if such care is recommended by the patient's treating physician after conferring with the patient. No such insurance policy may require mastectomy **surgery** or lymph node dissection to be performed on an outpatient basis. Outpatient **surgery** or shorter inpatient care is allowable under this section if the patient's treating physician recommends such outpatient **surgery** or shorter inpatient care after conferring with the patient.

(b) No group health insurance carrier may terminate the services of, require additional documentation from, require additional utilization review, reduce payments or otherwise penalize or provide financial disincentives to any attending health care provider on the basis that the provider orders care consistent with the provisions of this section.

History:

(P.A. 97-198, S. 2, 5.)

Conn. Gen. Stat. § 38a-542. Mandatory coverage for treatment of tumors and leukemia. Mandatory coverage for reconstructive surgery, prothesis, chemotherapy and wigs. Mandatory coverage for breast reconstruction after masteetomy.

(a) Each insurance company, hospital service corporation, medical service corporation, health care center or fraternal benefit society which delivers or issues for delivery in this state group health insurance policies providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 shall provide coverage under such policies for treatment of leukemia, including outpatient chemotherapy, reconstructive **surgery**, cost of any nondental prosthesis, including any maxillo-facial prosthesis used to replace anatomic structures lost during treatment for head and neck tumors or additional appliances essential for the support of such prosthesis, outpatient chemotherapy following surgical procedures in connection with the treatment of tumors, a wig if prescribed by a licensed oncologist for a patient who suffers hair loss as a result of chemotherapy, and costs of removal of any breast implant which was implanted on or before July 1, 1994, without regard to the purpose of such implantation, which removal is determined to be medically necessary. Such benefits shall be subject to the same terms and conditions applicable to all other benefits under such policies.

(b) Except as provided in subsection (c) of this section, the coverage required by subsection (a) of this section shall provide at least a yearly benefit of one thousand dollars for the costs of removal of any breast implant, five hundred dollars for the surgical removal of tumors, five hundred dollars for reconstructive **surgery,** five hundred dollars for outpatient chemotherapy, three hundred fifty dollars for a wig and three hundred dollars for prosthesis, except that for pnrposes of the surgical removal of breasts due to tumors the yearly benefit for prosthesis shall be at least three hundred dollars for each breast removed.

(c) The coverage required by subsection (a) of this section shall provide benefits for the reasonable costs of reconstructive **surgery** on each breast on which a mastectomy has been performed, and reconstructive **surgery** on a nondiseased breast to produce a symmetrical appearance. Such benefits shall be subject to the same terms and conditions applicable to all other benefits under such policies. For the purposes of this subsection, reconstructive **surgery** includes, but is not limited to, augmentation mammoplasty, reduction mammoplasty and mastopexy.

History:

(P.A. 90-243, S. 123; P.A. 94-71, S. 12; P.A. 97-198, S. 4, 5; P.A. 04-34, S. 2.)

Conn. Gen. Stat. § 38a-551. Definitions.

For the purposes of this section and sections 38a-552 to 38a-559, inclusive, the following terms shall have the following meanings:

(a) "Health insurance" means hospital and medical expenses incurred policies written on a direct basis, nonprofit service plan contracts, health care center contracts and self-insured or self-funded employee health benefit plans. For purposes of sections 38a-505, 38a-546 and 38a-551 to 38a-559, inclusive, "health insurance" does not include (1) accident only, credit, dental, vision, Medicare supplement, long-term care or disability insurance, hospital indemnity coverage, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical-payments insurance, or insurance under which beneficiaries are payable without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance, or (2) policies of specified disease or limited benefit health insurance, provided: (A) The carrier offering such policies files on or before March first of each year a certification with the commissioner that contains the following: (i) A statement from the carrier certifying that such policies are being offered and marketed as supplemental health insurance and not as a substitute for hospital or medical expense insurance; and (ii) a summary description of each such policy including the average annual premium rates, or range of premium rates in cases where premiums vary by age, gender or other factors, charged for such policy in the state; and (B) for each such policy that is offered for the first time in this state on or after July 1, 2005, the carrier files with the commissioner the information and statement required in subparagraph (A) of this subdivision at least thirty days prior to the date such policy is issued or delivered in this state.

(h) "Carrier" means an insurer, health care center, hospital service corporation or medical service corporation or fraternal benefit society.

(c) "Insurer" means an insurance company licensed to transact accident and health insurance business in this state.

(d) "Health care center" means a health care center, as defined in section 38a-175.

(e) "Self-insurer" means an employer or an employee welfare benefit fund or plan which provides payment for or reimbursement of the whole or any part of the cost of covered hospital or medical expenses for covered individuals. For purposes of sections 38a-505, 38a-546 and 38a-551 to 38a-559, inclusive, "self-insurer" shall not include any such employee welfare benefit fund or plan established prior to April 1, 1976, by any organization which is exempt from federal income taxes under the provisions of Section 501 of the United States Internal Revenue Code and amendments thereto and legal interpretations thereof, except any such organization described in Subsection (c)(15) of said Section 501.

(f) "Commissioner" means the Insurance Commissioner of the state of Connecticut.

(g) "Physician" means a doctor of medicine, chiropractic, natureopathy, podiatry, a qualified psychologist and, for purposes of oral **surgery** only, a doctor of dental **surgery** or a doctor of medical dentistry and, subject to the provisions of section 20-138d, optometrists duly licensed under the provisions of chapter 380.

(h) "Qualified psychologist" means a person who is duly licensed or certified as a clinical psychologist and has a doctoral degree in and at least two years of supervised experience in clinical psychology in a licensed hospital or mental health center.

(i) "Skilled nursing facility" shall have the same meaning as "skilled nursing facility", as defined in Section 1395x, Chapter 7 of Title 42, United States Code.

(j) "Hospital" shall have the same meaning as "hospital", as defined in Section 1395x, Chapter 7 of Title 42, United States Code.

(k) "Home health agency" shall have the same meaning as "home health agency", as defined in Section 1395x, Chapter 7 of Title 42, United States Code.

(l) "Copayment" means the portion of a charge that is covered by a plan and not payable by the plan and which is thus the obligation of the covered individual to pay.

(m) "Resident employer" means any person, partnership, association, trust, estate, limited liability company, corporation, whether foreign or domestic, or the legal representative, trustee in bankruptcy or receiver or trustee, thereof, or the legal representative of a deceased person, including the state of Connecticut and each municipality therein, which has in its employ one or more individuals during any calendar year, commencing January 1, 1976. For purposes of sections 38a-505, 38a-546 and 38a-551 to 38a-559, inclusive, the term "resident employer" shall refer only to an employer with a majority of employees employed within the state of Connecticut.

(n) "Eligible employee" means, with respect to any employer, an employee who either is considered a full-time employee, or who is expected to work at least twenty hours a week for at least twenty-six weeks during the next twelve months or who has actually worked at least twenty hours a week for at least twenty-six weeks in any continuous twelve-month period.

(o) "Alcoholism treatment facility" shall have the same meaning as in section 38a-533.

(p) "Totally disabled" means with respect to an employee, the inability of the employee because of an injury or disease to perform the duties of any occupation for which he is suited by reason of education, training or experience, and, with respect to a dependent, the inability of the dependent because of an injury or disease to engage in substantially all of the normal activities of persons of like age and sex in good health.

(q) "Deductible" means the amount of covered expenses which must be accumulated during each calendar year before benefits become payable as additional covered expenses incurred.

(r) For purposes of sections 38a-505, 38a-546 and 38a-551 to 38a-559, inclusive, "disease or injury" shall include pregnancy and resulting childbirth or miscarriage.

(s) "Complications of pregnancy" means (1) conditions requiring hospital stays, when the

pregnancy is not terminated, whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity, and shall not include false labor, occasional spotting, physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsia and similar conditions associated with management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy; and (2) nonelective caesarean section, ectopic pregnancy which is terminated, and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.

(t) "Resident" means (1) a person who maintains a residence in this state for a period of at least one hundred eighty days, or (2) a HIPAA or health care tax credit eligible individual who maintains a residence in this state.

(u) "HIPAA eligible individual" means an eligible individual as defined in subsection (b) of section 2741 of the Public Health Service Act, as set forth in the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) (HIPAA).

(v) "Health care tax credit eligible individual" means a person who is eligible for the credit for health insurance costs under Section 35 of the Internal Revenue Code of 1986 in accordance with the Pension Benefit Guaranty Corporation and Trade Adjustment Assistance programs of the Trade Act of 2002 (P.L. 107-210).

History:

(P.A. 75-616, S. 1, 12; P.A. 76-399, S. 2, 5; P.A. 77-614, S. 163, 610; P.A. 80-482, S. 331, 345, 348; P.A. 90-243, S. 154; P.A. 91-100, S. 1; P.A. 93-338, S. 1; P.A. 95-79, S. 143, 189; June 18 Sp. Sess. P.A. 97-8, S. 67, 72, 88; P.A. 99-102, S. 45; P.A. 01-174, S. 11; June 30 Sp. Sess. P.A. 03-6, S. 66; P.A. 05-270, S. 1.)

Conn. Gen. Stat. § 38a-553. Minimum standard benefits of comprehensive health care plans. Optional and excludable benefits. Preexisting conditions. Use of managed care plans.

All individual and all group comprehensive health care plans shall include minimum standard benefits as described in this section.

(a) Except as provided in subsections (b) and (c), minimum standard benefits shall be benefits, including coverage for catastrophic illness, with a lifetime maximum of one million dollars per individual, for reasonable charges or, when applicable, the allowance agreed upon between a provider and a carrier for charges actually incurred, for the following health care services, rendered to an individual covered by such plan for the diagnosis or treatment of nonoccupational disease or injury: (1) Hospital services; (2) professional services which are rendered by a physician or, at his direction, by a registered nurse, other than services for mental or dental conditions; (3) the diagnosis or treatment of mental conditions, in accordance with the minimum requirements established in section 38a-514; (4) legend drugs requiring a prescription of a

physician, advanced practice registered nurse or physician assistant; (5) services of a skilled nursing facility for not more than one hundred twenty days in a calendar year, provided such services commence within fourteen days following a confinement of at least three consecutive days in a hospital for the same condition; (6) home health agency services, as defined by the commissioner, up to a maximum of one hundred eighty visits in a calendar year, provided such services commence within seven days following confinement in a hospital or skilled nursing facility of at least three consecutive days for the same condition, provided further, in the case of an individual diagnosed by a physician as terminally ill with a prognosis of six months or less to live, such home health agency services may commence irrespective of whether such covered person was so confined or, if such covered person was so confined, irrespective of such seven-day period, and the yearly benefit for medical social services, as hereinafter defined, shall not exceed two hundred dollars. "Medical social services" means services rendered, under the direction of a physician by a qualified social worker holding a master's degree from an accredited school of social work, including but not limited to (A) assessment of the social, psychological and family problems related to or arising out of such covered person's illness and treatment; (B) appropriate action and utilization of community resources to assist in resolving such problems; (C) participation in the development of treatment for such covered person; (7) use of radium or other radioactive materials; (8) outpatient chemotherapy for the removal of tumors and treatment of leukemia, including outpatient chemotherapy; (9) oxygen; (10) anesthetics; (11) nondental prosthesis and maxillo-facial prosthesis used to replace any anatomic structure lost during treatment for head and neck tumors or additional appliances essential for the support of such prosthesis; (12) rental of durable medical equipment which has no personal use in the absence of the condition for which prescribed; (13) diagnostic x-rays and laboratory tests as defined by the commissioner; (14) oral **surgery** for: (A) Excision of partially or completely unerupted impacted teeth, or (B) excision of a tooth root without the extraction of the entire tooth; (15) services of a licensed physical therapist, rendered under the direction of a physician; (16) transportation by a local professional ambulance to the nearest health care institution qualified to treat the illness or injury; (17) certain other services which are medically necessary in the treatment or diagnosis of an illness or injury as may be designated or approved by the Insurance Commissioner; (18) confinement in a facility established primarily for the treatment of alcoholism and licensed for such care by the state, or in a part of a hospital used primarily for such treatment, shall be a covered expense for a period of at least forty-five days within any calendar year.

(b) Minimum standard benefits may include one or more of the following provisions: (1) For policies issued or renewed prior to April 1, 1994, subject to the provisions of subdivision (3) such plan may require deductibles. The "low option deductible" shall be two hundred dollars per person, the "middle option deductible" shall be five hundred dollars per person, and the "high option deductible" shall be seven hundred fifty dollars per person. The amount of the deductible may not be greater when a service is rendered on an outpatient basis than when that service is offered on an inpatient basis. Expenses incurred during the last three months of a calendar year and actually applied to an individual's deductible for that year shall be applied to that individual's deductible in the following calendar year. The two-hundred-dollar maximum, the five-hundred-dollar maximum and the seven-hundred-fifty-dollar maximum may be adjusted yearly to correspond with the change in the medical care component of the Consumer Price Index, as adjusted by the commissioner. The base year for such computation shall be the first full year of

operation of such plan. (2) For policies issued or renewed prior to April 1, 1994, subject to the provisions of subdivision (3), such plan shall require a maximum copayment of twenty per cent for charges for all types of health care in excess of the deductible and fifty per cent for services listed in subdivision (3) of subsection (a) in excess of the deductible. (3) The sum of any deductible and copayments required in any calendar year may not exceed a maximum limit of one thousand dollars per covered individual, or two thousand dollars per covered family; provided, covered expenses incurred after the applicable maximum limit has been reached shall be paid at the rate of one hundred per cent, except that expenses incurred for treatment of mental and nervous conditions may be paid at the rate of fifty per cent as specified in subdivision (3) of subsection (a). The one-thousand-dollar and two-thousand-dollar maximums shall be adjusted yearly to correspond with the change in the medical care component of the Consumer Price Index as adjusted by the commissioner. (4) The plan shall limit benefits with respect to each pregnancy, other than a pregnancy involving complications of pregnancy, to a maximum of two hundred fifty dollars. (5) The plan may limit lifetime benefits to a maximum of not less than one million dollars per covered individual. (6) No preexisting condition exclusion shall exclude coverage of any preexisting condition unless: (A) The condition first manifested itself within the period of six months immediately prior to the effective date of coverage in such a manner as would cause a reasonably prudent person to seek diagnosis, care or treatment; (B) medical advice or treatment was recommended or received within the period of six months immediately prior to the effective date of coverage; or (C) the condition is pregnancy existing on the effective date of coverage. No policy shall exclude coverage for a loss due to preexisting conditions for a period greater than twelve months following the effective date of coverage. Any individual comprehensive health care plan issued as a result of conversion from group health insurance or from a self-insured group shall credit the time covered under such group health insurance toward any such exclusion.

(c) Plans providing minimum standard benefits need not provide benefits for the following: (1) Any charge for any care for any injury or disease either (A) arising out of and in the course of an employment subject to a workers' compensation or similar law or where such benefit is required to be provided under a workers' compensation policy to a sole proprietor, business partner or corporation officer who elects such coverage pursuant to the provisions of chapter 568 or (B) to the extent benefits are payable without regard to fault under a coverage statutorily required to be contained in any motor vehicle or other liability insurance policy or equivalent self-insurance; (2) any charge for treatment for cosmetic purposes other than **surgery** for the prompt repair of an accidental injury sustained while covered, provided cosmetic shall not mean replacement of any anatomic structure removed during treatment of tumors; (3) any charge for travel, other than transportation by local professional ambulance to the nearest health care institution qualified to treat the illness or injury; (4) any charge for private room accommodations to the extent it is in excess of the institution's most common charge for a semiprivate room; (5) any charge by health care institutions to the extent that it is determined by the carrier that the charge exceeds the rates approved by the Office of Health Care Access; (6) any charge for services or articles to the extent that it exceeds the reasonable charge in the locality for the service; (7) any charge for services or articles which are determined not to be medically necessary, except that this shall not apply to the fabrication or placement of the prosthesis as specified in subdivision (11) of subsection (a) of this section and subdivision (2) of this subsection; (8) any charge for services or

articles the provisions of which is not within the scope of the license or certificate of the institution or individual rendering such services or articles; (9) any charge for services or articles furnished, paid for or reimbursed directly by or under any law of a government, except as otherwise provided herein; (10) any charge for services or articles for custodial care or designed primarily to assist an individual in meeting his activities of daily living; (11) any charge for services which would not have been made if no insurance existed or for which the covered individual is not legally obligated to pay; (12) any charge for eyeglasses, contact lenses or hearing aids or the fitting thereof; (13) any charge for dental care not specifically covered by sections 38a-505, 38a-546 and 38a-551 to 38a-559, inclusive; and (14) any charge for services of a registered nurse who ordinarily resides in the covered individual's home, or who is a member of the covered individual's family or the family of the covered individual's spouse.

(d) and (e) Repealed by P.A. 84-499, S. 2.

(f) The minimum standard benefits of any individual or group comprehensive health care plan may be satisfied by catastrophic coverage offered in conjunction with basic hospital or medical-surgical plans on an expense incurred or service basis as approved by the commissioner as providing at least equivalent benefits.

(g) Comprehensive health care plan carriers may offer alternative policy provisions and benefits, including cost containment features, consistent with the purposes of sections 38a-505, 38a-546 and 38a-551 to 38a-559, inclusive, provided such alternative provisions and benefits are approved by the Insurance Commissioner prior to their use. Cost containment features may include, but shall not be limited to, preferred provider provisions; utilization review of health care services, including review of the medical necessity of hospital and physician services; case management benefit alternatives; and other managed care provisions.

(h) Every comprehensive health care plan issued or renewed through the Health Reinsurance Association on or after April 1, 1994, shall be a managed care plan. Such managed care plans shall include one or more health care center plans or preferred provider network plans, as determined by the board of the association, with the approval of the commissioner. In the event that such managed care plans would not adequately serve enrollees in a particular area of the state, the board may offer to such enrollees a managed care product which contains alternative cost containment features, including but not limited to, utilization review of health care services, review of the medical necessity of hospital and physician services and case management benefit alternatives.

(i) No comprehensive health care plan issued through the Health Reinsurance Association to a HIPAA eligible individual shall include any limitation or exclusion of benefits based on a preexisting condition.

(j) No comprehensive health care plan issued through the Health Reinsurance Association to a health care tax credit eligible individual shall include any limitation or exclusion of benefit based on a preexisting condition if such individual maintained creditable health insurance coverage for an aggregate period of three months as of the date on which the individual seeks to enroll in the

Health Reinsurance Association issued plan, not counting any period prior to a sixty-three-day break in coverage.

(k) (1) Each comprehensive health care plan issued through the Health Reinsurance Association shall provide coverage, under the terms and conditions of the plan, for the preexisting conditions of any group member or dependent who is newly insured under the plan on or after October 1, 2005, and was previously covered for such preexisting condition under the terms of the group member's or dependent's preceding qualifying coverage, provided the preceding qualifying coverage was continuous to a date less than one hundred twenty days prior to the effective date of the new coverage, exclusive of any applicable waiting period, except in the case of a newly insured group member whose preceding qualifying coverage was terminated due to an involuntary loss of employment, the preceding qualifying coverage must have been continuous to a date not more than one hundred fifty days prior to the effective date of the new coverage under the plan, exclusive of any applicable waiting period, provided the requirements of this subdivision shall only apply if the newly insured group member or dependent applies for such succeeding coverage not later than thirty days after the first day of the member's or dependent's initial eligibility.

(2) With respect to a group member or dependent who was newly insured under the plan on or after October 1, 2005, and was previously covered under qualifying coverage, but was not covered under such qualifying coverage for a preexisting condition, as defined under the newly issued comprehensive health care plan, such plan shall credit the time such group member or dependent was previously covered by qualifying coverage to the exclusion period of the preexisting condition provision, provided the preceding qualifying coverage was continuous to a date less than one hundred twenty days prior to the effective date of the new coverage, exclusive of any applicable waiting period under such plan, except in the case of a newly insured group member whose preceding qualifying coverage was terminated due to an involuntary loss of employment, the preceding qualifying coverage must have been continuous to a date not more than one hundred fifty days prior to the effective date of the new coverage, exclusive of any applicable waiting period, provided the requirements of this subdivision shall only apply if such newly insured group member or dependent applies for such succeeding coverage not later than thirty days after the first day of the member's or dependent's initial eligibility.

(3) As used in this subsection, "qualifying coverage" means coverage under (A) any group health insurance plan, group insurance arrangement or self-insured plan covering a group, (B) Medicare or Medicaid, or (C) an individual health insurance plan that provides benefits which are actuarially equivalent to or exceeding the benefits provided under a small employer health care plan, as defined in section 38a-564, whether issued in this state or any other state, as determined by the Insurance Department.

History:

(P.A. 75-616, S. 3, 12; P.A. 76-399, S. 3, 5; P.A. 77-614, S. 163, 610; P.A. 78-76, S. 4; P.A. 79-327, S. 1; 79-376, S. 67; P.A. 80-482, S. 332, 348; P.A. 81-55; P.A. 82-112; P.A. 84-499, S. 2; P.A. 89-80; P.A. 93-338, S. 2; P.A. 95-257, S. 39, 58; P.A. 96-19, S. 8; June 18 Sp. Sess. P.A.

97-8, S. 68, 88; June 30 Sp. Sess. P.A. 03-6, S. 67; P.A. 04-10, S. 12; P.A. 05-271, S. 1.)

TITLE 45a PROBATE COURTS AND PROCEDURE

- **CHAPTER 802h PROTECTED PERSONS AND THEIR PROPERTY**

Conn. Gen. Stat. § 45a-654. Appointment of temporary conservator. Duties.

(a) Upon written application for appointment of a temporary conservator brought by any person considered by the court to have sufficient interest in the welfare of the respondent, including, but not limited to, the spouse or any relative of the respondent, the first selectman, chief executive officer or head of the department of welfare of the town of residence or domicile of any respondent, the Commissioner of Social Services, the board of directors of any charitable organization, as defined in section 21a-190a, or the chief administrative officer of any nonprofit hospital or such officer's designee, the Court of Probate may appoint a temporary conservator if the court finds by clear and convincing evidence that: (1) The respondent is incapable of managing his or her affairs or incapable of caring for himself or herself, (2) immediate and irreparable harm to the mental or physical health or financial or legal affairs of the respondent will result if a temporary conservator is not appointed, and (3) appointment of a temporary conservator is the least restrictive means of intervention available to prevent such harm. The court shall require the temporary conservator to give a probate bond. The court shall limit the duties and authority of the temporary conservator to the circumstances that gave rise to the application and shall make specific findings, by clear and convincing evidence, of the immediate and irreparable harm that will be prevented by the appointment of a temporary conservator and that support the appointment of a temporary conservator. In making such specific findings, the court shall consider the present and previously expressed wishes of the respondent, the abilities of the respondent, any prior appointment of an attorney-in-fact, health care representative, trustee or other fiduciary acting on behalf of the respondent, any support service otherwise available to the respondent and any other relevant evidence. In appointing a temporary conservator pursuant to this section, the court shall set forth each duty or authority of the temporary conservator. The temporary conservator shall have charge of the property or of the person of the conserved person, or both, for such period or for such specific occasion as the court finds to be necessary, provided a temporary appointment shall not be valid for more than thirty days, unless at any time while the appointment of a temporary conservator is in effect, an application is filed for appointment of a conservator of the person or estate under section 45a-650. The court may (A) extend the appointment of the temporary conservator until the disposition of such application under section 45a-650, or for an additional thirty days, whichever occurs first, or (B) terminate the appointment of a temporary conservator upon a showing that the circumstances that gave rise to the application for appointment of a temporary conservator no longer exist. No appointment of a temporary conservator under this section may be in effect for more than sixty days from the date of the initial appointment.

(b) Unless the court waives the medical evidence requirement pursuant to subsection (e) of this section, an appointment of a temporary conservator shall not be made unless a report is filed with the application for appointment of a temporary conservator, signed by a physician licensed to

practice medicine or surgery in this state, stating: (1) That the physician has examined the respondent and the date of such examination, which shall not be more than three days prior to the date of presentation to the judge; (2) that it is the opinion of the physician that the respondent is incapable of managing his or her affairs or incapable of caring for himself or herself; and (3) the reasons for such opinion. Any physician's report filed with the court pursuant to this subsection shall be confidential. The court shall provide for the disclosure of the medical information required pursuant to this subsection to the respondent on the respondent's request, the respondent's attorney and to any other party considered appropriate by the court.

(c) Upon receipt of an application for the appointment of a temporary conservator, the court shall issue notice to the respondent, appoint counsel for the respondent and conduct a hearing on the application in the manner set forth in sections 45a-649, 45a-649a and 45a-650, except that (1) notice to the respondent shall be given not less than five days before the hearing, which shall be conducted not later than seven days after the application is filed, excluding Saturdays, Sundays and holidays, or (2) where an application has been made ex parte for the appointment of a temporary conservator, notice shall be given to the respondent not more than forty-eight hours after the ex parte appointment of a temporary conservator, with the hearing on such ex parte appointment to be conducted not later than three days after the ex parte appointment, excluding Saturdays, Sundays and holidays. Service on the respondent of the notice of the application for the appointment of a temporary conservator shall be in hand and shall be made by a state marshal, constable or an indifferent person. Notice shall include (A) a copy of the application for appointment of a temporary conservator and any physician's report filed with the application pursuant to subsection (b) of this section, (B) a copy of an ex parte order, if any, appointing a temporary conservator, and (C) the date, time and place of the hearing on the application for the appointment of a temporary conservator. The court may not appoint a temporary conservator until the court has made the findings required in this section and held a hearing on the application, except as provided in subsection (d) of this section. If notice is provided to the next of kin with respect to an application filed under this section, the physician's report shall not be disclosed to the next of kin except by order of the court.

(d) (1) If the court determines that the delay resulting from giving notice and appointing an attorney to represent the respondent as required in subsection (c) of this section would cause immediate and irreparable harm to the mental or physical health or financial or legal affairs of the respondent, the court may, ex parte and without prior notice to the respondent, appoint a temporary conservator upon receiving evidence and making the findings required in subsection (a) of this section, provided the court makes a specific finding in any decree issued on the application stating the immediate or irreparable harm that formed the basis for the court's determination and why such hearing and appointment was not required before making an ex parte appointment. If an ex parte order of appointment of a temporary conservator is made, a hearing on the application for appointment of a temporary conservator shall be commenced not later than three days after the ex parte order was issued, excluding Saturdays, Sundays and holidays. An ex parte order shall expire not later than three days after the order was issued unless a hearing on the order that commenced prior to the expiration of the three-day period has been continued for good cause.

(2) After a hearing held under this subsection, the court may appoint a temporary conservator or may confirm or revoke the ex parte appointment of the temporary conservator or may modify the duties and authority assigned under such appointment.

(e) The court may waive the medical evidence requirement under subsection (b) of this section if the court finds that the evidence is impossible to obtain because of the refusal of the respondent to be examined by a physician. In any such case the court may, in lieu of medical evidence, accept other competent evidence. In any case in which the court waives the medical evidence requirement as provided in this subsection, the court may not appoint a temporary conservator unless the court finds, by clear and convincing evidence, that (1) the respondent is incapable of managing his or her affairs or incapable of caring for himself or herself, and (2) immediate and irreparable harm to the mental or physical health or financial or legal affairs of the respondent will result if a temporary conservator is not appointed pursuant to this section. In any case in which the court waives the requirement of medical evidence as provided in this subsection, the court shall make a specific finding in any decree issued on the application stating why medical evidence was not required.

(f) Upon the termination of the temporary conservatorship, the temporary conservator shall file a written report with the court and, if applicable, a final accounting as directed by the court, of his or her actions as temporary conservator.

History:

(1955, S. 2908d; 1957, P.A. 449; February, 1965, P.A. 590, S. 2; 1967, P.A. 385; P.A. 75-72; P.A. 77-446, S. 6; 77-614, S. 521, 610; P.A. 79-631, S. 83, 111; P.A. 80-227, S. 9, 24; 80-476, S. 130; P.A. 84-202; 84-271, S. 6; 84-294, S. 8; P.A. 90-230, S. 58, 101; P.A. 93-262, S. 65, 87; P.A. 95-89; P.A. 96-170, S. 9, 23; P.A. 97-90, S. 5, 6; P.A. 04-142, S. 4; P.A. 05-154, S. 1; P.A. 06-195, S. 77; P.A. 07-73, S. 2(a); 07-116, S. 18.)

Conn. Gen. Stat. § 45a-682. Application for temporary limited guardian. Notice and hearing. Appointment.

(a) An application for a temporary limited guardian may be filed by any interested party alleging that the respondent is in need of elective surgical, medical or dental procedures or treatment involving the use of general anesthesia, and that by reason of the severity of his mental retardation, he is unable to give informed consent to such treatment. Such application shall include two certificates, one signed by a physician licensed to practice medicine or **surgery** in this state, and one signed by a licensed psychologist stating that each has, within thirty days prior to the filing of the application, examined the respondent and in his opinion (1) the respondent's condition renders him incapable of giving informed consent to said procedure and (2) without such treatment, the respondent will suffer deterioration of his physical or mental health or serious discomfort.

(b) Immediately upon receipt of the application, the court shall order such notice of the application and the date and time of hearing as it may direct to the respondent, the respondent's

parents or spouse, if any, and to the Office of Protection and Advocacy for Persons with Disabilities. A hearing shall be held promptly, taking into consideration the condition of the respondent. If, after hearing, the court finds that the respondent by reason of the severity of the respondent's mental retardation is incapable of giving informed consent to such procedure, and that the respondent will suffer deterioration of the respondent's physical or mental health or serious discomfort if such procedure or treatment, or both, is not ordered, the court may appoint a temporary limited guardian for the purpose of consenting to such procedure or treatment, or both. In making such appointment, the court shall give preference to the parent, next of kin or other person whom the court deems proper. The court may appoint the Commissioner of Developmental Services, or the commissioner's designee, to serve in such capacity if it is unable to find a suitable guardian. The appointment shall not be valid for more than sixty days. A temporary limited guardian shall be subject to all limitations set forth in section 45a-677.

History:

(P.A. 82-337, S. 15; P.A. 85-523, S. 8, 9; P.A. 86-323, S. 11; P.A. 03-278, S. 125; P.A. 07-73, S. 2(b).)

TITLE 52 CIVIL ACTIONS

- **CHAPTER 925 STATUTORY RIGHTS OF ACTION AND DEFENSES**

Conn. Gen. Stat. § 52-557b. "Good samaritan law". Immunity from liability for emergency medical assistance, first aid or medication by injection. School personnel not required to administer or render.

(a) A person licensed to practice medicine and **surgery** under the provisions of chapter 370 or dentistry under the provisions of section 20-106 or members of the same professions licensed to practice in any other state of the United States, a person licensed as a registered nurse under section 20-93 or 20-94 or certified as a licensed practical nurse under section 20-96 or 20-97, a medical technician or any person operating a cardiopulmonary resuscitator or an automatic external defibrillator, or a person trained in cardiopulmonary resuscitation or in the use of an automatic external defibrillator in accordance with the standards set forth by the American Red Cross or American Heart Association, who, voluntarily and gratuitously and other than in the ordinary course of such person's employment or practice, renders emergency medical or professional assistance to a person in need thereof, shall not be liable to such person assisted for civil damages for any personal injuries which result from acts or omissions by such person in rendering the emergency care, which may constitute ordinary negligence. The immunity provided in this subsection does not apply to acts or omissions constituting gross, wilful or wanton negligence. Nothing in this subsection shall be construed to exempt paid or volunteer firefighters, police officers or emergency medical services personnel from completing training in cardiopulmonary resuscitation or in the use of an automatic external defibrillator in accordance with the standard set forth by the American Red Cross or American Heart Association. For the purposes of this subsection, "automatic external defibrillator" means a device that: (1) Is used to administer an electric shock through the chest wall to the heart; (2) contains internal decision-

making electronics, microcomputers or special software that allows it to interpret physiologic signals, make medical diagnosis and, if necessary, apply therapy; (3) guides the user through the process of using the device by audible or visual prompts; and (4) does not require the user to employ any discretion or judgment in its use.

(b) A paid or volunteer firefighter or police officer, a teacher or other school personnel on the school grounds or in the school building or at a school function, a member of a ski patrol, a lifeguard, a conservation officer, patrol officer or special police officer of the Department of Environmental Protection, or emergency medical service personnel, who has completed a course in first aid offered by the American Red Cross, the American Heart Association, the National Ski Patrol, the Department of Public Health or any director of health, as certified by the agency or director of health offering the course, and who renders emergency first aid to a person in need thereof, shall not be liable to such person assisted for civil damages for any personal injuries which result from acts or omissions by such person in rendering the emergency first aid, which may constitute ordinary negligence. No paid or volunteer firefighter, police officer or emergency medical service personnel who forcibly enters the residence of any person in order to render emergency first aid to a person whom such firefighter, police officer or emergency medical service personnel reasonably believes to be in need thereof shall be liable to such person for civil damages incurred as a result of such entry. The immunity provided in this subsection does not apply to acts or omissions constituting gross, wilful or wanton negligence.

(c) An employee of a railroad company, including any company operating a commuter rail line, who has successfully completed a course in first aid, offered by the American Red Cross, the American Heart Association, the National Ski Patrol, the Department of Public Health or any director of health, as certified by the agency or director of health offering the course, and who renders emergency first aid or cardiopulmonary resuscitation to a person in need thereof, shall not be liable to such person assisted for civil damages for any personal injury or death which results from acts or omissions by such employee in rendering the emergency first aid or cardiopulmonary resuscitation which may constitute ordinary negligence. The immunity provided in this subsection does not apply to acts or omissions constituting gross, wilful or wanton negligence.

(d) A railroad company, including any commuter rail line, which provides emergency medical training or equipment to any employee granted immunity pursuant to subsection (c) of this section shall not be liable for civil damages for any injury sustained by a person or for the death of a person which results from the company's acts or omissions in providing such training or equipment or which results from acts or omissions by such employee in rendering emergency first aid or cardiopulmonary resuscitation, which may constitute ordinary negligence. The immunity provided in this subsection does not apply to acts or omissions constituting gross, wilful or wanton negligence.

(e) (1) For purposes of this subsection, "cartridge injector" means an automatic prefilled cartridge injector or similar automatic injectable equipment used to deliver epinephrine in a standard dose for emergency first aid response to allergic reactions.

(2) Any volunteer worker associated with, or any person employed to work for, a program offered to children sixteen years of age or younger by a corporation, other than a licensed health care provider, that is exempt from federal income taxation under Section 501 of the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as from time to time amended, who (A) has been trained in the use of a cartridge injector by a licensed physician, physician assistant, advanced practice registered nurse or registered nurse, (B) has obtained the consent of a parent or legal guardian to use a cartridge injector on his or her child, and (C) uses a cartridge injector on such child in apparent need thereof participating in such program, shall not be liable to such child assisted or to such child's parent or guardian for civil damages for any personal injury or death which results from acts or omissions by such worker in using a cartridge injector which may constitute ordinary negligence. The immunity provided in this subsection does not apply to acts or omissions constituting gross, wilful or wanton negligence.

(3) A corporation, other than a licensed health care provider, that is exempt from federal income taxation under Section 501 of the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as from time to time amended, which provides training in the use of cartridge injectors to any volunteer worker granted immunity pursuant to subdivision (2) of this subsection shall not be liable for civil damages for any injury sustained by, or for the death of, a child sixteen years of age or younger who is participating in a program offered by such corporation, which injury or death results from acts or omissions by such worker in using a cartridge injector, which may constitute ordinary negligence. The immunity provided in this subsection does not apply to acts or omissions constituting gross, wilful or wanton negligence.

(f) A teacher or other school personnel, on the school grounds or in the school building or at a school function, who has completed both a course in first aid in accordance with subsection (b) of this section and a course given by the medical advisor of the school or by a licensed physician in the administration of medication by injection, who renders emergency care by administration of medication by injection to a person in need thereof, shall not be liable to the person assisted for civil damages for any injuries which result from acts or omissions by the person in rendering the emergency care of administration of medication by injection, which may constitute ordinary negligence. The immunity provided in this subsection does not apply to acts or omissions constituting gross, wilful or wanton negligence.

(g) The provisions of this section shall not be construed to require any teacher or other school personnel to render emergency first aid or administer medication by injection.

(h) Any person who has completed a course in first aid offered by the American Red Cross, the American Heart Association, the National Ski Patrol, the Department of Public Health or any director of health, as certified by the agency or director of health offering the course, or has been trained in the use of a cartridge injector by a licensed physician, physician assistant, advanced practice registered nurse or registered nurse, and who, voluntarily and gratuitously and other than in the ordinary course of such person's employment or practice, renders emergency assistance by using a cartridge injector on another person in need thereof, or any person who is an identified

staff member of a before or after school program, day camp or day care facility, as provided in section 19a-900, and who renders emergency assistance by using a cartridge injector on another person in need thereof, shall not be liable to such person assisted for civil damages for any personal injuries which result from acts or omissions by such person in using a cartridge injector, which may constitute ordinary negligence. The immunity provided in this subsection does not apply to acts or omissions constituting gross, wilful or wanton negligence. For the purposes of this subsection, "cartridge injector" has the same meaning as provided in subdivision (1) of subsection (e) of this section.

History:

(1963, P.A. 205; 1967, P.A. 282; 878; 1969, P.A. 785; 1971, P.A. 729; P.A. 75-132; 75-456, S. 1, 2; P.A. 77-225; 77-349, S. 3; 77-614, S. 323, 610; P.A. 78-122, S. 1, 2; P.A. 82-160, S. 224; 82-286; P.A. 83-375, S. 2; P.A. 84-546, S. 119, 173; P.A. 86-237, S. 1, 2; P.A. 87-589, S. 34, 87; P.A. 89-149; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58; P.A. 98-62, S. 1; P.A. 99-181, S. 13; P.A. 00-196, S. 36; June Sp. Sess. P.A. 01-4, S. 37, 58; P.A. 03-211, S. 10; P.A. 04-221, S. 27; P.A. 05-144, S. 1; 05-259, S. 6; P.A. 06-196, S. 181, 182.)

TITLE 53 CRIMES

- **CHAPTER 943 OFFENSES AGAINST PUBLIC PEACE AND SAFETY**

Conn. Gen. Stat. § 53-212. Use of Roentgen-rays, x-rays and radium.

(a) No person, unless such person holds a license to practice medicine and **surgery** or a license to practice dentistry, shall use the Roentgen-ray or the x-ray or radium for the therapeutic or cosmetic treatment of another person, unless such person uses the same under the prescription, direction or supervision of a licensed physician, surgeon or dentist.

(b) Any person who violates any provision of subsection (a) shall be fined not less than one hundred dollars nor more than three hundred dollars or be imprisoned not more than one year or be both fined and imprisoned for the first offense, and for each subsequent offense shall be fined not less than two hundred dollars nor more than five hundred dollars or be imprisoned not less than thirty days nor more than one year or be both fined and imprisoned.

(c) The provisions of this section shall not be construed to prohibit the use of the Roentgen-ray or the x-ray for diagnostic purposes.

History:

(1949 Rev., S. 8542; P.A. 99-102, S. 49.)

TITLE 54 CRIMINAL PROCEDURE

- CHAPTER 961 TRIAL AND PROCEEDINGS AFTER CONVICTION

Conn. Gen. Stat. § 54-102h. Procedure for collection of blood or other biological sample for DNA analysis.

(a)(1) The collection of a blood or other biological sample from persons required to submit to the taking of such sample pursuant to subsection (a) of section 54-102g shall be the responsibility of the Department of Correction and shall be taken at a time and place specified by the Department of Correction.

(2) The collection of a blood or other biological sample from persons required to submit to the taking of such sample pursuant to subsection (b) of section 54-102g shall be the responsibility of the Department of Public Safety and shall be taken at a time and place specified by the sentencing court.

(3) The collection of a blood or other biological sample from persons required to submit to the taking of such sample pursuant to subsection (c) of section 54-102g shall be the responsibility of the Commissioner of Mental Health and Addiction Services or the Commissioner of Developmental Services, as the case may be, and shall be taken at a time and place specified by said commissioner.

(4) The collection of a blood or other biological sample from persons required to submit to the taking of such sample pursuant to subsection (d) of section 54-102g shall be the responsibility of the Judicial Department if such person is serving a period of probation and of the Department of Correction if such person is serving a period of parole and shall be taken at a time and place specified by the Court Support Services Division or the Department of Correction, as the case may be.

(5) The collection of a blood or other biological sample from persons required to submit to the taking of such sample pursuant to subsection (e) of section 54-102g shall be the responsibility of the agency in whose custody or under whose supervision such person has been placed, and shall be taken at a time and place specified by such agency.

(b) Only a person licensed to practice medicine and **surgery** in this state, a qualified laboratory technician, a registered nurse or a phlebotomist shall take any blood sample to be submitted to analysis.

(c) No civil liability shall attach to any person authorized to take a blood or other biological sample as provided in this section as a result of the act of taking such sample from any person submitting thereto, if the blood or other biological sample was taken according to recognized medical procedures, provided no person shall be relieved from liability for negligence in the taking of any such sample.

(d) Chemically clean sterile disposable needles and vacuum draw tubes shall be used for all blood samples. The tube or container for a blood or other biological sample shall be sealed and

labeled with the subject's name, Social Security number, date of birth, race and gender, the name of the person collecting the sample, and the date and place of collection. The tube or container shall be secured to prevent tampering with the contents.

(e) The steps set forth in this section relating to the taking, handling, identification and disposition of blood or other biological samples are procedural and not substantive. Substantial compliance therewith shall be deemed to be sufficient. The samples shall be transported to the Division of Scientific Services within the Department of Public Safety not more than fifteen days following their collection and shall be analyzed and stored in the DNA data bank in accordance with sections 54-102i and 54-102j.

History:

(P.A. 94-246, S. 2; P.A. 99-218, S. 11, 16; P.A. 03-242, S. 2; P.A. 04-188, S. 2; 04-234, S. 2; P.A. 07-73, S. 2(b); 07-158, S. 5.)

Exhibit 3

American Board of Surgery Booklet of Information – Surgery

The AMERICAN BOARD *of* SURGERY

BOOKLET OF INFORMATION

Surgery

2011–2012

The

AMERICAN BOARD

of

SURGERY

Booklet of Information

Surgery

2011 – 2012

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The Booklet of Information – Surgery is published by the American Board of Surgery (ABS) to outline the requirements for certification in surgery. Applicants are expected to be familiar with these requirements and bear ultimate responsibility for ensuring their training complies with ABS requirements, as well as for acting in accordance with the ABS policies governing each stage of the certification process.

This edition of the booklet supersedes all previous publications of the ABS concerning its policies, procedures and requirements for examination and certification in surgery. The ABS, however, reserves the right to make changes to its fees, policies, procedures and requirements at any time. Admission to the certification process is governed by the policies and requirements in effect at the time an application is submitted and is at the discretion of the ABS.

Applicants should visit the ABS website at *www.absurgery.org* for the most recent updates.

TABLE OF CONTENTS

I. INTRODUCTION

A. Purpose of the ABS

The American Board of Surgery Inc. is a private, nonprofit, autonomous organization formed for the following purposes:

- To conduct examinations of acceptable candidates who seek certification or maintenance of certification by the board.
- To issue certificates to all candidates meeting the board's requirements and satisfactorily completing its prescribed examinations.
- To improve and broaden the opportunities for the graduate education and training of surgeons.

The ABS considers certification to be voluntary and limits its responsibilities to fulfilling the purposes stated above. Its principal objective is to pass judgment on the education, training and knowledge of broadly qualified and responsible surgeons and not to designate who shall or shall not perform surgical operations. It is not concerned with the attainment of special recognition in the practice of surgery. Furthermore, it is neither the intent nor the purpose of the board to define the requirements for membership on the staff of hospitals or institutions involved in the practice or teaching of surgery.

B. History of the ABS

The American Board of Surgery was organized on January 9, 1937, and formally chartered on July 19, 1937. The formation of the ABS was the result of a committee created a year earlier by the American Surgical Association, along with representatives from other national and regional surgical societies, to establish a certification process and national certifying body for individual surgeons practicing in the U.S.

The committee decided that the ABS should be formed of members from the represented organizations and, once organized, it would establish a comprehensive certification process. These findings and recommendations were approved by the cooperating societies, leading to the board's formation in 1937. This was done to protect the public and improve the specialty.

The ABS was created in accordance with the Advisory Board of Medical Specialties, the accepted governing body for determining certain specialty fields of medicine as suitable for certification. In 1970 it became known as the American Board of

Medical Specialties (ABMS), and is currently composed of 24 member boards including the American Board of Surgery.

C. The Certification Process

The ABS considers certification in surgery to be based upon a process of education, evaluation and examination. The ABS holds undergraduate and graduate education to be of the utmost importance and requires the attestation of the residency program director that an applicant has completed an appropriate educational experience and attained a sufficiently high level of knowledge, clinical judgment and technical skills, as well as ethical standing, to be admitted to the certification process.

Individuals who believe they meet the ABS' educational and ethical requirements may begin the certification process by applying for admission to the Qualifying Examination (QE). The application is reviewed and, if approved, the applicant is granted admission to the examination.

Upon successful completion of the Qualifying Examination, the applicant is considered a *candidate* for certification and granted the opportunity to take the Certifying Examination (CE). If the candidate is also successful at this examination, the candidate is deemed certified in surgery and becomes a diplomate of the ABS.

Possession of a certificate is not meant to imply that a diplomate is competent in the performance of the full range of complex procedures that encompass each content area of general surgery as defined in section I-D. It is not the intent nor the role of the ABS to designate who shall or shall not perform surgical procedures or any category thereof. Credentialing decisions are best made by locally constituted bodies and should be based on an applicant's extent of training, depth of experience, patient outcomes relative to peers, and certification status.

D. Specialty of General Surgery Defined

1. The scope of general surgery

General surgery is a discipline that requires knowledge of and familiarity with a broad spectrum of diseases that may require surgical treatment. By necessity, the breadth and depth of this knowledge will vary by disease category. In most areas, the surgeon will be expected to be competent in diagnosing and treating the full spectrum of disease. However, there are some

types of disease in which comprehensive knowledge and experience is not generally gained in the course of a standard surgical residency. In these areas the surgeon will be able to recognize and treat a select group of conditions within a disease category.

2. The required residency experience for initial certification in general surgery

Residency training in general surgery requires experience in all of the following content areas:

- Alimentary Tract (including Bariatric Surgery)
- Abdomen and its Contents
- Breast, Skin and Soft Tissue
- Endocrine System
- Solid Organ Transplantation
- Pediatric Surgery
- Surgical Critical Care
- Surgical Oncology (including Head and Neck Surgery)
- Trauma/Burns and Emergency Surgery
- Vascular Surgery

General surgery as a field comprises, but is not limited to, the performance of operations and procedures (including endoscopies) relevant to the content areas listed above. Additional expected knowledge and experience in the above areas includes:

- Technical proficiency in the performance of essential operations/procedures in the above areas, plus knowledge, familiarity and in some cases technical proficiency with more uncommon and complex operations in each of the above areas.
- Clinical knowledge, including epidemiology, anatomy, physiology, clinical presentation, and pathology (including neoplasia).
- Knowledge of wound healing; infection; fluid management; shock and resuscitation; immunology; antibiotic usage; metabolism; management of postoperative pain; and use of enteral and parenteral nutrition.
- Experience and skill in the following areas: clinical evaluation and management, or stabilization and referral, of patients with surgical diseases; management of preoperative, operative and postoperative care; management of comorbidities and complications; and knowledge of appropriate use and interpretation of radiologic and other diagnostic imaging.

3. The following disciplines have training programs related to, but separate from, general surgery. As the primary surgical practitioner in many circumstances, the certified general surgeon is required to be familiar with diseases and operative techniques in these areas. The certified general surgeon will have experience during training that will allow for diagnosis and management of a select group of conditions in these areas. **However, comprehensive knowledge and management of conditions in these areas generally requires additional training.**

- Bariatric Surgery
- Solid Organ Transplantation
- Pediatric Surgery
- Thoracic surgery
- Vascular Surgery

4. In addition, the certified general surgeon is expected to be able to recognize and provide early management and appropriate referral for urgent and emergent problems in the surgical fields of:

- Gynecology
- Urology
- Orthopaedic Injuries
- Hand Surgery

5. The certified general surgeon is also expected to have knowledge and skills in the management and team-based interdisciplinary care of the following specific patient groups:

- Terminally ill patients, to include palliative care and management of pain, weight loss, and cachexia in patients with malignant and chronic conditions.
- Morbidly obese patients, to include metabolic derangements, weight-loss surgery and the counseling of patients and families.
- Geriatric surgical patients, to include operative and nonoperative care, management of co-morbid chronic diseases, and the counseling of patients and families.
- Culturally diverse groups of patients.

E. Website Resources

The ABS website, *www.absurgery.org*, offers many resources for individuals interested in ABS certification. Potential applicants are encouraged to familiarize themselves with the website. Applicants and candidates should use the website to update their personal information, submit online applications, check their application's status, and view their recent examination history.

In addition, the following policies are posted on the website. They are reviewed regularly and supersede any previous versions.

- *Credit for Foreign Graduate Medical Education*
- *Ethics and Professionalism*
- *Examination of Persons with Disabilities*
- *Leave Policy*
- *Limitation on Number of Residency Programs*
- *Military Activation*
- *Privacy Policy*
- *Reconsideration and Appeals*
- *Regaining Admissibility to General Surgery Examinations*
- *Reporting of Status*
- *Representation of Certification Status*
- *Revocation of Certificates*
- *Substance Abuse*

II. REQUIREMENTS FOR CERTIFICATION

A. General Requirements

Applicants for certification in surgery must meet these general requirements:

- **Have demonstrated to the satisfaction of the program director** of an accredited graduate medical education program in general surgery that they have attained the level of qualifications required by the ABS. All phases of the graduate educational process must be completed in a manner satisfactory to the ABS.
- **Have an ethical, professional, and moral status** acceptable to the ABS.
- **Be actively engaged in the practice of general surgery** as indicated by holding admitting privileges to a surgical service in an accredited health care organization, or be currently engaged in pursuing additional graduate education in a component of surgery or other recognized surgical specialty. An exception to this requirement is active military duty.
- **Hold a currently registered full and unrestricted license to practice medicine** in the United States or Canada within six months after completion of general surgery residency. A full and unrestricted medical license is not required for the Qualifying Examination if it is taken within six months following completion of residency. However, if successful on the QE, candidates must have a full and unrestricted license to take the Certifying Examination regardless of when it is taken. Temporary, limited, educational or institutional medical licenses will not be accepted, even if the candidate is in a fellowship.

  An applicant must immediately inform the ABS of any conditions or restrictions in force on any active medical license he or she holds in any state or province. When there is a restriction or condition in force on any of the applicant's medical licenses, the Credentials Committee of the ABS will determine whether the applicant satisfies the above licensure requirement.

B. Undergraduate Medical Education

Applicants must have graduated from an accredited school of allopathic or osteopathic medicine in the United States or Canada. Graduates of schools of medicine in countries other than the United States or Canada must present evidence of certification by the Educational Commission for Foreign Medical Graduates (ECFMG). *(See also II-G-2. Credit for Foreign Graduate Education)*

C. Graduate Surgical Education

1. General Information

The purpose of graduate education in surgery is to provide the opportunity to acquire a broad understanding of human biology as it relates to disorders of a surgical nature, and the technical knowledge and skills appropriate to be applied by a specialist in surgery. This goal can best be attained by means of a progressively graded curriculum of study and clinical experience under the guidance and supervision of certified surgeons, which provides progression through succeeding stages of responsibility for patient care up to the final stage of complete management. Major operative experience and independent decision making at the final stage of the program are essential components of surgical education. The ABS will not accept into the certification process anyone who has not had such an experience in the specialty of surgery, as previously defined in section I-D, regardless of the number of years spent in educational programs.

The graduate educational requirements set forth on these pages are considered to be the minimal requirements of the ABS and should not be interpreted to be restrictive in nature. The time required for the total educational process should be sufficient to provide adequate clinical experience for the development of sound surgical judgment and adequate technical skill. These requirements do not preclude additional desirable educational experience, and program directors are encouraged to retain residents in a program as long as is required to achieve the necessary level of qualifications.

The integration of basic sciences with clinical experience is considered to be superior to formal courses in such subjects. Accordingly, while recognizing the value of formal courses in the study of surgery and the basic sciences at approved graduate schools of medicine, the ABS will not accept such courses in lieu of any part of the required clinical years of surgical education.

The ABS may at its discretion require that a member of the ABS or a designated diplomate observe and report upon the clinical performance of an applicant before establishing admissibility to examination, or before awarding or renewing certification.

While residency programs may develop their own vacation, illness and leave policies for residents, one year of approved residency toward ABS requirements must be 52 weeks in duration and include at least 48 weeks of full-time surgical experience. All time away from training must be accounted for on the application for certification. *(See also II-E. Leave Policy)*

2. Specific Requirements

To be accepted into the certification process, applicants must have completed the following:

- **A minimum of five years of *progressive* residency education** satisfactorily following graduation from medical school in a program in general surgery accredited by the Accreditation Council for Graduate Medical Education (ACGME) or Royal College of Physicians and Surgeons of Canada (RCPSC).

  Repetition of one clinical level may not replace another year in the sequence of training. For example, completing two years at the PGY-2 level does not permit promotion to PGY-4; a categorical PGY-3 year must be completed.

  A list of U.S. programs accredited by the ACGME may be found at *www.acgme.org*.

- **All phases of graduate education in general surgery in an accredited general surgery program.** Experience obtained in accredited programs in other recognized specialties, although containing some exposure to surgery, is not acceptable.

  In addition, a flexible or transitional first year will not be credited toward PGY-1 training unless it is accomplished in an institution with an accredited program in surgery and at least six months of the year is spent in surgical disciplines.

- **Sixty months of residency training at no more than three residency programs**. This limit applies regardless of whether an applicant completed clinical years as a preliminary or categorical resident. Individuals who completed their training at more than three programs will be required to repeat one or more years of training to comply with this limit.

  For applicants who trained at more than one program, documentation of satisfactory completion of years in prior programs from the appropriate program directors must be submitted. When credit is granted for prior training outside the U.S. or Canada, it will be counted as one institution.

- **No fewer than 48 weeks of full-time experience in each residency year**. This is required regardless of the amount of operative experience obtained.

- **At least 54 months of clinical surgical experience with progressively increasing levels of responsibility** over the five years in an accredited surgery program, including **no fewer than 42 months devoted to the content areas of general surgery** as previously defined in section I-D.

- **The programs *Advanced Cardiovascular Life Support (ACLS)*, *Advanced Trauma Life Support® (ATLS®)* and *Fundamentals of Laparoscopic Surgery (FLS)*.** Applicants are not required to be currently certified in these programs; however documentation of prior successful completion must be provided with the application.

- **No more than six months during all junior years assigned to non-clinical or non-surgical disciplines** that are supportive of the needs of the individual resident and appropriate to the overall goals of the general surgery training program. Experience in surgical pathology and endoscopy is considered to be clinical surgery, but obstetrics and ophthalmology are not. No more than 12 months total during all junior years may be allocated to any one surgical specialty other than general surgery.

- **The entire chief resident experience in either the content areas of general surgery, as defined in section I-D, or thoracic surgery**, with no more than four months devoted to any one component. *(Exceptions will be made for residents who have been approved under the flexibility option; see II-G-3.)* All resident rotations at the PGY-4 and PGY-5 levels should involve substantive major operative experience and independent decision making.

- **Acting in the capacity of chief resident in general surgery for a 12-month period**, with the majority of the 12 months served in the final year. The term "chief resident" indicates that a resident has assumed ultimate clinical responsibility for patient care under the supervision of the teaching staff and is the most senior resident involved with the direct care of the patient.

  A portion of the chief residency may be served in the next to the last year, provided it is no earlier than the fourth clinical year and has been approved by the Residency Review Committee for Surgery (RRC-Surgery) followed by notification to the ABS. *(Special requirements apply to early specialization in vascular surgery and thoracic surgery; see www.absurgery.org.)*

- **The final two residency years in the same program**, unless prior approval for a different arrangement has been granted by the ABS.

D. Operative Experience

Applicants for examination must have been the operating surgeon for a minimum of **750 operative procedures in five years,** including at least **150 operative procedures in the chief resident year**. The procedures must include operative experience in each of the content areas listed in the definition of general surgery set forth in section I-D.

A minimum of 25 cases is required in the area of surgical critical care patient management, with at least one case in each of the area's seven categories.

Applicants must submit a report that tabulates their operative experience during residency, including the number of patients with multiple organ trauma where a major general surgical operation was not required. Applicants must also indicate their level of responsibility (e.g., surgeon chief year, surgeon junior years, teaching assistant, first assistant) for the procedures listed.

Applicants may claim credit as "surgeon chief year" or "surgeon junior years" only when they have actively participated in making or confirming the diagnosis, selecting the appropriate operative plan, and administering preoperative and postoperative care. Additionally, they must have personally performed either the entire operative procedure or the critical parts thereof and participated in postoperative follow-up. All of the above must be accomplished under appropriate supervision.

When previous personal operative experience justifies a teaching role, residents may act as teaching assistants and list such cases during the fourth and fifth year only. Applicants may claim credit as teaching assistant only when they have been present and scrubbed and acted as assistant to guide a more junior trainee through the procedure. **Applicants may count up to 50 cases as teaching assistant toward the 750 operative case total; however these cases may not count toward the 150 chief year cases**. Applicants may not claim credit both as surgeon (surgeon chief or surgeon junior) *and* teaching assistant.

E. Leave Policy

1. Leave During a Standard Five-Year Residency

For documented medical problems or maternity leave, the ABS will accept 46 weeks of training in **one** of the first three years of residency and 46 weeks of training in **one** of the last two years, for a total of 142 weeks in the first three years and 94 weeks in the last two years. Unused vacation or leave time cannot

be applied to reduce the amount of full-time experience required per year without written permission from the ABS. Such requests may only be made by the program director.

2. Six-Year Option

If permitted by the residency program, the five clinical years of residency training may be completed over six academic years. All training must be completed at a single program with advance approval from the ABS. Forty-eight weeks of training are required in each clinical year and all individual rotations must be full-time. The first 12 months of clinical training would be counted as PGY-1, the second 12 months as PGY-2, and so forth. No block of clinical training may be shorter than one month (four weeks).

Under this option, a resident may take up to 12 months off during training. The resident would first work with his or her program to determine an appropriate leave period or schedule. The program would then request approval for this plan from the ABS.

Use of the six-year option is solely at the program's discretion, and contingent on advance approval from the ABS. The option may be used for any purpose approved by the residency program, including but not limited to family issues, visa issues, medical problems, maternity leave, external commitments, volunteerism, pursuit of outside interests, educational opportunities, etc.

F. Ethics and Professionalism

The ABS believes that certification in surgery carries an obligation for ethical behavior and professionalism in all conduct. The exhibition of unethical behavior or a lack of professionalism by an applicant or diplomate may prevent the certification of an applicant or may result in the suspension or revocation of certification. All such determinations shall be at the sole discretion of the ABS.

Unethical and unprofessional behavior is denoted by any dishonest behavior, including: cheating; lying; falsifying information; misrepresenting one's educational background, certification status and/or professional experience; and failure to report misconduct. The American Board of Surgery has adopted a "zero tolerance" policy toward these behaviors, and individuals exhibiting such behaviors may be permanently barred from certification, reported to state medical boards, and/or legally prosecuted for copyright or other violations if identified.

Unethical behavior is specifically defined by the ABS to include the disclosure, publication, reproduction or transmission of ABS examinations, in whole or in part, in any form or by any means, verbal or written, electronic or mechanical, for any purposes. This also extends to sharing examination information or discussing an examination while still in progress. Unethical behavior also includes the possession, reproduction or disclosure of materials or information, including examination questions or answers or specific information regarding the content of the examination, before, during or after the examination. This definition specifically includes the recall and reconstruction of examination questions by any means and such efforts may violate federal copyright law. All ABS examinations are copyrighted and protected by law; the ABS will prosecute violations to the full extent provided by law and seek monetary damages for any loss of examination materials. *(See also III-D-2. Examination Irregularities)*

G. Additional Considerations

1. Military Service

Credit will not be granted toward the requirements of the ABS for service in the U.S. Armed Forces, the U.S. Public Health Service, the National Institutes of Health or other governmental agencies unless the service was as a duly appointed resident in an accredited program in surgery.

2. Credit for Foreign Graduate Education

The ABS does not grant credit directly to residents for surgical education outside the U.S. or Canada. The ABS will consider granting partial credit for foreign graduate medical education to a resident in a U.S. general surgery residency program accredited by the ACGME, but **only upon request of the program director**. Preliminary evaluations will not be provided before enrollment in a residency program, either to a resident or program director.

All requests for credit and related inquiries must come from the program director and must be sent in writing by letter, not email. Program directors will be notified of credit decisions by letter from the ABS executive director.

The program director is the primary judge of the resident's proficiency level and should make the request for credit only after having observed the individual as a junior resident for at least six months to ascertain that clinical performance is consistent with the level of credit to be requested. If a resident is felt

to be a candidate for credit, he or she should normally begin residency at the PGY-2 or PGY-3 level so that the appropriate level of clinical skills can be assessed.

Requests for credit from the program director must be accompanied by documentation of the following:

- Satisfactory completion of foreign medical school and foreign residency training
- Specialty certification in the foreign venue, if achieved
- Chronological listing of former foreign and U.S. practice after specialty training
- Chronological listing of all U.S. training, with specific description of accreditation status of training program and whether or not resident occupied an accredited or supernumerary (above accredited limit) position in program
- Attestation by program director of satisfactory completion of all U.S. or Canadian surgical resident training years for which credit is sought
- All scores on the ABS In-Training Examination (ABSITE)

Residents must take the ABSITE before any credit may be requested. The resident's scores on the ABSITE should be consonant with the level of credit requested. Requests for credit should only be submitted once all required documentation is available.

Credit for foreign training may be granted in lieu of the first or second clinical years of residency, and rarely the third. Credit is never given for the fourth or fifth clinical years, which must be completed satisfactorily in an accredited U.S. program.

Program directors who wish to advance residents to senior levels (PGY-4) must have obtained ABS approval prior to beginning the PGY-4 year; otherwise credit for these years will be denied. When seeking three years of credit to enter training at the PGY-4 level, a resident should complete at least six months of general surgery training at the PGY-3 level under the program director's supervision, or be participating in a surgical fellowship at the same institution (e.g., transplantation, advanced GI, etc.) for a similar period, to allow for assessment of their clinical skills.

Requests for three years of credit should include an operative log of cases completed by the resident as operating surgeon during the PGY-3 or fellowship

experience at the requesting institution. These individuals must also take the senior ABSITE at least once prior to the request for credit and demonstrate the expected level of knowledge for their level of training.

Typically one year of credit will be granted for three or more years of foreign training. Two years of credit will be granted for full surgical training plus board certification or its equivalent in the foreign venue, if the training is similar in length and in the breadth of experience obtained. **The granting of credit is not guaranteed**. If the resident moves to another program, the credit is **not transferable** and must be requested by the resident's new program director after a new period of evaluation.

Canadian Residents

Applicants who trained in Canada must have completed all of the requirements in a Canadian surgery program accredited by the RCPSC or in combination with a U.S. surgery program accredited by the ACGME. No credit for surgical education outside the U.S. and Canada will be granted to applicants who complete a Canadian program. Applicants from Canadian programs must comply with ABS requirements for certification.

International Rotations

The ABS will not normally accept any rotations outside the U.S. or Canada toward its requirements, even if completed as part of an accredited residency program. If program directors wish to credit training abroad toward ABS requirements, they must obtain ABS approval in advance. All training for which credit is requested must be completed under the direct supervision of a surgeon certified in general surgery by the ABS from either the parent institution or the institution where the training is occurring.

(See the Credit for Foreign Graduate Medical Education Policy at www.absurgery.org for further details)

3. Flexibility Option

The ABS has instituted a policy to permit greater flexibility in the clinical rotations completed by general surgery residents. Program directors, with advance approval of the ABS, are allowed to customize up to 12 months of a resident's rotations in the last 36 months of residency to reflect his or her future specialty interest. No more than six months of flexible rotations are allowed in any one year. This is an entirely voluntary option for program directors and may be done on a selective case-by-case basis.

Program directors must make the requests for ABS approval in advance by letter, not email, addressed to the ABS executive director and outline the plan for the flexible rotations. The ABS requirement that no more than four months in the chief year be devoted to any one area will be extended to six months, if necessary, upon approval. This policy does not affect any of the ABS' other requirements for certification.

4. Further Information for Program Directors

When making advancement determinations, program directors are cautioned against appointing residents to advanced levels without first ensuring that their previous training is in accordance with ABS certification requirements. Program directors should contact the ABS prior to making a promotion decision if there is any question of a resident's completed training not meeting ABS requirements.

At the end of each academic year, the ABS requires that program directors verify the satisfactory completion of the preceding year of training for each resident in their program, using the resident roster information submitted to the ABS. For residents who have transferred into their program, program directors must obtain written verification of satisfactory completion for all prior years of training. Upon applying for certification, residents who have transferred programs must provide this verification to the ABS.

In addition to its own requirements, the ABS adheres to ACGME program requirements for residency training in general surgery. These include that program directors must obtain RRC-Surgery approval in these situations: (1) for resident assignments of six months or more at a participating non-integrated site; or (2) if chief resident rotations are carried out prior to the last 12 months of residency. Documentation of such approval or prior ABS approval should accompany the individual's application.

5. Reconsideration and Appeals

The ABS may deny or grant an applicant or candidate the privilege of examination whenever the facts in the case are deemed by the ABS to so warrant.

Applicants and candidates may request reconsideration and appeal as outlined in the ABS' published policy. A copy of the ABS *Reconsideration and Appeals Policy* is available from the ABS office or website, *www.absurgery.org*. A request for reconsideration, the first step, must be made in writing to the ABS office within 90 days of receipt of notice of the action in question.

III. EXAMINATIONS IN SURGERY

All ABS examinations are developed by committees consisting of ABS directors and experienced diplomates nominated by directors to serve as examination consultants. All are required to hold current, time-limited certificates. Neither directors nor consultants receive any remuneration for their services. All ABS examinations are protected by federal copyright.

A. The In-Training Examination (ABSITE)

The ABS offers annually to residency programs the In-Training Examination, a multiple-choice examination designed to measure the progress attained by residents in their knowledge of the basic sciences and the management of clinical problems related to surgery. It is offered in two versions: a junior-level version for PGY 1-2 with an emphasis on surgical anatomy, pathophysiology, diagnosis and evaluation; and a senior-level version for PGY 3-5 focusing on clinical management. The exam is administered to programs in a secure online format.

The ABSITE is solely meant to be used by program directors as an evaluation instrument in assessing residents' progress and results of the examination are released to program directors only. The ABS will not release score reports to residents. The examination is not available to residents on an individual basis and is not required by the ABS as part of the certification process.

The ABS reserves the right to withhold participation in the examination by an institution where in prior instances there were cases of improper use, unacceptable test administration, or irregular behavior by residents taking the examination.

B. The Qualifying Examination (QE)

1. General Information

The Qualifying Examination is an eight-hour, computer-based examination offered once annually. The examination consists of approximately 300 multiple-choice questions designed to evaluate an applicant's knowledge of general surgical principles and the basic sciences applicable to surgery. Information regarding exam dates and fees, as well as an exam content outline, is available at *www.absurgery.org*.

Examination results are mailed and posted on the ABS website two to three weeks after the exam. Examinees' results are also reported to the director of the program in which they completed their final year of residency.

2. Application Process

Individuals who believe they meet the requirements for certification in surgery may apply to the ABS for admission to the certification process. All training must be completed by July 1 for the applicant to be eligible for that year's QE. Application requirements and the online application process are available from the ABS website, *www.absurgery.org*.

The individual who served as the applicant's program director during residency must attest that all information supplied by the applicant is accurate.

An application will not be approved unless:

- Every rotation completed during residency training is listed separately and consecutively.
- All time away from training for vacation, medical leave, etc., is reported accurately.
- Documentation of completion of ACLS, ATLS and FLS is provided.
- Cases are listed for patient care/non-operative trauma, in addition to the 25 cases required in surgical critical care patient management.
- For applicants who trained in more than one program, documentation of satisfactory completion for all years in each program is provided.
- For international medical graduates, a copy of their ECFMG certificate is provided.

Applicants should keep a copy of all submitted information as the ABS will not furnish copies. Applicants are also strongly advised to maintain a current mailing address with the ABS during the application process to avoid unnecessary delays.

Note that the acceptability of an applicant does not depend solely upon completion of an approved program of education, but also upon information received by the ABS regarding professional maturity, surgical judgment, technical capabilities and ethical standing.

3. Admissibility

An applicant will be considered admissible to the Qualifying Examination only when all requirements of the ABS currently in force at the time of application have been satisfactorily fulfilled, including acceptable operative experience and the attestation of the program director regarding the applicant's surgical skills, ethics and professionalism.

In addition:

- Applicants who desire certification **must apply for certification within three academic years** after completion of residency.
- Once an application is approved, the applicant **must take the Qualifying Examination for the first time** in the year of application approval or the year following.

Applicants who exceed either of the above time limits will lose admissibility to the ABS certification process and must fulfill a readmissibility pathway if they still wish to seek certification.

4. Examination Opportunities

Once an application is approved, the applicant is granted a maximum of **five opportunities within a five-year period** to pass the QE. A new application is not required during this period. If the applicant chooses not to take the examination in a given year, this is considered a lost opportunity as **the five-year limit is absolute**. Applicants who fail to pass within the five-year period may regain admissibility through the readmissibility pathways described below.

5. Readmissibility

Individuals who are no longer admissible to the ABS certification process may regain admissibility through the following pathways.

Standard Pathway

The individual must complete an additional year (12 months) of structured education in surgery in an ACGME-accredited general surgery residency program, in which the program director has agreed to provide the applicant with structured teaching that meets ABS guidelines. The structured educational program must be submitted to the ABS in advance for approval and must be a full-time activity. The program director is required to submit quarterly summaries to the ABS of the applicant's progress. Upon completion of the year, the program director must provide written attestation that the individual has successfully completed all requirements. He or she must then complete an application for readmissibility and provide documentation of a current full and unrestricted medical license.

Alternative Pathway

The individual may pursue an alternative educational pathway to acquire and demonstrate adequate surgical knowledge, which may be accomplished at a

pace determined by the applicant. The initial readmissibility application requires evidence of 100 hours of continuing medical education completed in the past 24 months with 60 hours in Category I, satisfactory completion of the American College of Surgeons' Surgical Education and Self-Assessment Program (SESAP), reference letters and an operative experience report. Upon approval of the application, the applicant must take and pass two secure examinations: one derived from the ABSITE and another derived from the two latest versions of SESAP. Please refer to *Regaining Admissibility to General Surgery Examinations* at *www.absurgery.org* for complete details.

Upon successful completion of either of the above pathways, the individual will again be admissible to the QE for five opportunities within five years. If the individual is not successful in satisfactorily completing a readmissibility pathway or passing the QE during the readmissibility period, he or she must re-enter formal residency training for PGY-4 and PGY-5 level training in a surgery program accredited by the ACGME or RCPSC to regain admissibility to another five-year period.

Time Limitations

If an individual has not actively pursued admissibility or readmissibility to the certification process within 10 years after completion of residency, he or she will be required to re-enter formal residency training for PGY-4 and PGY-5 level training in a surgery program accredited by the ACGME or RCPSC to regain admissibility to the certification process.

C. The Certifying Examination (CE)

1. General Information

The Certifying Examination is an oral examination consisting of three 30-minute sessions conducted by teams of two examiners that evaluates a candidate's clinical skills in organizing the diagnostic evaluation of common surgical problems and determining appropriate therapy. It is the final step toward certification in surgery. The examination focuses on the application of knowledge to clinical problems; evaluation of surgical judgment and decision making; management of complications; and assessment of technical knowledge.

The CE is administered several times a year in various U.S. cities. The examinations are conducted by ABS directors along with associate examiners

who are experienced ABS diplomates in the local or regional medical community. All examiners are active in the practice of surgery and hold current, time-limited certificates. The ABS makes every effort to avoid conflicts of interest between candidates and their examiners.

Please refer to *www.absurgery.org* for further information about the CE, including exam dates and fees. Examination results are mailed and posted on the ABS website the day after the final day of examination. Examinees' results are also reported to the director of the program in which they completed their final year of residency.

2. Admissibility

To be admissible to the CE, a candidate must have successfully completed the QE and hold a **full and unrestricted license** to practice medicine in the United States or Canada and provide evidence of this to the ABS office. The license must be valid through the date of the examination. **Temporary, limited, educational or institutional medical licenses will not be accepted, even if a candidate is currently in a fellowship.**

3. Examination Opportunities

Upon successful completion of the QE, candidates are offered **five opportunities within a five-year period** to pass the CE. **Both of these limits are absolute**; exceptions will only be made for active duty military service outside the United States.

Candidates may take the CE **no more than twice in an academic year**. If a specific CE site has limited availability, priority for assignment to that site will be given to candidates who have yet to take a CE in that academic year.

Candidates for certification are encouraged not to unduly delay taking the CE, as such delays may adversely affect performance. Candidates are discouraged from taking the CE more than once in an academic year as the examination evaluates a candidate's clinical knowledge and judgment, which in general do not significantly improve over the course of only a few months.

Candidates who are not successful in the five opportunities during the five-year period must fulfill a readmissibility pathway if they still wish to seek certification. This process may begin as soon as the five opportunities are exhausted by the candidate.

4. Readmissibility

Individuals who are no longer admissible to the CE may regain their admissibility through the following pathways.

Standard Pathway

The individual must complete an additional year (12 months) of structured education in surgery in an ACGME-approved surgical residency program, in which the program director has agreed to provide the applicant with structured teaching that meets ABS guidelines. The structured educational program must be submitted to the ABS in advance for approval and must be a full-time activity. The program director is required to submit quarterly summaries to the ABS of the applicant's progress. Upon completion of the year, the program director must provide written attestation that the individual has successfully completed all requirements.

Alternative Pathway

The individual may pursue an alternative educational pathway to acquire and demonstrate adequate surgical knowledge, which may be accomplished at a pace determined by the applicant. The initial readmissibility application requires evidence of 100 hours of continuing medical education completed in the past 24 months with 60 hours in Category I, satisfactory completion of SESAP, reference letters and an operative experience report. Upon approval of the application, the applicant must take and pass three secure examinations: one derived from the ABSITE; another derived the two latest versions of SESAP; and the Qualifying Examination. Please refer to *Regaining Admissibility to General Surgery Examinations* at *www.absurgery.org* for complete details.

Upon successful completion of either of the above pathways, the individual will again be admissible to the CE for five opportunities within five years. If the individual is not successful in satisfactorily completing a readmissibility pathway or achieving certification during the readmissibility period, he or she must reenter formal residency training for PGY-4 and PGY-5 level training in a surgery program accredited by the ACGME or RCPSC to regain admissibility to another five-year period.

D. Special Circumstances

1. Persons with Disabilities

The American Board of Surgery complies with the Americans with Disabilities Act by making a reasonable effort to provide modifications in its examination process to applicants with documented disabilities. These modifications are appropriate for such disabilities but do not alter the measurement of skills or knowledge that the examination process is intended to test. The ABS has adopted a specific policy and procedure regarding the examination of such applicants, which is available at *www.absurgery.org*. Any disability that an applicant believes requires modification of the administration of an examination must be identified and documented by the applicant in accordance with this policy. All materials submitted to the ABS documenting the disability must be received no later than the published application deadline for the examination in question.

2. Examination Irregularities and Unethical Behavior

Examination irregularities, i.e., cheating in any form, or other unethical behavior by an applicant or diplomate may result in the barring of the individual from examination on a temporary or permanent basis, the denial or revocation of a certificate, and/or other appropriate actions, up to and including legal prosecution. Determination of sanctions for irregular or unethical behavior will be at the sole discretion of the ABS. *(See also II-F. for the ABS Ethics and Professionalism Policy)*

3. Substance Abuse

Applicants with a history of substance abuse will not be admitted to any examination unless they present evidence satisfactory to the ABS that they have successfully completed the program of treatment prescribed for their condition. The ABS must additionally be satisfied that they are currently free of substance abuse.

IV. ISSUANCE OF CERTIFICATES AND MAINTENANCE OF CERTIFICATION

A candidate who has met all requirements and successfully completed the Qualifying and Certifying Examinations of the ABS will be deemed certified in surgery and issued a certificate by the ABS, signed by its officers, attesting to these qualifications.

It is the current policy of the ABS that all certificates issued on or after January 1, 1976, are valid for a period of 10 years, from the date of issuance through June 30 of the year of expiration. Certificates issued prior to January 1, 1976, are valid indefinitely.

Diplomates who certify or recertify after July 1, 2005, must participate in the ABS Maintenance of Certification (MOC) Program to maintain their certificate. The ABS reserves the right to change the duration of its certificates or the requirements of MOC at any time.

A. Reporting of Status

The ABS considers the personal information and examination record of an applicant or diplomate to be private and confidential. When an inquiry is received regarding an individual's status with the ABS, a general statement is provided indicating the person's current situation as pertains to ABS certification, along with his or her certification history.

The ABS will report an individual's status as either *Certified* or *Not Certified*. In certain cases, one of the following descriptions may also be reported: *In the Examination Process*, *Clinically Inactive*, *Suspended* or *Revoked*. Starting in 2012, the ABS will also report whether a diplomate enrolled in the ABS MOC Program is in compliance with its requirements. Please refer to the *Reporting of Status Policy* on the ABS website for definitions of the above terms.

Individuals may describe themselves as certified by the ABS or as an ABS diplomate only when they hold a **current** ABS certificate. Those whose certificates have expired will be considered "Not Certified." An individual's status may be verified through the ABS website, *www.absurgery.org*.

The ABS supplies biographical and demographic data on diplomates to the ABMS for its *Directory of Certified Medical Specialists*, which is available at *www.abms.org*. Upon certification, diplomates will be contacted by the ABMS and asked to specify which information they would like to appear in the directory. Diplomates will have their listings retained in the directory only if they maintain their certification according to the ABS MOC Program.

B. Maintenance of Certification

Maintenance of Certification is a program of continuous professional development created by the ABS in conjunction with the ABMS and its 23 other member boards. MOC, which replaces the ABS' previous recertification requirements, is intended to document to the public and the health care community the ongoing commitment of diplomates to lifelong learning and quality patient care.

MOC consists of four parts to be fulfilled over the 10-year certification period:

1) *Professional Standing* – a full and unrestricted medical license, hospital privileges and professional references
2) *Lifelong Learning and Self-Assessment* – ongoing continuing medical education and self-assessment activities
3) *Cognitive Expertise* – successful completion of a secure examination at 10-year intervals
4) *Evaluation of Performance in Practice* – ongoing participation in an outcomes database or quality assessment program

Please refer to *www.absurgery.org* for information on current MOC requirements. Once a candidate becomes certified, MOC takes effect the following July 1. MOC requirements run in three-year cycles (July 1–June 30). At the end of each cycle, diplomates report to the ABS by completing an online form about their MOC activities.

The ABS considers MOC to be voluntary in the same manner as original certification. MOC is also offered to diplomates holding ABS certificates in other specialties, with comparable requirements.

Surgeons who pass the secure exam prior to the expiration date of their certificate will receive a new certificate with an expiration date extending from the expiration date of the previous certificate.

To assure receipt of materials pertaining to MOC, diplomates are strongly encouraged to notify the ABS promptly of any changes of address.

C. Sanction of Certificate

Certification by the American Board of Surgery may be subject to sanction such as revocation or suspension at any time that the directors shall determine, in their sole judgment, that the diplomate holding the certification was in some respect not properly qualified to receive it or is no longer properly qualified to retain it.

The directors of the ABS may consider sanction for just and sufficient reason, including, but not limited to, any of the following:

- The diplomate did not possess the necessary qualifications nor meet the requirements to receive certification at the time it was issued; falsified any part of the application or other required documentation; participated in any form of examination irregularities; or made any material misstatement or omission to the ABS, whether or not the ABS knew of such deficiencies at the time.
- The diplomate engaged in the unauthorized disclosure, publication, reproduction or transmission of ABS examination content, or had knowledge of such activity and failed to report it to the ABS.
- The diplomate misrepresented his or her status with regard to board certification, including any misstatement of fact about being board certified in any specialty or subspecialty.
- The diplomate engaged in conduct resulting in a revocation, suspension, qualification or other limitation of his or her license to practice medicine in any jurisdiction and/or failed to inform the ABS of the license restriction.
- The diplomate engaged in conduct resulting in the expulsion, suspension, disqualification or other limitation from membership in a local, regional, national or other organization of his or her professional peers.
- The diplomate engaged in conduct resulting in revocation, suspension or other limitation on his or her privileges to practice surgery in a health care organization.
- The diplomate failed to respond to inquiries from the ABS regarding his or her credentials, or to participate in investigations conducted by the board.
- The diplomate failed to provide an acceptable level of care or demonstrate sufficient competence and technical proficiency in the treatment of patients.
- The diplomate failed to maintain ethical, professional and moral standards acceptable to the ABS.

The holder of a revoked or suspended certificate will be given written notice of the reasons for its sanction by express letter carrier (e.g., FedEx) to the last address that the holder has provided to the ABS. Sanction is final upon mailing of the notification.

Upon revocation of certification, the holder's name shall be removed from the list of certified surgeons and the holder is required to return the certificate to the ABS office.

Individuals may appeal the decision to revoke or suspend a certificate by complying with the ABS *Reconsideration and Appeals Policy*, available from the ABS office or website (*www.absurgery.org*). A request for reconsideration, the first step, must be made in writing to the ABS office within 90 days of receipt of notice from the ABS of the action in question.

Should the circumstances that justified the revocation of certification be corrected, the directors of the ABS at their sole discretion may reinstate the certificate after appropriate review of the individual's licensure and performance using the same standards as applied to applicants for certification, and following fulfillment by the individual of requirements for certification or recertification as previously determined by the ABS.

Requirements for certificate reinstatement will be determined by the ABS on a case-by-case basis in parallel with the type and severity of the original infraction, up to and including complete repetition of the initial certification process. Individuals who have had their certification revoked or suspended and then restored, regardless of their initial certification status or prior dates of certification, will be required to take and pass the next recertification examination to reinstate their certification. Upon passing the examination, they will be awarded a new, time-limited certificate and enrolled in the ABS MOC Program.

D. Certification in Surgical Specialties

The ABS has been authorized by the ABMS to award certification to individuals who have pursued specialized training and meet defined requirements in certain disciplines related to the specialty of surgery. These currently include vascular surgery, pediatric surgery, surgical critical care (SCC), surgery of the hand, hospice and palliative medicine, and complex general surgical oncology.

In general, those seeking specialty certification by the ABS must fulfill the following requirements:

- Be currently certified by the ABS in general surgery *(see next page for exceptions)*.
- Possess a full and unrestricted license to practice medicine in the U.S. or Canada.

- Have completed the required training in the discipline.
- Demonstrate operative experience and/or patient care data acceptable to the ABS.
- Show evidence of dedication to the discipline as specified by the ABS.
- Receive favorable endorsement by the director of the training program in the particular discipline.
- Successfully complete the prescribed examinations.

Individuals interested in certification in these specialties should refer to *www.absurgery.org* for further information.

Primary Certification in Vascular Surgery

A primary certificate in vascular surgery took effect July 1, 2006. Individuals who complete a non-integrated vascular surgery fellowship accredited by the ACGME or RCPSC following general surgery residency are no longer required to obtain certification in general surgery prior to pursuing vascular surgery certification.

Applicants who complete a non-integrated program and wish to pursue certification in both general and vascular surgery must first apply for and successfully complete the General Surgery Qualifying Examination before entering the vascular surgery certification process. Upon passing the QE, applicants may then pursue certification in both disciplines in whichever order they prefer.

Other applicants for vascular surgery certification are required to successfully complete the Surgical Principles Examination (SPE) before being admitted to the vascular surgery certification process. Applicants who are eligible for general surgery certification but elect to take the SPE instead of the QE, permanently forfeit their admissibility to the general surgery certification process.

Options for SCC Certification

Individuals who have completed an ACGME-accredited training program in SCC or anesthesiology critical care after three years of progressive general surgery residency may take the SCC Certifying Examination while still in residency. A full and unrestricted medical license is not required at that time. However, if successful on the examination, they will only be considered certified in SCC once they become certified in surgery following completion of

residency. When entering an SCC training program while in residency, applicants must have a guaranteed categorical residency position in an accredited surgery program available to them upon completion.

Joint Training in Thoracic Surgery

Individuals may pursue a pathway leading to certification in both general surgery and thoracic surgery to be accomplished in a joint training program accredited by the ACGME of four years of general surgery followed by three years of thoracic surgery at the same institution. PGY-4 and PGY-5 are used as transitional years that fulfill the required surgery curriculum and simultaneously begin thoracic surgical training. For further information on this pathway, see *www.absurgery.org*.

V. ABOUT THE ABS

A. Nominating Organizations

The American Board of Surgery is composed of a board of directors elected to single six-year terms from among nominees provided by national and regional surgical societies, known as nominating organizations. In addition, three directors are elected through an at-large process. The ABS also has one public member, elected by open nomination.

Founding Organizations
American College of Surgeons
American Medical Association
American Surgical Association

Regional Surgical Organizations
Central Surgical Association
New England Surgical Society
Pacific Coast Surgical Association
Southeastern Surgical Congress
Southern Surgical Association
Southwestern Surgical Congress
Western Surgical Association

Academic/Research Organizations
Association for Academic Surgery
Society of University Surgeons

Specialty Surgical Organizations
American Association for the Surgery of Trauma
American Pediatric Surgical Association
American Society of Transplant Surgeons
Society of American Gastrointestinal Endoscopic Surgeons
Society for Surgery of the Alimentary Tract
Society of Surgical Oncology
Society for Vascular Surgery

Program Director Associations
Association of Pediatric Surgery Training Program Directors
Association of Program Directors in Surgery
Association of Program Directors in Vascular Surgery
Surgical Critical Care Program Directors Society

Other ABMS Surgical Boards
American Board of Colon and Rectal Surgery
American Board of Plastic Surgery
American Board of Thoracic Surgery

B. Officers and Directors

The officers of the ABS include a chair and vice chair elected by the directors from among themselves. The vice chair is elected for a one-year term and then serves the succeeding year as chair. A third elected officer, the secretary-treasurer, also serves as executive director and is not necessarily chosen from among the directors, although prior experience in some capacity with the ABS as a director, exam consultant or associate examiner is highly desirable.

2011-2012 Officers

Stanley W. Ashley, M.D., *Chair*
Thomas H. Cogbill, M.D., *Vice Chair*
Frank R. Lewis Jr., M.D., *Secretary-Treasurer*

2011-2012 Directors

Stanley W. Ashley, M.D.	Boston, Mass.
Kevin E. Behrns, M.D.	Gainesville, Fla.
L.D. Britt, M.D.	Norfolk, Va.
Jo Buyske, M.D.	Philadelphia, Pa.
Joseph B. Cofer, M.D.	Chattanooga, Tenn.
Thomas H. Cogbill, M.D.	LaCrosse, Wis.
John F. Eidt, M.D.	Little Rock, Ark.
Stephen R.T. Evans, M.D.	Washington, D.C.
B. Mark Evers, M.D.	Lexington, Ky.
John B. Hanks, M.D.	Charlottesville, Va.
Douglas W. Hanto, M.D.	Boston, Mass.
Ronald B. Hirschl, M.D.	Ann Arbor, Mich.
John G. Hunter, M.D.	Portland, Ore.
Lenworth M. Jacobs Jr., M.B.B.S.	Hartford, Conn.
Nathalie M. Johnson, M.D.	Portland, Ore.
Gregory J. Jurkovich, M.D.	Seattle, Wash.
V. Suzanne Klimberg, M.D.	Little Rock, Ark.
Mary E. Klingensmith, M.D.	St. Louis, Mo.
Frank R. Lewis Jr., M.D.	Philadelphia, Pa.
Frederick A. Luchette, M.D.	Maywood, Ill.
David M. Mahvi, M.D.	Chicago, Ill.
Mark A. Malangoni, M.D.	Philadelphia, Pa.
David W. Mercer, M.D.	Omaha, Neb.
J. Wayne Meredith, M.D.	Winston-Salem, N.C.
Fabrizio Michelassi, M.D.	New York, N.Y.
Joseph L. Mills, M.D.	Tucson, Ariz.
Lena M. Napolitano, M.D.	Ann Arbor, Mich.
John R. Potts III, M.D.	Houston, Texas
Robert S. Rhodes, M.D.	Philadelphia, Pa.
William J. Scanlon, Ph.D.*	Oak Hill, Va.
Bruce D. Schirmer, M.D.	Charlottesville, Va.
Anthony J. Senagore, M.D.	Los Angeles, Calif.
Kenneth W. Sharp, M.D.	Nashville, Tenn.
Spence M. Taylor, M.D.	Greenville, S.C.
Richard C. Thirlby, M.D.	Seattle, Wash.
Thomas F. Tracy Jr., M.D.	Providence, R.I.
Douglas S. Tyler, M.D.	Durham, N.C.
R. James Valentine, M.D.	Dallas, Texas
Selwyn M. Vickers, M.D.	Minneapolis, Minn.
J. Patrick Walker, M.D.	Crockett, Texas
Cameron D. Wright, M.D.	Boston, Mass.

* *Public member*

C. Committees, Component Boards and Advisory Councils

Standing Committees and Chairs

Credentials Committee
L.D. Britt, M.D.

General Surgery Residency Committee
John R. Potts III, M.D.
Advanced Surgical Education Committee
David M. Mahvi, M.D.
Diplomates Committee
Richard C. Thirlby, M.D.

Component Boards and Advisory Councils

Vascular Surgery Board

Joseph L. Mills, M.D., *Chair*	Frank R. Lewis Jr., M.D. *(ex officio)*
Michael C. Dalsing, M.D.	Samuel R. Money, M.D.
John F. Eidt, M.D.	Amy B. Reed, M.D.
Vivian Gahtan, M.D.	Robert S. Rhodes, M.D. *(ex officio)*
Karl A. Illig, M.D.	Spence M. Taylor, M.D.
K. Craig Kent, M.D.	R. James Valentine, M.D.

Pediatric Surgery Board

Thomas F. Tracy Jr., M.D., *Chair*	Frank R. Lewis Jr., M.D. *(ex officio)*
Mary E. Fallat, M.D.	David J. Schmeling, M.D.
Henri R. Ford, M.D.	Charles J. H. Stolar, M.D.
Ronald B. Hirschl, M.D.	

Trauma, Burns and Critical Care Board

J. Wayne Meredith, M.D., *Chair*	Frank R. Lewis Jr., M.D. *(ex officio)*
L.D. Britt, M.D.	Pamela A. Lipsett, M.D.
William G. Cioffi Jr., M.D.	Frederick A. Luchette, M.D.
Martin A. Croce, M.D.	Robert C. Mackersie, M.D.
David G. Greenhalgh, M.D.	Lena M. Napolitano, M.D.
Lenworth M. Jacobs Jr., M.B.B.S.	Michael F. Rotondo, M.D.
Gregory J. Jurkovich, M.D.	

Surgical Oncology Board

Fabrizio Michelassi, M.D., *Chair*	Christopher R. McHenry, M.D.
B. Mark Evers, M.D.	Jeffrey F. Moley, M.D.
Jeffrey E. Gershenwald, M.D.	Mitchell C. Posner, M.D.
Nathalie M. Johnson, M.D.	Rache M. Simmons, M.D.
V. Suzanne Klimberg, M.D.	Douglas S. Tyler, M.D.
Frank R. Lewis Jr., M.D. *(ex officio)*	Selwyn M. Vickers, M.D.

Gastrointestinal Surgery Advisory Council

Kenneth W. Sharp, M.D., *Chair*	David W. Mercer, M.D.
Reid B. Adams, M.D.	Bruce D. Schirmer, M.D.
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D. Senior Members, Former Officers and Executive Staff

Senior Members

Frank F. Allbritten Jr., M.D.	1958-1964
K. Alvin Merendino, M.D.	1958-1964
William H. Muller Jr., M.D.	1959-1965
Wiley F. Barker, M.D.	1964-1970
Ben Eiseman, M.D.	1964-1970
John M. Beal, M.D.	1965-1971
William R. Waddell, M.D.	1967-1973
Marshall J. Orloff, M.D.	1969-1972
W. Gerald Austen, M.D.	1969-1974

Isidore Cohn Jr., M.D.	1969-1975
George D. Zuidema, M.D.	1969-1976
William Silen, M.D.	1970-1973
John A. Mannick, M.D.	1971-1977
Frank G. Moody, M.D.	1972-1978
Harry A. Oberhelman, Jr., M.D.	1972-1978
John H. Davis, M.D.	1973-1979
Judson G. Randolph, M.D.	1973-1979
Seymour I. Schwartz, M.D.	1973-1979
Walter Lawrence Jr., M.D.	1974-1978
Marc I. Rowe, M.D.	1974-1978
F. William Blaisdell, M.D.	1974-1980
Larry C. Carey, M.D.	1974-1982
William J. Fry, M.D.	1974-1982
Hiram C. Polk Jr., M.D.	1974-1982
Arlie R. Mansberger Jr., M.D.	1974-1983
Stanley J. Dudrick, M.D.	1974-1984
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Lazar J. Greenfield, M.D.	1976-1982
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Andrew L. Warshaw, M.D.	1985-1993
James A. DeWeese, M.D.	1986-1991
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Arnold G. Diethelm, M.D.	1987-1993
Ira J. Kodner, M.D.	1987-1993
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Wallace P. Ritchie Jr., M.D.	1988-1994
Michael J. Zinner, M.D.	1988-1994
Layton F. Rikkers, M.D.	1988-1995

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Haile T. Debas, M.D.	1990-1996
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David L. Nahrwold, M.D.	1990-1996
Robert B. Rutherford, M.D.	1990-1996
Calvin B. Ernst, M.D.	1991-1997
Josef E. Fischer, M.D.	1991-1998
Palmer Q. Bessey, M.D.	1992-1998
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David M. Heimbach, M.D.	1992-1998
J. David Richardson, M.D.	1992-1999
Robert W. Beart Jr., M.D.	1993-1996
Henry W. Neale, M.D.	1993-1996
Richard H. Dean, M.D.	1993-1999
Glenn D. Steele Jr., M.D.	1993-2000
Laurence Y. Cheung, M.D.	1994-2000
Daniel L. Diamond, M.D.	1994-2000
Anthony A. Meyer, M.D.	1994-2000
Richard A. Prinz, M.D.	1994-2000
Ronald G. Tompkins, M.D.	1994-2000
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David Fromm, M.D.	1995-2001
David E. Hutchison, M.D.	1995-2001
Frank R. Lewis Jr., M.D.	1995-2001
Peter C. Pairolero, M.D.	1995-2001
William L. Russell, M.D.	1995-2001
Robert W. Barnes, M.D.	1996-2002
Robert D. Fry, M.D.	1996-2002
Donald J. Kaminski, M.D.	1996-2002
Mark A. Malangoni, M.D.	1996-2003
Ronald V. Maier, M.D.	1996-2004
G. Patrick Clagett, M.D.	1997-2003
Thomas M. Krummel, M.D.	1997-2003
Bradley M. Rodgers, M.D.	1997-2003
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Julie A. Freischlag, M.D.	1998-2004
Frank W. LoGerfo, M.D.	1998-2004
Bruce E. Stabile, M.D.	1998-2004
Barbara L. Bass, M.D.	1998-2005
Jeffrey L. Ponsky, M.D.	1998-2006
Richard L. Gamelli, M.D.	1999-2005
Marshall M. Urist, M.D.	1999-2005
William G. Cioffi, M.D.	2000-2006
Keith E. Georgeson, M.D.	2000-2006
James C. Hebert, M.D.	2000-2006
Keith D. Lillemoe, M.D.	2000-2006
Michael S. Nussbaum, M.D.	2000-2006
Courtney M. Townsend Jr., M.D.	2000-2007
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Luis O. Vasconez, M.D.	2001-2003
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Michael G. Sarr, M.D.	2001-2007
Theodore N. Pappas, M.D.	2001-2007
Jon S. Thompson, M.D.	2001-2007
Richard H. Bell Jr., M.D.	2002-2006
James W. Fleshman Jr., M.D.	2002-2008
Russell G. Postier, M.D.	2002-2009
Steven C. Stain, M.D.	2002-2010
Thomas Stevenson, M.D.	2003-2004
Jonathan B. Towne, M.D.	2003-2007
Carlos A. Pellegrini, M.D.	2003-2009
James A. Schulak, M.D.	2003-2009
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Fordyce B. St. John, M.D.*	1947-1949
Warfield M. Firor, M.D.*	1949-1951
Warren H. Cole, M.D.*	1951-1953
Thomas H. Lanman, M.D.*	1953-1955
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William P. Longmire Jr., M.D.*	1961-1962
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Jay L. Grosfeld, M.D.	1996-1997
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J. David Richardson, M.D.	1998-1999
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Mark A. Malangoni, M.D.	2002-2003
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John H. Mulholland, M.D.*	1953-1955
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G. Rainey Williams, M.D.*	1979-1981
Arlie R. Mansberger Jr., M.D.	1981-1983
Alexander J. Walt, M.D.*	1983-1985
Donald D. Trunkey, M.D.	1985-1987
Samuel A. Wells Jr., M.D.	1987-1988
George F. Sheldon, M.D.	1988-1989
Edward M. Copeland III, M.D.	1989-1990
C. James Carrico, M.D.*	1990-1991
Andrew L. Warshaw, M.D.	1991-1992
Jerry M. Shuck, M.D.	1992-1993
Layton F. Rikkers, M.D.	1993-1994
David L. Nahrwold, M.D.	1994-1995
Jay L. Grosfeld, M.D.	1995-1996
Josef E. Fischer, M.D.	1996-1997
J. David Richardson, M.D.	1997-1998
Glenn D. Steele Jr., M.D.	1998-1999
Frank R. Lewis Jr., M.D.	1999-2000
Patricia J. Numann, M.D.	2000-2001
Mark A. Malangoni, M.D.	2001-2002
Ronald V. Maier, M.D.	2002-2003
Barbara L. Bass, M.D.	2003-2004
Jeffrey L. Ponsky, M.D.	2004-2005
Courtney M. Townsend Jr., M.D.	2005-2006
Timothy C. Flynn, M.D.	2006-2007
Russell G. Postier, M.D.	2007-2008
Steven C. Stain, M.D.	2008-2009
E. Christopher Ellison, M.D.	2009-2010
Stanley W. Ashley, M.D.	2010-2011

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Robert M. Moore, M.D.*	1963-1971
Francis A. Sutherland, M.D. (Associate)*	1965-1973
J.W. Humphreys Jr., M.D.*	1971-1984
Ward O. Griffen Jr., M.D.	1984-1994
Wallace P. Ritchie Jr., M.D.	1994-2002

* *Deceased*

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Associate Executive Director – Jo Buyske, M.D.

Associate Executive Director – Mark A. Malangoni, M.D.

Associate Executive Director for Vascular Surgery – Robert S. Rhodes, M.D.

General Counsel – Gabriel L.I. Bevilacqua, Esq.

Director of Psychometrics and Data Analysis – Thomas W. Biester

Operations Manager – Jessica A. Schreader

Information Technology Manager – James F. Fiore

Communications Manager – Christine D. Shiffer

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Exhibit 4

ACGME Program Requirements for Graduate Medical Education in General Surgery

ACGME Program Requirements for Graduate Medical Education in General Surgery

Common Program Requirements are in BOLD

Effective: January 1, 2008

Introduction

Int.A. **Residency is an essential dimension of the transformation of the medical student to the independent practitioner along the continuum of medical education. It is physically, emotionally, and intellectually demanding, and requires longitudinally-concentrated effort on the part of the resident.**

The specialty education of physicians to practice independently is experiential, and necessarily occurs within the context of the health care delivery system. Developing the skills, knowledge, and attitudes leading to proficiency in all the domains of clinical competency requires the resident physician to assume personal responsibility for the care of individual patients. For the resident, the essential learning activity is interaction with patients under the guidance and supervision of faculty members who give value, context, and meaning to those interactions. As residents gain experience and demonstrate growth in their ability to care for patients, they assume roles that permit them to exercise those skills with greater independence. This concept—graded and progressive responsibility—is one of the core tenets of American graduate medical education. Supervision in the setting of graduate medical education has the goals of assuring the provision of safe and effective care to the individual patient; assuring each resident's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishing a foundation for continued professional growth.

Int.B. Definition and Scope of the Specialty

The goal of a surgical residency program is to prepare the resident to function as a qualified practitioner of surgery at the advanced level of performance expected of a board-certified specialist. The education of surgeons in the practice of general surgery encompasses both didactic instruction in the basic and clinical sciences of surgical diseases and conditions, as well as education in procedural skills and operative techniques. The educational process must lead to the acquisition of an appropriate fund of knowledge and technical skills, the ability to integrate the acquired knowledge into the clinical situation, and the development of surgical judgment.

Int.C. Duration and Scope of Education

The length of a surgery residency program is five clinical years. Each resident must be notified in writing of the length of the program prior to admission. Programs must comply with the resident eligibility and admission prerequisites as outlined in the Institutional Requirements.

I. Institutions

I.A. Sponsoring Institution

One sponsoring institution must assume ultimate responsibility for the program, as described in the Institutional Requirements, and this responsibility extends to resident assignments at all participating sites.

The sponsoring institution and the program must ensure that the program director has sufficient protected time and financial support for his or her educational and administrative responsibilities to the program.

I.A.1. An accredited surgery program must be conducted in an institution that can document a sufficient breadth of patient care. At a minimum, the institution must routinely care for patients with a broad spectrum of surgical diseases and conditions, including all of the essential content areas in surgical education. In addition, these institutions must include facilities and staff for a variety of other services that provide a critical role in the care of patients with surgical conditions, including radiology and pathology.

I.A.2. The program director must be provided with a minimum of 30% protected time, which may take the form of direct or indirect salary support, such as release from clinical activities provided by the institution.

I.B. Participating Sites

I.B.1. There must be a program letter of agreement (PLA) between the program and each participating site providing a required assignment. The PLA must be renewed at least every five years.

The PLA should:

I.B.1.a) identify the faculty who will assume both educational and supervisory responsibilities for residents;

I.B.1.b) specify their responsibilities for teaching, supervision, and formal evaluation of residents, as specified later in this document;

I.B.1.c) specify the duration and content of the educational experience; and,

I.B.1.d) state the policies and procedures that will govern resident education during the assignment.

I.B.2. The program director must submit any additions or deletions of participating sites routinely providing an educational experience, required for all residents, of one month full time equivalent (FTE) or more through the Accreditation Council for Graduate Medical Education (ACGME) Accreditation Data System (ADS).

I.B.3. Integrated and Non-Integrated Sites

An integrated or non-integrated site is defined as any site to which residents rotate for an assigned experience. There are two types of institutional relationships: integrated and non-integrated.

I.B.3.a) An integrated site contributes substantially to the educational activities of the residency program.

I.B.3.a).(1) The program director must appoint the members of the teaching staff and the local program director at an integrated site.

I.B.3.a).(2) The faculty at an integrated site must demonstrate a commitment to scholarly pursuits.

I.B.3.a).(3) Clinical experiences in the essential content areas should be obtained in integrated sites. Exceptions will be considered on a case-by-case basis.

I.B.3.a).(4) An integrated site should be in geographic proximity to allow all residents to attend core conferences. If the integrated site is geographically remote and joint conferences cannot be held, an equivalent educational program of lectures and conferences in the integrated site must occur and must be fully documented. Morbidity and mortality reviews must occur at each integrated site or at a combined central location.

I.B.3.a).(5) Integration will not be approved between two sites if both have an accredited residency program in the same specialty.

I.B.3.a).(6) Chief residents may be assigned only to participating integrated sites or to the primary clinical site/sponsoring institution.

I.B.3.b) A participating non-integrated site should supplement resident education by providing focused clinical experience not available at the primary clinical site or at the integrated site.

I.B.3.b).(1) Assignment to participating non-integrated sites must have a clear educational rationale.

I.B.3.b).(2) Advance approval of the Review Committee is required for resident assignment of six months or more at a participating non-integrated site.

I.B.3.b).(3) Advance approval of the Review Committee is not required for resident assignment of less than six months, but the

educational rationale for such assignments will be evaluated at the time of each site-visit and accreditation review.

II. Program Personnel and Resources

II.A. Program Director

II.A.1. There must be a single program director with authority and accountability for the operation of the program. The sponsoring institution's GMEC must approve a change in program director. After approval, the program director must submit this change to the ACGME via the ADS.

II.A.2. The program director should continue in his or her position for a length of time adequate to maintain continuity of leadership and program stability.

II.A.2.a) The program director's initial appointment should be for at least six years.

II.A.3. Qualifications of the program director must include:

II.A.3.a) requisite specialty expertise and documented educational and administrative experience acceptable to the Review Committee;

II.A.3.b) current certification in the specialty by the American Board of Surgery**, or specialty qualifications that are acceptable to the Review Committee;**

II.A.3.c) current medical licensure and appropriate medical staff appointment;

II.A.3.d) unrestricted credentials at the primary clinical site/sponsoring institution, and license to practice medicine in the state where the sponsoring institution is located; and,

II.A.3.e) scholarly activity in at least one of the areas of scholarly activity delineated in Section II.B.5 of this document.

II.A.4. The program director must administer and maintain an educational environment conducive to educating the residents in each of the ACGME competency areas. The program director must:

II.A.4.a) oversee and ensure the quality of didactic and clinical education in all sites that participate in the program;

II.A.4.b) approve a local director at each participating site who is accountable for resident education;

II.A.4.c) approve the selection of program faculty as appropriate;

II.A.4.d) evaluate program faculty and approve the continued participation of program faculty based on evaluation;

II.A.4.e) monitor resident supervision at all participating sites;

II.A.4.f) prepare and submit all information required and requested by the ACGME, including but not limited to the program information forms and annual program resident updates to the ADS, and ensure that the information submitted is accurate and complete;

II.A.4.g) provide each resident with documented semiannual evaluation of performance with feedback;

II.A.4.h) ensure compliance with grievance and due process procedures as set forth in the Institutional Requirements and implemented by the sponsoring institution;

II.A.4.i) provide verification of residency education for all residents, including those who leave the program prior to completion;

II.A.4.j) implement policies and procedures consistent with the institutional and program requirements for resident duty hours and the working environment, including moonlighting, and, to that end, must:

II.A.4.j).(1) distribute these policies and procedures to the residents and faculty;

II.A.4.j).(2) monitor resident duty hours, according to sponsoring institutional policies, with a frequency sufficient to ensure compliance with ACGME requirements;

II.A.4.j).(3) adjust schedules as necessary to mitigate excessive service demands and/or fatigue; and,

II.A.4.j).(4) if applicable, monitor the demands of at-home call and adjust schedules as necessary to mitigate excessive service demands and/or fatigue.

II.A.4.k) monitor the need for and ensure the provision of back up support systems when patient care responsibilities are unusually difficult or prolonged;

II.A.4.l) comply with the sponsoring institution’s written policies and procedures, including those specified in the Institutional Requirements, for selection, evaluation and promotion of residents, disciplinary action, and supervision of residents;

II.A.4.m) **be familiar with and comply with ACGME and Review Committee policies and procedures as outlined in the ACGME Manual of Policies and Procedures;**

II.A.4.n) **obtain review and approval of the sponsoring institution's GMEC/DIO before submitting to the ACGME information or requests for the following:**

II.A.4.n).(1) **all applications for ACGME accreditation of new programs;**

II.A.4.n).(2) **changes in resident complement;**

II.A.4.n).(3) **major changes in program structure or length of training;**

II.A.4.n).(4) **progress reports requested by the Review Committee;**

II.A.4.n).(5) **responses to all proposed adverse actions;**

II.A.4.n).(6) **requests for increases or any change to resident duty hours;**

II.A.4.n).(7) **voluntary withdrawals of ACGME-accredited programs;**

II.A.4.n).(8) **requests for appeal of an adverse action;**

II.A.4.n).(9) **appeal presentations to a Board of Appeal or the ACGME; and,**

II.A.4.n).(10) **proposals to ACGME for approval of innovative educational approaches.**

II.A.4.o) **obtain DIO review and co-signature on all program information forms, as well as any correspondence or document submitted to the ACGME that addresses:**

II.A.4.o).(1) **program citations, and/or**

II.A.4.o).(2) **request for changes in the program that would have significant impact, including financial, on the program or institution.**

II.A.4.p) devote his or her principal effort to the program.

II.A.4.q) designate other well-qualified surgeons to assist in the supervision and education of the residents;

II.A.4.r) be responsible for all clinical assignments and input into the teaching staff appointments at all sites;

II.A.4.s) along with the faculty, be responsible for the preparation and implementation of a comprehensive, effective, and well-organized educational curriculum;

II.A.4.t) ensure that conferences should be scheduled to permit resident attendance on a regular basis, and resident time must be protected from interruption by routine clinical duties. Documentation of attendance by 75% of residents at the core conferences must be achieved;

II.A.4.u) ensure that the following types of conferences must exist within a program:

II.A.4.u).(1) a course or a structured series of lectures that ensures education in the basic and clinical sciences fundamental to surgery, including technological advances that relate to surgery and the care of patients with surgical diseases, as well as education in critical thinking, design of experiments and evaluation of data;

II.A.4.u).(2) regular organized clinical teaching, such as grand rounds, ward rounds, and clinical conferences;

II.A.4.u).(3) a weekly morbidity and mortality or quality improvement conference.

II.A.4.u).(3).(a) Sole reliance on textbook review is inadequate;

II.A.4.v) along with the physician faculty, assess the technical competence of each resident. The Review Committee requires that each resident perform a minimum number of certain cases for accreditation. Performance of this minimum number of cases by a resident must not be interpreted as an equivalent to competence achievement;

II.A.4.w) ensure that each resident has at least 750 major cases across the five years of training. This must include a minimum of 150 major cases in the resident's chief year;

II.A.4.x) ensure that residents have required experience with a variety of endoscopic procedures, including esophogastro-duodenoscopy, colonoscopy and bronchoscopy as well as experience in advanced laparoscopy; and,

II.A.4.y) ensure that residents have required experience with evolving diagnostic and therapeutic methods.

II.B. Faculty

II.B.1. At each participating institution, there must be a sufficient number

of faculty with documented qualifications to instruct and supervise all residents at that location.

The faculty must:

II.B.1.a) **devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities; and to demonstrate a strong interest in the education of residents, and**

II.B.1.b) **administer and maintain an educational environment conducive to educating residents in each of the ACGME competency areas.**

II.B.1.c) for each approved chief resident position, consist of at least one full-time faculty member in addition to the program director (i.e., if there are three approved chief residents, there must be at least four fulltime faculty). The major function of these faculty is to support the program. These faculty must be appointed for a period sufficient to ensure continuity in the educational activities of the residency program and, (N.B.: moved from III. A. 4f); and,

II.B.1.d) appoint an associate program director for programs with more than 20 categorical residents.

II.B.2. **The physician faculty must have current certification in the specialty by the American Board of** Surgery**, or possess qualifications acceptable to the Review Committee.**

II.B.3. **The physician faculty must possess current medical licensure and appropriate medical staff appointment.**

II.B.4. **The nonphysician faculty must have appropriate qualifications in their field and hold appropriate institutional appointments.**

II.B.5. **The faculty must establish and maintain an environment of inquiry and scholarship with an active research component.**

II.B.5.a) **The faculty must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences.**

II.B.5.b) **Some members of the faculty should also demonstrate scholarship by one or more of the following:**

II.B.5.b).(1) **peer-reviewed funding;**

II.B.5.b).(2) **publication of original research or review articles in peer-reviewed journals, or chapters in textbooks;**

II.B.5.b).(3) **publication or presentation of case reports or clinical series at local, regional, or national professional and**

scientific society meetings; or,

II.B.5.b).(4) **participation in national committees or educational organizations.**

II.B.5.c) **Faculty should encourage and support residents in scholarly activities.**

II.B.5.d) The faculty must collectively document active involvement in scholarly activity.

II.B.5.e) While not all members of the faculty can be investigators, clinical and/or basic science research must be:

II.B.5.e).(1) ongoing in the residency program;

II.B.5.e).(2) based at the institution where residents spend the majority of their clinical time; and,

II.B.5.e).(3) performed by faculty with frequent, direct resident involvement.

II.B.5.f) Resident research is not a substitute for the involvement of the program director and faculty in research.

II.C. Other Program Personnel

The institution and the program must jointly ensure the availability of all necessary professional, technical, and clerical personnel for the effective administration of the program.

II.D. Resources

The institution and the program must jointly ensure the availability of adequate resources for resident education, as defined in the specialty program requirements.

II.D.1. These resources must include:

II.D.1.a) a common office space for residents that includes a sufficient number of computers and adequate workspace at the primary clinical site;

II.D.1.b) internet access to appropriate full-text journals and electronic medical reference resources for education and patient care at all participating sites;

II.D.1.c) on-line radiographic and laboratory reporting systems at the primary clinical site and integrated sites; and

II.D.1.d) software resources for production of presentations, manuscripts,

and portfolios.

II.D.2. Resources must include simulation and skills laboratories. These facilities must address acquisition and maintenance of skills with a competency-based method of evaluation.

II.D.3. There must be a full-time surgery program coordinator designated specifically for surgical education. Programs with more than 20 categorical residents should be provided with additional administrative personnel.

II.D.4. The institutional volume and variety of operative experience must be adequate to ensure a sufficient number and distribution of complex cases (as determined by the Review Committee) for each resident in the program.

II.E. Medical Information Access

Residents must have ready access to specialty-specific and other appropriate reference material in print or electronic format. Electronic medical literature databases with search capabilities should be available.

III. Resident Appointments

III.A. Eligibility Criteria

The program director must comply with the criteria for resident eligibility as specified in the Institutional Requirements.

III.B. Number of Residents

The program director may not appoint more residents than approved by the Review Committee, unless otherwise stated in the specialty-specific requirements. The program's educational resources must be adequate to support the number of residents appointed to the program.

All resident positions must be approved in advance by the Review Committee.

III.B.1. Residency positions must be allocated to one of two groups: categorical or preliminary positions.

III.B.1.a) Categorical (C) residents are accepted into the residency program with the expectation of completing the surgery program, assuming satisfactory performance. At the PG1, PG2, PG3, and PG4 levels, the number of categorical residents must not exceed the number of approved chief residency positions.

III.B.1.b) Preliminary (P) residents are accepted into the program for one or two years before continuing their education.

III.B.1.b).(1) The number of preliminary positions in the PG1 and PG2

years combined must not exceed 300% of the number of approved categorical chief resident positions.

III.B.1.b).(2) Documentation of continuation in graduate medical education for the P residents must be provided at the time of each site visit.

III.B.1.b).(3) It is the responsibility of the program director to counsel and assist preliminary residents in obtaining future positions.

III.B.2. Increases in resident complement:

III.B.2.a) Both temporary and permanent increases in resident complement must be approved in advance by the Review Committee.

III.B.2.b) A sound educational rationale for an increase in complement must be submitted. Documentation of adequate clinical material and complex operative cases, as well as documentation of a quality didactic education, must also be submitted. A clearly outlined block diagram must accompany the request to illustrate the proposed clinical assignments.

III.C. Resident Transfers

III.C.1. Before accepting a resident who is transferring from another program, the program director must obtain written or electronic verification of previous educational experiences and a summative competency-based performance evaluation of the transferring resident.

III.C.1.a) The final two years of residency education (i.e., the PG 4 and PG 5 [chief] years) must be spent in the same program.

III.C.2. A program director must provide timely verification of residency education and summative performance evaluations for residents who leave the program prior to completion.

III.D. Appointment of Fellows and Other Learners

The presence of other learners (including, but not limited to, residents from other specialties, subspecialty fellows, PhD students, and nurse practitioners) in the program must not interfere with the appointed residents' education. The program director must report the presence of other learners to the DIO and GMEC in accordance with sponsoring institution guidelines.

III.D.1. All trainees in both ACGME-accredited and non-accredited programs in the sponsoring and integrated sites that may impact the educational experience of the surgery residents must be identified and their relationship to the surgery residents must be detailed.

III.D.2. A chief resident and a fellow (whether the fellow is in an ACGME-accredited position or not) must not have primary responsibility for the same patient except that general surgeon and surgical critical care fellows may co-manage the non-operative care of the same patient.

IV. Educational Program

IV.A. The curriculum must contain the following educational components:

IV.A.1. Overall educational goals for the program, which the program must distribute to residents and faculty annually;

IV.A.2. Competency-based goals and objectives for each assignment at each educational level, which the program must distribute to residents and faculty annually, in either written or electronic form. These should be reviewed by the resident at the start of each rotation;

IV.A.3. Regularly scheduled didactic sessions;

IV.A.4. Delineation of resident responsibilities for patient care, progressive responsibility for patient management, and supervision of residents over the continuum of the program; and,

IV.A.5. ACGME Competencies

The program must integrate the following ACGME competencies into the curriculum:

IV.A.5.a) Patient Care

Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Residents:

IV.A.5.a).(1) will demonstrate manual dexterity appropriate for their level;

IV.A.5.a).(2) will develop and execute patient care plans appropriate for the resident's level, including management of pain;

IV.A.5.a).(3) will participate in a program that must document a clinical curriculum that is sequential, comprehensive, and organized from basic to complex. The clinical assignments should be carefully structured to ensure that graded levels of responsibility, continuity in patient care, a balance between education and service, and progressive clinical experiences are achieved for each resident;

The 60-month clinical program should be organized as

follows:

IV.A.5.a).(3).(a) At least 54 months of the 60-month program must be spent on clinical assignments in surgery, with documented experience in emergency care and surgical critical care in order to enable residents to manage patients with severe and complex illnesses and with major injuries;

IV.A.5.a).(3).(b) 42 months of these 54 months must be spent on clinical assignments in the essential content areas of surgery. The essential content areas are: the abdomen and its contents; the alimentary tract; skin, soft tissues, and breast; endocrine surgery; head and neck surgery; pediatric surgery; surgical critical care; surgical oncology; trauma and non-operative trauma (burn experience that includes patient management may be counted toward non-operative trauma); and the vascular system;

IV.A.5.a).(3).(c) A formal rotation in burn care, gynecology, neurological surgery, orthopaedic surgery, cardiac surgery, and urology is not required. Clearly documented goals and objectives must be presented if these components are included as rotations;

IV.A.5.a).(3).(c).(i) Knowledge of burn physiology and initial burn management is required;

IV.A.5.a).(3).(d) A formal transplant experience is required. It must include patient management and cover knowledge of the principles of immunology, immunosuppression, and the management of general surgical conditions arising in transplant patients. Clearly documented goals and objectives must be presented for this experience;

IV.A.5.a).(3).(e) No more than six months total may be allocated to research or to non- surgical disciplines such as anesthesiology, internal medicine, pediatrics, or surgical pathology. (Gastroenterology is exempt from this limit if this rotation provides endoscopic experiences.)

No more than 12 months may be devoted to surgical discipline other than the principal components of surgery;

IV.A.5.a).(3).(f) The Chief Year

IV.A.5.a).(3).(f).(i)	Clinical assignments at the chief resident level should be scheduled in the final (5th) year of the program;
IV.A.5.a).(3).(f).(ii)	To take advantage of a unique educational opportunity in a program, up to 6 months of the chief year may be served in the next to the last year (4th). This experience must not occur any earlier than the 4th clinical year. Any special Program of this type must be approved in advance by the Review Committee. Operative cases counted as the chief cases must be performed during the 12 months designated as the chief year;
IV.A.5.a).(3).(f).(iii)	The clinical assignments during the chief year must be scheduled at the primary clinical site or at participating integrated site(s);
IV.A.5.a).(3).(f).(iv)	Clinical assignments during the chief year must be in the essential content areas of general surgery. No more than six months of the chief year may be devoted exclusively to only one essential content area;
IV.A.5.a).(3).(f).(v)	Noncardiac thoracic surgery and transplantation rotations may be considered an acceptable chief resident assignment as long as the chief resident performs an appropriate number of complex cases with documented participation in pre and post-operative care (program director may use the flexibility outlined in IV.A.5.a.3.d.ii.);
IV.A.5.a).(3).(g)	Operative Experience
IV.A.5.a).(3).(g).(i)	The program must document that residents are performing a sufficient breadth of complex procedures to graduate qualified surgeons;
IV.A.5.a).(3).(g).(ii)	All residents (categorical and preliminary residents in ACGME-accredited positions) must enter their operative experience concurrently during each year of the residency in the ACGME case log system;
IV.A.5.a).(3).(g).(iii)	A resident may be considered the surgeon only when he or she can document a significant role in the following aspects of

management: determination or confirmation of the diagnosis, provision of preoperative care, selection, and accomplishment of the appropriate operative procedure, and direction of the postoperative care;

IV.A.5.a).(3).(g).(iv) When justified by experience, a PG 5 (chief) resident may act as a teaching assistant (TA) to a more junior resident with appropriate faculty supervision. Up to 50 cases listed by the chief resident as TA will be credited for the total requirement of 750 cases. TA cases may not count towards the 150 minimum cases needed to fulfill the operative requirements for the chief resident year. The junior resident performing the case will also be credited as surgeon for these cases; and,

IV.A.5.a).(3).(g).(v) Each program is required to provide residents with an outpatient experience to evaluate patients both pre-operatively, including initial evaluation, and post-operatively. At least 75% of the assignments in the essential content areas must include an outpatient experience of 1/2 day per week. (An outpatient experience is not required for assignments in the secondary components of surgery or surgical critical care).

IV.A.5.b) Medical Knowledge

Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care. Residents:

IV.A.5.b).(1) will critically evaluate and demonstrate knowledge of pertinent scientific information and,

IV.A.5.b).(2) will participate in an educational program that should include the fundamentals of basic science as applied to clinical surgery, including: applied surgical anatomy and surgical pathology; the elements of wound healing; homeostasis, shock and circulatory physiology; hematologic disorders; immunobiology and transplantation; oncology; surgical endocrinology; surgical nutrition, fluid and electrolyte balance; and the metabolic response to injury, including burns.

IV.A.5.c) **Practice-based Learning and Improvement**

Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning. Residents are expected to develop skills and habits to be able to meet the following goals:

IV.A.5.c).(1) **identify strengths, deficiencies, and limits in one's knowledge and expertise;**

IV.A.5.c).(2) **set learning and improvement goals;**

IV.A.5.c).(3) **identify and perform appropriate learning activities;**

IV.A.5.c).(4) **systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement;**

IV.A.5.c).(5) **incorporate formative evaluation feedback into daily practice;**

IV.A.5.c).(6) **locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems;**

IV.A.5.c).(7) **use information technology to optimize learning;**

IV.A.5.c).(8) **participate in the education of patients, families, students, residents and other health professionals;**

IV.A.5.c).(9) participate in mortality and morbidity conferences that evaluate and analyze patient care outcomes; and,

IV.A.5.c).(10) utilize an evidence-based approach to patient care.

IV.A.5.d) **Interpersonal and Communication Skills**

Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. Residents are expected to:

IV.A.5.d).(1) **communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds;**

IV.A.5.d).(2) **communicate effectively with physicians, other health professionals, and health related agencies;**

IV.A.5.d).(3) **work effectively as a member or leader of a health care team or other professional group;**

IV.A.5.d).(4) **act in a consultative role to other physicians and health professionals;**

IV.A.5.d).(5) **maintain comprehensive, timely, and legible medical records, if applicable;**

IV.A.5.d).(6) counsel and educate patients and families; and,

IV.A.5.d).(7) effectively document practice activities.

IV.A.5.e) **Professionalism**

Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. Residents are expected to demonstrate:

IV.A.5.e).(1) **compassion, integrity, and respect for others;**

IV.A.5.e).(2) **responsiveness to patient needs that supersedes self-interest;**

IV.A.5.e).(3) **respect for patient privacy and autonomy;**

IV.A.5.e).(4) **accountability to patients, society and the profession;**

IV.A.5.e).(5) **sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation;**

IV.A.5.e).(6) high standards of ethical behavior; and,

IV.A.5.e).(7) a commitment to continuity of patient care.

IV.A.5.f) **Systems-based Practice**

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care. Residents are expected to:

IV.A.5.f).(1) **work effectively in various health care delivery settings and systems relevant to their clinical specialty;**

IV.A.5.f).(2) **coordinate patient care within the health care system relevant to their clinical specialty;**

IV.A.5.f).(3) **incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate;**

IV.A.5.f).(4) **advocate for quality patient care and optimal patient care systems;**

IV.A.5.f).(5) **work in interprofessional teams to enhance patient safety and improve patient care quality;**

IV.A.5.f).(6) **participate in identifying system errors and implementing potential systems solutions;**

IV.A.5.f).(7) practice high quality, cost effective patient care;

IV.A.5.f).(8) demonstrate knowledge of risk-benefit analysis; and,

IV.A.5.f).(9) demonstrate an understanding of the role of different specialists and other health care professionals in overall patient management.

IV.B. Residents' Scholarly Activities

IV.B.1. The curriculum must advance residents' knowledge of the basic principles of research, including how research is conducted, evaluated, explained to patients, and applied to patient care.

IV.B.2. Residents should participate in scholarly activity.

IV.B.2.a) The participation of residents in clinical and/or laboratory research is encouraged.

IV.B.3. The sponsoring institution and program should allocate adequate educational resources to facilitate resident involvement in scholarly activities.

V. Evaluation

V.A. Resident Evaluation

V.A.1. Formative Evaluation

V.A.1.a) The faculty must evaluate resident performance in a timely manner during each rotation or similar educational assignment, and document this evaluation at completion of the assignment.

V.A.1.b) The program must:

V.A.1.b).(1) provide objective assessments of competence in

patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice;

V.A.1.b).(2) **use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff);**

V.A.1.b).(3) **document progressive resident performance improvement appropriate to educational level; and,**

V.A.1.b).(4) **provide each resident with documented semiannual evaluation of performance with feedback.**

V.A.1.c) **The evaluations of resident performance must be accessible for review by the resident, in accordance with institutional policy.**

V.A.1.d) Biannual assessment must include a review of case volume, breadth, and complexity, and must ensure that residents are entering cases concurrently.

V.A.1.e) Assessment should specifically monitor the resident's knowledge by use of a formal exam such as the American Board of Surgery In Training Examination (ABSITE) or other cognitive exams. Test results should not be the sole criterion of resident knowledge, and should not be used as the sole criterion for promotion to a subsequent PG level.

V.A.2. **Summative Evaluation**

The program director must provide a summative evaluation for each resident upon completion of the program. This evaluation must become part of the resident's permanent record maintained by the institution, and must be accessible for review by the resident in accordance with institutional policy. This evaluation must:

V.A.2.a) **document the resident's performance during the final period of education, and**

V.A.2.b) **verify that the resident has demonstrated sufficient competence to enter practice without direct supervision.**

V.B. **Faculty Evaluation**

V.B.1. **At least annually, the program must evaluate faculty performance as it relates to the educational program.**

V.B.2. **These evaluations should include a review of the faculty's clinical teaching abilities, commitment to the educational program, clinical knowledge, professionalism, and scholarly activities.**

V.B.3. **This evaluation must include at least annual written confidential evaluations by the residents.**

V.C. Program Evaluation and Improvement

V.C.1. **The program must document formal, systematic evaluation of the curriculum at least annually. The program must monitor and track each of the following areas:**

V.C.1.a) **resident performance;**

V.C.1.b) **faculty development;**

V.C.1.c) **graduate performance, including performance of program graduates on the certification examination; and,**

V.C.1.d) **program quality. Specifically:**

V.C.1.d).(1) **Residents and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually, and**

V.C.1.d).(2) **The program must use the results of residents' assessments of the program together with other program evaluation results to improve the program.**

V.C.2. **If deficiencies are found, the program should prepare a written plan of action to document initiatives to improve performance in the areas listed in section V.C.1. The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes.**

V.C.3. The performance of program graduates on the certification examination should be used as one measure of evaluating program effectiveness. At minimum, for the most recent five-year period, 65% of the graduates must pass each of the qualifying and certifying examinations on the first attempt.

VI. Resident Duty Hours in the Learning and Working Environment

VI.A. Professionalism, Personal Responsibility, and Patient Safety

VI.A.1. **Programs and sponsoring institutions must educate residents and faculty members concerning the professional responsibilities of physicians to appear for duty appropriately rested and fit to provide the services required by their patients.**

VI.A.2. **The program must be committed to and responsible for promoting patient safety and resident well-being in a supportive educational environment.**

VI.A.3. **The program director must ensure that residents are integrated and actively participate in interdisciplinary clinical quality improvement and patient safety programs.**

VI.A.4. **The learning objectives of the program must:**

VI.A.4.a) **be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events; and,**

VI.A.4.b) **not be compromised by excessive reliance on residents to fulfill non-physician service obligations.**

VI.A.5. **The program director and institution must ensure a culture of professionalism that supports patient safety and personal responsibility. Residents and faculty members must demonstrate an understanding and acceptance of their personal role in the following:**

VI.A.5.a) **assurance of the safety and welfare of patients entrusted to their care;**

VI.A.5.b) **provision of patient- and family-centered care;**

VI.A.5.c) **assurance of their fitness for duty;**

VI.A.5.d) **management of their time before, during, and after clinical assignments;**

VI.A.5.e) **recognition of impairment, including illness and fatigue, in themselves and in their peers;**

VI.A.5.f) **attention to lifelong learning;**

VI.A.5.g) **the monitoring of their patient care performance improvement indicators; and,**

VI.A.5.h) **honest and accurate reporting of duty hours, patient outcomes, and clinical experience data.**

VI.A.6. **All residents and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. Physicians must recognize that under certain circumstances, the best interests of the patient may be served by transitioning that patient's care to another qualified and rested provider.**

VI.B. **Transitions of Care**

VI.B.1. **Programs must design clinical assignments to minimize the number of transitions in patient care.**

VI.B.2. **Sponsoring institutions and programs must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety.**

VI.B.3. **Programs must ensure that residents are competent in communicating with team members in the hand-over process.**

VI.B.4. **The sponsoring institution must ensure the availability of schedules that inform all members of the health care team of attending physicians and residents currently responsible for each patient's care.**

VI.C. Alertness Management/Fatigue Mitigation

VI.C.1. **The program must:**

VI.C.1.a) **educate all faculty members and residents to recognize the signs of fatigue and sleep deprivation;**

VI.C.1.b) **educate all faculty members and residents in alertness management and fatigue mitigation processes; and,**

VI.C.1.c) **adopt fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning, such as naps or back-up call schedules.**

VI.C.2. **Each program must have a process to ensure continuity of patient care in the event that a resident may be unable to perform his/her patient care duties.**

VI.C.3. **The sponsoring institution must provide adequate sleep facilities and/or safe transportation options for residents who may be too fatigued to safely return home.**

VI.D. Supervision of Residents

VI.D.1. **In the clinical learning environment, each patient must have an identifiable, appropriately-credentialed and privileged attending physician (or licensed independent practitioner as approved by each Review Committee) who is ultimately responsible for that patient's care.**

VI.D.1.a) **This information should be available to residents, faculty members, and patients.**

VI.D.1.b) **Residents and faculty members should inform patients of their respective roles in each patient's care.**

VI.D.2. **The program must demonstrate that the appropriate level of supervision is in place for all residents who care for patients.**

Supervision may be exercised through a variety of methods. Some activities require the physical presence of the supervising faculty member. For many aspects of patient care, the supervising physician may be a more advanced resident or fellow. Other portions of care provided by the resident can be adequately supervised by the immediate availability of the supervising faculty member or resident physician, either in the institution, or by means of telephonic and/or electronic modalities. In some circumstances, supervision may include post-hoc review of resident-delivered care with feedback as to the appropriateness of that care.

VI.D.3. **Levels of Supervision**

To ensure oversight of resident supervision and graded authority and responsibility, the program must use the following classification of supervision:

VI.D.3.a) **Direct Supervision – the supervising physician is physically present with the resident and patient.**

VI.D.3.b) **Indirect Supervision:**

VI.D.3.b).(1) **with direct supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.**

VI.D.3.b).(2) **with direct supervision available – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.**

VI.D.3.c) **Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.**

VI.D.4. **The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members.**

VI.D.4.a) **The program director must evaluate each resident's abilities based on specific criteria. When available, evaluation should be guided by specific national standards-based criteria.**

VI.D.4.b) **Faculty members functioning as supervising physicians should delegate portions of care to residents, based on the needs of the patient and the skills of the residents.**

VI.D.4.c) **Senior residents or fellows should serve in a supervisory role of junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow.**

VI.D.5. **Programs must set guidelines for circumstances and events in which residents must communicate with appropriate supervising faculty members, such as the transfer of a patient to an intensive care unit, or end-of-life decisions.**

VI.D.5.a) **Each resident must know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence.**

VI.D.5.a).(1) **In particular, PGY-1 residents should be supervised either directly or indirectly with direct supervision immediately available.**

VI.D.5.a).(1).(a) The program must define those physician tasks for which PGY-1 residents may be supervised indirectly, with direct supervision available, and must define “direct supervision” in the context of the program.

VI.D.5.a).(1).(b) The program must define those physician tasks for which PGY-1 residents must be supervised directly until they have demonstrated competence as defined by the program director, and must maintain records of such demonstrations of competence.

VI.D.5.a).(1).(c) The program should use the template of definitions provided in the FAQ or a variation of the template to develop these definitions.

VI.D.6. **Faculty supervision assignments should be of sufficient duration to assess the knowledge and skills of each resident and delegate to him/her the appropriate level of patient care authority and responsibility.**

VI.E. **Clinical Responsibilities**

The clinical responsibilities for each resident must be based on PGY-level, patient safety, resident education, severity and complexity of patient illness/condition and available support services.

VI.E.1. The workload associated with optimal clinical care of surgical patients is a continuum from the moment of admission to the point of discharge.

VI.E.2. During the residency education process, surgical teams should be made up of attending surgeons, residents at various PG levels, medical

students (when appropriate), and other health care providers.

VI.E.3. The work of the caregiver team should be assigned to team members based on each resident's level of education, experience, and competence.

VI.F. Teamwork

Residents must care for patients in an environment that maximizes effective communication. This must include the opportunity to work as a member of effective interprofessional teams that are appropriate to the delivery of care in the specialty.

VI.F.1. Effective surgical practices entail the involvement of members with a mix of complementary skills and attributes (physicians, nurses, and other staff). Success requires both an unwavering mutual respect for those skills and contributions, and a shared commitment to the process of patient care.

VI.F.2. Residents must collaborate with fellow surgical residents, and especially with faculty, other physicians outside of their specialty, and non-traditional health care providers, to best formulate treatment plans for an increasingly diverse patient population.

VI.F.3. Residents must assume personal responsibility to complete all tasks to which they are assigned (or which they voluntarily assume) in a timely fashion. These tasks must be completed in the hours assigned, or, if that is not possible, residents must learn and utilize the established methods for handing off remaining tasks to another member of the resident team so that patient care is not compromised.

VI.F.4. Lines of authority should be defined by programs, and all residents must have a working knowledge of these expected reporting relationships to maximize quality care and patient safety.

VI.G. Resident Duty Hours

VI.G.1. Maximum Hours of Work per Week

Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities and all moonlighting.

VI.G.1.a) Duty Hour Exceptions

A Review Committee may grant exceptions for up to 10% or a maximum of 88 hours to individual programs based on a sound educational rationale.

The Review Committee for General Surgery will not consider requests for exceptions to the 80-hour limit to the residents' work

week.

VI.G.1.a).(1) **In preparing a request for an exception the program director must follow the duty hour exception policy from the ACGME Manual on Policies and Procedures.**

VI.G.1.a).(2) **Prior to submitting the request to the Review Committee, the program director must obtain approval of the institution's GMEC and DIO.**

VI.G.2. **Moonlighting**

VI.G.2.a) **Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program.**

VI.G.2.b) **Time spent by residents in Internal and External Moonlighting (as defined in the ACGME Glossary of Terms) must be counted towards the 80-hour Maximum Weekly Hour Limit.**

VI.G.2.c) **PGY-1 residents are not permitted to moonlight.**

VI.G.3. **Mandatory Time Free of Duty**

Residents must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At-home call cannot be assigned on these free days.

VI.G.4. **Maximum Duty Period Length**

VI.G.4.a) **Duty periods of PGY-1 residents must not exceed 16 hours in duration.**

VI.G.4.b) **Duty periods of PGY-2 residents and above may be scheduled to a maximum of 24 hours of continuous duty in the hospital. Programs must encourage residents to use alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m., is strongly suggested.**

VI.G.4.b).(1) **It is essential for patient safety and resident education that effective transitions in care occur. Residents may be allowed to remain on-site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours.**

VI.G.4.b).(2) **Residents must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.**

VI.G.4.b).(3) **In unusual circumstances, residents, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family.**

VI.G.4.b).(3).(a) **Under those circumstances, the resident must:**

VI.G.4.b).(3).(a).(i) **appropriately hand over the care of all other patients to the team responsible for their continuing care; and,**

VI.G.4.b).(3).(a).(ii) **document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director.**

VI.G.4.b).(3).(b) **The program director must review each submission of additional service, and track both individual resident and program-wide episodes of additional duty.**

VI.G.5. **Minimum Time Off between Scheduled Duty Periods**

VI.G.5.a) **PGY-1 residents should have 10 hours, and must have eight hours, free of duty between scheduled duty periods.**

VI.G.5.b) **Intermediate-level residents should have 10 hours free of duty, and must have eight hours between scheduled duty periods. They must have at least 14 hours free of duty after 24 hours of in-house duty.**

PGY-2 and PGY-3 residents are considered to be at the intermediate level.

VI.G.5.c) **Residents in the final years of education must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods.**

Residents at the PGY-4 level and beyond are considered to be in the final years of education.

VI.G.5.c).(1) **This preparation must occur within the context of the 80-hour, maximum duty period length, and one-day-off-in-seven standards. While it is desirable that residents in their final years of education have eight hours free of duty between scheduled duty periods, there may be circumstances when these residents**

must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty.

VI.G.5.c).(1).(a) **Circumstances of return-to-hospital activities with fewer than eight hours away from the hospital by residents in their final years of education must be monitored by the program director.**

VI.G.5.c).(1).(b) The Review Committee defines such circumstances as: required continuity of care for a severely ill or unstable patient, or a complex patient with whom the resident has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family.

VI.G.6. Maximum Frequency of In-House Night Float

Residents must not be scheduled for more than six consecutive nights of night float.

VI.G.6.a) Residents must not be scheduled for more than six consecutive nights of night float.

VI.G.6.b) Night float rotations must not exceed two months in duration, and there can be no more than three months of night float per year.

VI.G.6.c) Night float rotations must not exceed two months in duration, four months of night float per PGY level, and 15 months for the entire program.

VI.G.7. Maximum In-House On-Call Frequency

PGY-2 residents and above must be scheduled for in-house call no more frequently than every-third-night (when averaged over a four-week period).

VI.G.8. At-Home Call

VI.G.8.a) **Time spent in the hospital by residents on at-home call must count towards the 80-hour maximum weekly hour limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks.**

VI.G.8.a).(1) **At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.**

VI.G.8.b) **Residents are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the**

80-hour weekly maximum, will not initiate a new "off-duty period".

VII. Innovative Projects

Requests for innovative projects that may deviate from the institutional, common and/or specialty specific program requirements must be approved in advance by the Review Committee. In preparing requests, the program director must follow Procedures for Approving Proposals for Innovative Projects located in the ACGME Manual on Policies and Procedures. Once a Review Committee approves a project, the sponsoring institution and program are jointly responsible for the quality of education offered to residents for the duration of such a project.

****

ACGME-approved: June 12, 2007 Effective: January 1, 2008
Minor Revision Approved: June 10, 2008 Effective: August 10, 2008
Editorial Revision: July 1, 2009
Revised Common Program Requirements Effective: July 1, 2011
ACGME-approved: October 1, 2011; Effective: July 1, 2012

Exhibit 5

American Board of Medical Specialties Maintenance of Certification (MOC) Process

American Board of Medical Specialties
Higher standards. Better care®

Search

MOC Competencies and Criteria

MOC Competencies and Criteria

Through ABMS' Maintenance of Certification (MOC) process, board certified physicians in **24 medical specialties** build six core competencies for quality patient care in their medical specialty. These competencies were first adopted by the Accreditation Council for Graduate Medical Education (ACGME) and ABMS in 1999.

About the Six Core Competencies

- **Professionalism**—Demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles and sensitivity to diverse patient populations.
- **Patient Care and Procedural Skills**—Provide care that is compassionate, appropriate and effective treatment for health problems and to promote health.
- **Medical Knowledge**—Demonstrate knowledge about established and evolving biomedical, clinical and cognate sciences and their application in patient care.
- **Practice-based Learning and Improvement**—Able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence and improve their practice of medicine.
- **Interpersonal and Communication Skills**—Demonstrate skills that result in effective information exchange and teaming with patients, their families and professional associates (e.g. fostering a therapeutic relationship that is ethically sounds, uses effective listening skills with non-verbal and verbal communication; working as both a team member and at times as a leader).
- **Systems-based Practice**—Demonstrate awareness of and responsibility to larger context and systems of healthcare. Be able to call on system resources to provide optimal care (e.g. coordinating care across sites or serving as the primary case manager when care involves multiple specialties, professions or sites).

A Four-part Process for Continuous Learning

While ABMS guides the MOC process, ABMS' 24 Member Boards set the criteria and curriculum for each specialty. The four-part MOC process includes:

Part I —Licensure and Professional Standing
Medical specialists must hold a valid, unrestricted medical license in at least one state or jurisdiction in the United States, its territories or Canada.

Part II—Lifelong Learning and Self-Assessment
Physicians participate in educational and self-assessment programs that meet specialty-specifi c standards that are set by their member board.

Part III—Cognitive Expertise
They demonstrate, through formalized examination, that they have the fundamental, practice-related and practice environment-related knowledge to provide quality care in their specialty.

Part IV—Practice Performance Assessment
They are evaluated in their clinical practice according to specialty-specifi c standards for patient care. They are asked to demonstrate that they can assess the quality of care they provide compared to peers and national benchmarks and then apply the best evidence or consensus recommendations to improve that care using follow-up assessments.

American Board of Surgery

Maintenance of Certification Program

About MOC

- Maintenance of Certification goes beyond traditional recertification to a process of lifelong learning, assessment and improvement
- ABS diplomates who certify or recertify in **any specialty after July 1, 2005**, must thereafter participate in MOC to maintain their certification
- MOC is an evolving process—the requirements outlined below will be modified as new learning and assessment tools are developed

Key Points

- **MOC consists of four parts**
- **MOC requirements run in three-year cycles**
- **MOC cycles run from July 1 to June 30**

ABS MOC Requirements

- MOC requirements run in **three-year cycles** (July 1-June 30). Diplomates begin MOC the July 1 following certification or recertification
- After each cycle, diplomates complete an **online form** for Parts 1, 2 and 4. A secure examination (Part 3) is also required at 10-year intervals

MOC PART	ABS REQUIREMENT
Part 1 – Professional Standing	▪ A valid, full and unrestricted **medical license** ▪ **Hospital privileges** in the specialty, if clinically active ▪ **Hospital references**—name and contact information for the chief of surgery and chair of credentials at the institution where most work is performed
Part 2 – Lifelong Learning and Self-Assessment (Effective July 1, 2012. For current requirements, see *www.absurgery.org*)	▪ **Continuing medical education** (CME)—a minimum of **90 hours** of Category I CME to be completed over a three-year cycle ▪ At least **60** of the 90 hours must include a **self-assessment activity**—a written or electronic question-and-answer exercise that assesses the surgeon's understanding of the material presented in the CME program ▪ A score of **75% or higher** must be attained on the self-assessment exercise. There is no minimum number of questions and repeated attempts are allowed ▪ Diplomates who pass a certifying or recertification exam may **waive up to 60 hours** of CME/self-assessment; this includes the exam that enrolls you in MOC
Part 3 – Cognitive Expertise	▪ Successful completion of a **secure examination**, which may first be taken three years prior to certificate expiration. A full exam application is required. All MOC requirements must be fulfilled up to this point to apply ▪ For diplomates who hold more than one certificate, this is the **only requirement** that must be repeated for each specialty
Part 4 – Evaluation of Performance in Practice	▪ Participation in a national, regional or local **outcomes database or quality assessment program** (SCIP, NTDB, NCDB, NSQIP or the ACS case log system meets this requirement; see *www.absurgery.org* for others)

- Diplomates who do not complete the online form or otherwise fail to fulfill the requirements of MOC will be reported as not meeting MOC requirements and will face additional requirements to later re-enter MOC. They also cannot certify or recertify in any ABS specialty until all MOC requirements are met
- Diplomates may track their MOC status by viewing their personalized MOC Timeline at *www.absurgery.org*. The ABS will also notify diplomates when action is required—please keep your contact information up to date

For more information about the ABS MOC Program, visit *www.absurgery.org*

12.11

Exhibit 6

American College of Surgeons Statement 11: Statement on surgery using lasers, pulsed light, radiofrequency devices, or other techniques

AMERICAN COLLEGE OF SURGEONS

Inspiring Quality: Highest Standards, Better Outcomes

[ST-11] Statement on surgery using lasers, pulsed light, radiofrequency devices, or other techniques

[by the American College of Surgeons]

Recognizing the increased usage of laser surgery and to provide professional guidance to state and federal regulatory bodies addressing laser and other surgery issues, the American College of Surgeons wishes to make the following revised statement regarding these operative techniques. The original statement was published in the March 1991 issue of the ***Bulletin****, and this revised statement was approved by the Board of Regents at its February 2007 meeting.*

Surgery is performed for the purpose of structurally altering the human body by the incision or destruction of tissues and is a part of the practice of medicine. Surgery is also the diagnostic or therapeutic treatment of conditions or disease processes by any instruments causing localized alteration or transposition of live human tissue, which include lasers, ultrasound, ionizing radiation, scalpels, probes, and needles. The tissue can be cut, burned, vaporized, frozen, sutured, probed, or manipulated by closed reduction for major dislocations and fractures, or otherwise altered by any mechanical, thermal, light-based, electromagnetic, or chemical means. Injection of diagnostic or therapeutic substances into body cavities, internal organs, joints, sensory organs, and the central nervous system is also considered to be surgery (this does not include administration by nursing personnel of some injections, such as subcutaneous, intramuscular, and intravenous when ordered by a physician). All of these surgical procedures are invasive, including those that are performed with lasers, and the risks of any surgical intervention are not eliminated by using a light knife or laser in place of a metal knife or scalpel.

In recent years, technological advances have made it possible to perform cosmetic surgical procedures of the skin using a variety of devices and techniques. Lasers, pulsed light, and radiofrequency devices are often used for ablative and nonablative treatments. An ablative treatment is expected to excise, burn, or vaporize the skin below the dermo-epidermal junction. Nonablative treatments are those that are not expected or intended to excise, burn, or vaporize the epidermal surface of the skin. Any procedures that can damage the eye (cornea to retina) are ablative and should only be performed by a licensed physician.

The American College of Surgeons believes that surgery using lasers, pulsed light, radiofrequency devices, or other means is part of the practice of medicine and constitutes standard forms of surgical intervention. It is subject to the same regulations that govern the performance of all surgical procedures, including those that are ablative or nonablative, regardless of site of service (that is, hospital, ambulatory surgery center, physician's office, or other locations). Patient safety and quality of care are paramount, and the College therefore believes that patients should be assured that individuals who perform these types of surgery are licensed physicians (defined as doctors of medicine or osteopathy) who meet appropriate professional standards. This is evidenced by comprehensive surgical training and experience, including the management of complications, and the acquisition and maintenance of

credentials in the appropriate surgical specialties (that is, board certification) and in the use of lasers, pulsed light, radiofrequency devices, or other similar techniques.

However, the College also recognizes that the use of ablative lasers may be delegated to non-physician advanced health care practitioners (defined as nurse practitioners or physician assistants) who are appropriately trained and licensed by the state in which they practice. Ablative treatments or procedures performed by nonphysician advanced health care practitioners should fall within the statutory and/or regulatory scope of the practitioner's profession. The physician may delegate the performance of ablative treatments through the use of written protocols to an advanced health care practitioner. Direct supervision should be provided by the physician whenever performance of ablative treatments has been delegated to an advanced health practitioner, unless specific state regulations allow for lesser amounts of supervision. The physician is responsible for doing the initial review of the patient and for authorizing the treatment plan. This should be appropriately noted in the patient's chart prior to any initial ablative treatment.

Physicians may also delegate the performance of nonablative treatments to nonphysician health practitioners (defined as registered nurses, cosmetologists, aestheticians, and medical assistants or other qualified personnel), provided the treatments are performed under direct supervision by the physician consistent with state laws and regulations in the state where they practice. The physician must also assure that these practitioners are appropriately trained, licensed by the state in which they practice, practicing within the scope of their licensure, and provided with written protocols. Similar to ablative treatments, the physician is responsible for doing the initial review of the patient and for authorizing the treatment plan, and this should be appropriately noted in the patient's chart prior to any initial nonablative treatment.

In those cases where the surgeon may utilize the services of a nonphysician advanced health practitioner or nonphysician health practitioner as an assistant during the performance of laser surgery (including ablative or nonablative procedures), the assistant must meet the following requirements:

- Be properly licensed, certified, and/or credentialed to practice his or her profession
- Have appropriate education and training for assisting the surgeon in laser surgery procedures
- Complete assigned duties under the direct supervision of the surgeon performing the procedure

Individuals who perform laser surgery utilizing lasers, pulsed light, radiofrequency devices, or other techniques should meet the principles of the College in all respects (see http://www.facs.org/fellows_info/statements/stonprin.html), to include the avoidance of any misrepresentations to the public regarding unfounded advantages of the laser compared with traditional operative techniques.

_____

Reprinted from **Bulletin of the American College of Surgeons**
Vol.92, No. 4, April 2007

Statements

Appendix D

Impact Statements

From: Marsha Sawdon
To: Wilson, Karen
Subject: Definition of Surgery
Date: Monday, September 05, 2016 2:35:53 PM

Dear Ms. Karen Wilson, HPA, Sept 6, 2016

I am writing to oppose the the consideration to change the Definition of Surgery which might eliminate the right of licensed Electrologists in Connecticut to continue in their profession of electrology.
Electrolysis is a permanent hair removal method involving the insertion of a very fine probe into hair follicles and treating them with an electronic pulse. The Connecticut state Electrologists are licensed and have had 600 hours of training in their field. The training includes; sterilization, skin and hair theory and hands on training. After the graduation from an accredited Electrology School, then they must pass a written and practical exam given by the Dept of Public Health. Then they must get 10 hours per year of continuing education in electrology.

If using a probe for electrolysis is ever considered surgery, then many women, men and transgender individuals who rely on electrolysis to remove their unwanted hair, will have to rely on Doctors for this service. I only guess that will make the cost of electrolysis multiply.
In Connecticut we have approximately 160 licensed electrologists at this time. If their licenses do not allow them to continuing practicing their profession, they will be unemployed and unable to continuing making a living for themselves and their families.
There are a number of other procedures and professions that will be negatively impacted; immunizations, emergency medical care bye EMT's, tattooing and others.

I ask that you pass this letter onto the review committee of "Definition of Surgery".

If anyone has ever had an electrolysis treatment and seen the minute size of our probes, they would know that it is not a surgery instrument.

Respectfully,
Marsha Adams
President, Connecticut State Electrology Association

From:	merry Schlamowitz-burke
To:	Wilson, Karen
Subject:	scope iof practice
Date:	Sunday, September 18, 2016 9:53:22 PM

Dear Ms Wilson,
I have been practicing electrolysis since 1982.
If the legislation on the floor would consider my procedure to be surgery, I would no longer be able to practice.
This would impact over 200 clients whom I serve.
Please do your best to kill this bill
Thanks
Merry Schlamowitz, CPE

CONNECTICUT PHYSICAL THERAPY ASSOCIATION
A COMPONENT OF THE AMERICAN PHYSICAL THERAPY ASSOCIATION
15 NORTH RIVER ROAD, TOLLAND, CT 06084
(860) 246-4414 • FAX (860) 656-9069
www.ctpt.org

September 20, 2016

Karen G. Wilson, HPA
Practitioner Licensing & Investigation Section
Department of Public Health
410 Capitol Avenue
PO Box 340308
Hartford, CT 06134
e-mail: Karen.Wilson@ct.gov

RE: Definition of Surgery 2016 Scope of Practice Request

Dear Ms. Wilson:

In accordance with Public Act 11-209, the Connecticut Physical Therapy Association (CPTA) is submitting thi impact statement in response to the Connecticut State Medical Society (CSMS) submission for a scope of practice review request to the Department of Public Health.

If the Department of Public Health moves forward with CSMS request for a scope of practice review, CPTA respectfully requests participation in the scope of practice review committee. CPTA would like to participate i the scope of practice review committee to ensure that physical therapists are allowed to work to the full extent of their education and training in an effort to support patients with non-surgical interventions.

Should you have questions or require further information, please contact me at your convenience.

Sincerely,

James Leahy, CAE
Executive Director

cc: Michael Dugan, Capitol Consulting – CPTA Lobbyist

American

Connecticut Association of Nurse Anesthetists

Sept 22, 2016

Karen G. Wilson, HRA
Practitioner Licensing and Investigation Section
410 Capitol Ave, MS #12APP
P.O. Box 340308
Hartford, CT. 06134

RE: Connecticut Chapter of the American College of Surgeons Professional Association Scope of Practice Request for 2016-2017

Dear Ms. Wilson,

The Connecticut Association of Nurse Anesthetists (CANA) is submitting an impact statement according with Public Act 11-209, in response to the Connecticut Chapter of the American College of Surgeons Professional Association's (CTACSPA) request for scope of practice review.

The CTACSPA are requesting the CGA to codify the definition of surgery after the Department of Public Health reviews their request. While their request acknowledges there are many healthcare professionals qualified and granted the authority by the state of Connecticut to perform specific procedures, they ask for one clear and specific definition of surgery.

The very nature of one clear and specific definition of surgery can impede all other healthcare professionals from performing certain procedures and infringes upon their scope of practice. Each healthcare professional needs to retain the ability by state statutes to practice to the fullest extent of their individual scope of practice, their training and their licensure. This continues to best support Connecticut's residents access to care.

The administration and delivery of anesthesia care is necessary for the majority of surgical procedures. Certified Registered Nurse Anesthetists (CRNAs) are an integral part of the surgical team and support the patient's best surgical outcomes. CRNAs are also Advanced Practice Registered Nurses (APRNs) and are trained and educated to be independent practitioners. CRNAs are fully trained, educated and licensed to delivery all types of anesthesia in any setting in which anesthesia is delivered including: traditional hospital surgical suites, obstetrical delivery rooms, critical access hospitals, ambulatory surgical centers, the offices of dentists, podiatrists, ophthalmogists, plastic surgeons, pain management specialists as well as public health services in the U.S. Military, and the Department of Veterans Affairs facilities. Therefore, we respectfully request CANA's participation in the scope of practice review.

Should you have any questions or require further information, please contact us at your convenience.

Please reply to confirm delivery of this letter.

Sincerely,

Donna M. Sanchez, MS, CRNA, APRN
Chair, Connecticut Association of Nurse Anesthetists, Government Relations Committee.

Cc: Christopher Bartels, CANA President
Michael Dugan, Capitol Consulting, CANA Lobbyist

CPMA
Connecticut Podiatric Medical Association | 342 North Main Street, West Hartford, CT 06117-2507 | 860.586.7512 | Fax 860.586.7550 | www.CPMA.org

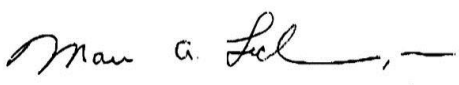
September 24, 2016

TO: Ms. Karen G. Wilson, HPA
Practitioner Licensing & Investigations Section
Department of Public Health
410 Capitol Avenue
Hartford, CT 06134

FR: Peter Blume, DPM
President
Connecticut Podiatric Medical Association

Our organization, the Connecticut Podiatric Medical Association, would like to submit this impact statement in regard to the Definition of Surgery Scope of Practice request. We have reviewed the proposal and believe it could have significant ramifications for the Podiatric profession. Current law provides specific authority for qualified Podiatric Doctors to perform surgery on the ankle and foot. This proposal, as submitted, could restrict that activity. As such, we request two appointments to a Scope of Practice Review Committee in the event the Commissioner accepts this proposal for further consideration.

Sincerely,



Marc A. Lederman, DPM
Executive Director
860.586.7512
marclederman@comcast.net

September 25th, 2016

Ms. Karen G. Wilson, HPA
Practitioner Licensing and Investigations Section
Department of Public Health
410 Capitol Avenue, MS 12APP
P.O. Box 340308
Hartford, CT 06134

VIA EMAIL: karen.wilson@ct.gov

Dear Ms. Wilson:

The Connecticut Naturopathic Medical Association (CNPA) has concerns about the proposed "definition of surgery" proposal that has been submitted by the Connecticut Chapter of the American College of Physicians. The proposed language defining surgery is so broad that it could limit Naturopathic Physicians in performing a number of current procedures and treatments. If the Commissioner decides to accept this proposal, CNPA would like to have two members of the Scope of Practice Review Committee. I will be the contact for CNPA: Rick Liva, ND, email: rickliva@yournaturalhealth.com

We will send a copy of this Impact Statement to the Connecticut Chapter of the American College of Surgeons. Thank you.

Sincerely,

Rick Liva, RPh, N.D.
President & Legislative Chair

Connecticut Academy of Physician Assistants

One Regency Drive • PO Box 30 • Bloomfield, CT 06002
860/243-3977 • Fax: 860/286-0787 • connapa@ssmgt.com • www.connapa.org

September 26, 2016

TO: Ms. Karen G. Wilson, HPA
Practitioner Licensing & Investigations Section
Department of Public Health
410 Capitol Avenue
Hartford, CT 06134

FR: Jonathan Weber, PA-C
Legislative Co-Chair
Connecticut Academy of Physician Assistants

Our organization, the Connecticut Academy of Physician Assistants, would like to submit this impact statement in regard to the Definition of Surgery Scope of Practice Request. We have reviewed the proposal and believe it could have significant ramifications for the Physician Assistant profession. As such, we request two appointments to a Scope of Practice Review Committee in the event the Commissioner accepts this proposal for further consideration.

Please let me know if you have any questions on this issue. I will be the point of contact on this matter and can be reached at the following email address: jonathan.weber@yale.edu

Thank you for considering this impact statement.

Sincerely,

Jonathan Weber, MA, PA-C
Co-Chair, Legislative Affairs

Jason P. Prevelige, MHS, PA-C
President

Connecticut State Dental Association

835 West Queen Street
Southington, CT 06489

860.378.1800 / phone
860.378.1807 / fax

CSDA.com

September 26, 2016

Karen G. Wilson, HPA
Practitioner Licensing and Investigations Section
Department of Public Health
410 Capitol Avenue, MS #12APP
P.O. Box 340308
Hartford, CT 06134

Dear Ms. Wilson,

Per Public Act 11-209, An Act Concerning the Department of Public Health's Oversight Responsibilities Relating to Scope of Practice Determinations for Health Care Professions, the Connecticut State Dental Association (CSDA) is formally submitting this document as an impact statement to the Definition of Surgery Scope of Practice Request which was submitted by the Connecticut Chapter of the American College of Surgeons Professional Association, Inc. The CSDA has been the trusted leader and voice for oral healthcare in Connecticut since 1864. The CSDA currently represents 1,852 licensed dentists, or nearly 71% of all Connecticut dentists.

The CSDA is in support of a clear and concise definition of surgery in the Connecticut General Statutes, as described by the Connecticut Chapter of the American College of Surgeons Professional Association's recent scope of practice request submitted to the Department of Public Health. However, the definition must include the dental profession to ensure that dentists can continue to practice to the fullest extent of their education without unnecessary and inadvertent limitations which could result if the issue is decided solely by the medical profession. For example, most aspects of dentistry, from restorative procedures to full maxillofacial reconstruction would meet the definition of surgery as proposed and, as such, dentistry should be represented in any discussion.

A concise definition of surgery to include the educational qualifications for performing such procedures, ensures public safety by allowing only appropriately trained professionals to perform these surgical procedures. This must include language that educationally qualified practitioners who have special knowledge of certain areas (e.g. dentistry) be allowed to utilize their particular skills. The CSDA wants to assure that the procedures that are now routinely and safely being performed by dentists continue to be an approved activity.

Dentists are licensed and regulated under Connecticut General Statute Chapter 379 Section 20-103a through Section 20-126e. The Connecticut State Dental Commission and the Department of Public Health provide regulatory oversight of the profession. In order to be licensed to practice dentistry, including dental surgery, in the state of Connecticut, an individual must receive at least a 4-year baccalaureate degree, followed by four years of dental school. In addition, many dentists have additional specialty education between three to six years, such as oral and maxillofacial surgery, endodontology, and periodontology. Dentists receive the DDS (Doctor of Dental Surgery) or DMD (Doctor of Dental Medicine) degrees. Many skills taught to the level of proficiency in Dental Schools are not taught anywhere else. Furthermore, dentists take continuing education courses on a regular basis and have a unique understanding of oral conditions and their relation to overall health. Dentistry has a long history of safe, effective, and efficacious surgical and nonsurgical treatment of the oral cavity, and the CSDA wants to assure that the outcome of this process does not impose onerous or unnecessary requirements that will increase the cost of dental care to the public.

In summary, the CSDA supports a clarification of the definition of surgery with the caveat that the discussion must include the dental profession to ensure that the ability of dentists to provide the full range of surgical dental services is not inadvertently limited by a conversation that includes only the medical profession. Therefore, we would very much like to be involved in the process should the Department wish to explore the scope request further.

Sincerely,

Michael Ungerleider DMD

Michael A. Ungerleider, DMD
President, CSDA

9/27/2016

IMPACT STATEMENT submitted regarding, scope of practice request "CONCERNING THE DEFINITION OF SURGERY", to adopt a definition of surgery.

The Department of Public Health Committee:

My name is Nikki Rasmussen. I am a Family Nurse Practitioner and a business owner of a business that primarily provides cosmetic medical procedures, including the use of laser and light devices. I submit this testimony noting my opposition to the above request.

1. Plain Language Description of the Request:

The Connecticut Chapter of the American College of Surgeons Professional Association, Inc. (CTACSPA) has submitted a scope of practice request to define surgery. This request defines surgery in very broad terms to reflect any alteration of tissue for both diagnostic or therapeutic purposes.

The current proposal to define "surgery," has long reaching effects on who can then perform, delegate and be reimbursed for such procedures that are routinely and safely done, by non-surgeons/non-physicians including APRNs. Some of the procedures that would be affected by the proposed "definition of surgery" include: laser hair removal, IPL, skin tightening, and laser resurfacing. These are procedures that I perform daily.

2. Public Health and Safety Benefits and Risks

The intent of this request is to "codify" and clarify the definition of surgery for the public. However, the definition of surgery to include alteration of tissue applies broadly to many professions and specifically to medical providers that provide cosmetic laser services. The request does little to protect the public as it does not specifically address levels of anesthesia which could easily define what actual "surgery" is and who could perform. Instead the proposed definition includes all procedures that manipulate tissue as classifies them as "surgery" and thus can only be performed by a physician or under a physician's supervision and control. If this broad definition of surgery is adopted it will pose more risk than benefit to the public by limiting the public's access to care.

3. Impact on Public Access to Health Care:

The CTACSPA states that defining surgery will not impact access to care, but improve the quality of care. The public would have decreased access to many services that they currently receive from non-physician providers, including cosmetic laser services, would debridement, skin tag removal, and destruction of suspicious lesions using cryosurgery.

4. Summary of Known Scope of Practice Changes Requested or Enacted Concerning the Profession in the Five Years Preceding the Request:

The CTACSPA submitted the same scope of practice request for the definition of surgery in 2015.

5. Identification of Any Health Care Professions that can Reasonably be Anticipated to be Directly Affected by the Request, the Nature of the Impact, and Efforts Made by the Requestor to Discuss It with Such Health Care Professions

The current proposal has the potential to impact APRN scope of practice by disallowing the independent use of lasers for cosmetic laser procedures, as well as other procedures routinely and independently performed by APRNs.

Currently, the Connecticut board of nursing considers cosmetic medical procedures, including the use of lasers for hair removal, age and sun spot removal, capillary removal and impulse light treatment to be the practice of medicine (note: not the practice of surgery) and to be within the scope of practice of an APRNs. If the suggested version of surgery is adopted as it is written in the proposal, it will impact and change, the scope of practice for RNs and APRNs. The issue of who can perform cosmetic laser procedures was further defined by Public ACT 14-119 in 2014 where it was determined that APRNs can independently perform cosmetic laser services without the need for Physician delegation.

Specific to my circumstance, the scope of practice request, if adopted would prevent me from owning a business that has been in successful operation for 7 years.

Respectfully,

Nikki Rasmussen, APRN-FNP-C

Principal- Yolo LLC, DBA Yolo Laser Center & Med Spa

Connecticut College of Emergency Physicians
60 Kings Highway, North Haven, CT 06473
www.ctacep.org - 203-464-3793

September 28, 2016

Karen G. Wilson, HPA
Practitioner Licensing and Investigations Section
Department of Public Health
410 Capitol Ave., MS#12APP
PO. Box 340308
Hartford, CT 06134

RE: Definition of Surgery Scope of Practice Request

Dear Ms. Wilson:

In accordance with Public Act 11-209, the Connecticut College of Emergency Physicians (CCEP) is submitting this impact statement in response to the Connecticut Chapter of the American College of Surgeons Professional Association (CTACSPA) submission for a scope of practice review request to the Department of Public Health.

If the Department of Public Health moves forward with CTACSPA's request for a scope of practice review, CCEP respectfully requests participation in the scope of practice review committee. Emergency physicians perform a number of surgical and surgical-type procedures daily. As such, CCEP would like to participate in the scope of practice review committee. As this committee seeks to clarify what constitutes "surgery," this may impact the care provided to emergency department patients and their treatments.

Should you have questions or require further information, please contact me at your convenience.

Sincerely,

Thomas A. Brunell, M.D., F.A.C.E.P.
President

Connecticut College of Emergency Physicians

cc:
Michael Dugan, Capitol Consulting – CCEP Lobbyist

Connecticut State Medical Society
FOUNDED IN 1792

127 Washington Avenue, East Building, 3rd Floor, North Haven, CT 06473
Phone (203) 865-0587 Fax (203) 865-4997 www.csms.org

September 29, 2016

Karen G. Wilson, HPA
Practitioner Licensing and Investigations Section
410 Capitol Avenue, MS # 12APP
P.O. Box 340308
Hartford, CT 06134

Dear Ms. Wilson:

On behalf of the physicians and physician in training members of the Connecticut State Medical Society (CSMS) we submit these comments regarding the Connecticut Chapter of the American College of Surgeons Professional Association's submission as consistent with the requirements of Public Act 11-209.

You currently have before you an impact statement submitted by the Connecticut Chapter of the American College of Surgeons Professional Association and the American College of Surgeons. These organizations, with the support of many other physician organizations including CSMS, have provided comprehensive and significant information as to why the proposal is in the best interest of the public's quality of care particularly as it relates to the provision of surgical services. CSMS supports, concurs with and makes the same request for adoption as these organizations.

Thank you for the opportunity to submit these comments in support to this submission. We respectful urge that this request be approved and should a review committee be composed that CSMS be allowed a representative.

Sincerely,

Ken Ferrucci
Senior Vice President of Government Affairs

cc: Chris Tasik, Executive Director, CT Chapter of the American College of Surgeons

CTChiro
Connecticut Chiropractic Association

2257 Silas Deane Highway
Rocky Hill, CT 06067
Tel. (860) 257-0404 ~ Fax. (860) 257-0406
CTChiro.com

September 29, 2016

Karen G. Wilson, HPA
Practitioner Licensing and Investigations Section
Department of Public Health
410 Capitol Avenue, MS#12APP
P.O. Box 340308
Hartford, CT 06134
karen.wilson@ct.gov

RE: Definition of Surgery Proposal

Dear Ms. Wilson:

The Connecticut Chiropractic Association (CCA) submits this impact statement with regard to a Scope of Practice proposal submitted by the Connecticut Chapter of the American College of Surgeons Professional Association, Inc. (CTACSPA). The proposal in question would place in statute a "definition of surgery" that has been adopted by the American College of Surgeons.

As drafted, the proposal would deem as surgery any action that transposes (i.e. moves, changes) live human tissue including ultrasound. As Chiropractic Physicians, much of our practice for nearly 100 years in Connecticut relates to touching, manipulating and penetrating tissue for the purpose of restoring normal health to the individual. We do so while the patient is fully awake or at times during the use of anesthesia. Since the proposal states that only Medical Doctors may do so, the proposal would seriously harm the chiropractic profession in terms of the current scope of practice and the delivery of new developments in practice established in national and regional accredited chiropractic colleges thus compromising patient care now and in the future.

We also have concerns that the autonomy of the Connecticut Chiropractic Board of Examiners to determine the chiropractic scope of practice in Connecticut may be compromised by this action.

We urge you not to approve a scope of practice review committee for this proposal. However, if a committee is created, we request that the CCA be permitted to designate two individuals to serve as members of the committee.

Sincerely,

Richard Duenas, D.C.
President

Copy: File
Michael Deren, MD, American College of Surgeons, CT chapter, info@ctacs.org

Connecticut
Dental Hygienists' Association

September 30, 2016

Ms. Karen G. Wilson, HPA
Practitioner Licensing & Investigations Section
Department of Public Health
410 Capitol Avenue, MS#12APP
Hartford, CT 06134

Marie Paulis, RDH, MSDH
Legislative Chairperson
ADHA-Connecticut

Our organization, the Connecticut Dental Hygienists' Association, would like to submit this impact statement in regard to the Definition of Surgery Scope of Practice Request. We believe it could have ramifications for the dental hygiene profession. Therefore, we request two appointments to a Scope of Practice Review Committee in the event that the Commissioner accepts this proposal for further consideration.

Please note that I will be the point of contact for ADHA-Connecticut on this matter. I can be reached at (203) 260-0668 or (email) at mpaulis@newhaven.edu.

Thank you for considering this impact statement.

Sincerely,

Marie R. Paulis RDH, MSDH
Marie R. Paulis, RDH, MSDH
Legislative Chairperson, ADHA-Connecticut

phone: 860-690-1146
email: ctorthoexec@gmail.com
www.ctortho.org

Connecticut ORTHOPAEDIC Society

September 30, 2016

Karen G. Wilson, HPA
Practitioner Licensing and Investigations Section
Department of Public Health
410 Capitol Avenue – MS 12APP
P.O. Box 340308
Hartford, CT 06134

Dear. Ms. Wilson,

On behalf of the orthopaedic surgeon members of the Connecticut Orthopaedic Society (COS), we submit this letter in support of the Connecticut Chapter of the American College of Surgeons professional association's scope of practice review request previously submitted.

The COS joins with other medical specialty organizations in Connecticut to request the definition of surgery, as written by the American College of Surgeons, and adopted by the American Medical Association, be reviewed by the Department of Public Health for submission to the Connecticut General Assembly for their consideration and adoption. The definition would provide for a consistent definition and assist the public in understanding the provision of surgical services.

It has always been the position of the COS that patients have surgical services provided by only the most qualified and highly trained medical providers. Adoption of this definition of "surgery" is an important step in continuing to ensure that patient safety during surgical procedures is maintained at the highest level in the State of Connecticut.

Thank you for your review and consideration. We respectfully ask that this request be approved and should a review committee be composed that COS be allowed two representatives.

Sincerely,

F. Scott Gray, MD
President, Connecticut Orthopaedic Society

CONNECTICUT NURSES' ASSOCIATION

Karen G. Wilson, HPA
Practitioner Licensing and Investigations Section
Department of Public Health
410 Capitol Avenue, MS#12APP
P.O. Box 340308
Hartford, CT 06134

September 30, 2016

Dear Ms. Wilson:

The Connecticut Nurses' Association, a professional association for Registered Nurses, respectfully submits this impact statement for the Definition of Surgery Scope of Practice Determination.

There are over 60,000 licensed Registered Nurses in CT. Nurses are a member of the health care team and work in many settings to care for clients. Part of nursing practice may include cleaning and dressing wounds and providing medication regimens that pierce the skin.

Changing the definition of surgery in the regulations will limit basic nursing practice. The Connecticut Nurses' Association has submitted testimony on the proposed bill addressing the definition of surgery.

We request to be part of this discussion to advocate for nursing practices and their care for patients.

Thank you and we look forward to the discussion.

Sincerely,

Mary Jane Williams

Kimberly A. Sandor

Mary Jane Williams
Chair, Government Relations

Kimberly A. Sandor
Executive Director, CT Nurses' Association

1224 Mill St. Bldg B
East Berlin, CT 06023

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WWW.CTNURSES.ORG

CONNECTICUT ASSOCIATION OF OPTOMETRISTS

October 1, 2016

Karen G. Wilson, HPA
Practitioner Licensing & Investigations
Connecticut Department of Public Health
410 Capitol Avenue, MS#12APP
P.O. Box 340308
Hartford, CT 06134

Dear Ms. Wilson:

This impact statement is respectfully submitted under the provisions of Public Act 11-209 on behalf of the nearly 350 members of the Connecticut Association of Optometrists, Inc. (CAO) practicing in Connecticut in response to the purported "Scope of Practice Request" submitted by the Connecticut Chapter of the American College of Surgeons Professional Association. The CAO represents hundreds of licensed Optometric Doctors who provide vision care services to patients in every town and city within the State of Connecticut. Connecticut's Optometrists are the front-line vision care provider for the overwhelming majority of Connecticut's eye care patients.

The CAO strongly opposes the creation of a statutory definition for the word "surgery" as proposed by the American College of Surgeons Professional Association.

At the outset, we respectfully urge you to dismiss the proceedings under P.A. 11-209 in connection with this request as it is outside of the ambit and purview of the Public Act. These proceedings are reserved for *"Any person or entity acting on behalf of a health care profession that seeks to establish a **new scope** of practice **or change a profession's scope** of practice…"* (emphasis added; see Section 1 of Public Act 11-209). This request neither seeks to establish a new scope of practice by the College of Surgeons nor does it seek to change the profession's scope of practice. Rather, it attempts to define a statutory word ("surgery") based on the claim that it will provide "consistency" in Connecticut's health care law. The requestor by its own admission in a nearly identical application filed in 2012 (see page 6 subsection (10) of the requestor's August 15, 2012 submission) states that its request does not seek to establish a new scope or change its professions' scope of practice:

"Adoption of a definition of surgery for physicians and surgeons does not change their scope of practice as they are already licensed by the state to perform surgery."

The legislature created the process set forth in P.A. 11-209 to provide an enhanced mechanism for its Joint Standing Committee on Public Health to consider possible changes to the scopes of practice for Connecticut's health care providers. However, the legislature did not intend that this process should be open to any proposed change in Connecticut's health care laws. If it intended to do so, it would have not restricted the process to new scopes of practice or changes in existing scopes of practice. The Department does not have the authority to open these statutory proceedings for the consideration of *any* change to Connecticut's health care laws.

The proper venue for consideration of the creation of the definition of "surgery" is the Connecticut General Assembly and not the Department of Public Health utilizing the procedures set forth in P.A. 11-209. Accordingly, we respectfully request that this request be dismissed.

However, in the event the Department does not dismiss the request then, in that event, the CAO offers the following response in connection with the proposal to define the word "surgery" as proposed by the American College of Surgeons Professional Association.

The CAO believes that instead of bringing consistency within the Connecticut health care laws the proposed definition will do the opposite and create contradictions, ambiguities and inconsistencies in the current statutory scheme of health care providers including optometrists licensed under Chapter 380 of the Connecticut General Statutes.

The Optometrists' scope of practice statute, C.G.S. 20-127, permits, among other procedures the following:

- Foreign removal corneal 65222
- Foreign removal conjunctival 65205
- Epilation (removal of eyelash) 67820
- Dilation of punctum (tx for dry eye, closure of punctual) 68801
- Punctum closure by plug 68761

The proposed definition would be in direct contradiction to the language in C.G.S. 20-127 which currently permits these procedures when performed by licensed optometrists. At the very least, the proposed definition would create ambiguity and confusion within the health care statutes. Moreover, the proposed definition contains dozens of otherwise undefined words and phrases (e.g. "transposition of live human tissue", "altering the human by…destruction of tissues", etc.). In effect, by not defining these other words and phrases, the proposed definition results in less consistency, more ambiguity and confusion within our Health care laws.

In summary, the CAO believes that the request does not fall within the mission of P.A. 11-209 in that it does not seek a change in the scope of practice and further believes that the adoption of the proposed definition of the word "surgery" will not benefit the public health system but will have the opposite effect by causing ambiguity and confusion within the State's health care laws. For these reasons, The CAO strongly opposes the creation of a statutory definition for the word "surgery" as proposed by the American College of Surgeons Professional Association.

If this proposal moves forward to a full committee review, CAO would request two members of the committee. Thank you.

Sincerely,

Brian T. Lynch, OD
Legislative Chair

CONNECTICUT HOSPITAL ASSOCIATION

MEMORANDUM

TO: Karen G. Wilson, HPA
Practitioner Licensing and Investigations Section
Connecticut Department of Public Health

FROM: Karen Buckley, Vice President, Advocacy

DATE: October 1, 2016

SUBJECT: Impact Statement – Scope of Practice Request – Definition of Surgery

The Connecticut Hospital Association (CHA), a trade association representing 27 acute care hospitals in Connecticut, submits this impact statement, in accordance with Chapter 368a of the Connecticut General Statutes, in response to the scope of practice change requested by the Connecticut Chapter of the American College of Surgeons. The change requested is to define "surgery" within the Connecticut General Statutes.

A change to the definition of surgery along the lines suggested in the proponent's filing would cause a significant, if not extreme, shift in the healthcare delivery system in Connecticut, and potentially across the region. It would drastically affect all hospital and outpatient surgical facility personnel and staff. More importantly, patients and the community would be substantially affected.

Connecticut hospitals employ or utilize a significant number of licensed healthcare professionals including physicians, advanced practice registered nurses, physician assistants, and other allied health professionals. As noted in the submission, the term "surgery" is currently used in more than 100 sections of the Connecticut General Statutes. To define surgery, it is essential that each and every use of the word be reviewed. The request will impact various licensed practitioners as well as the delivery of care to hospital patients. In addition, a change of this magnitude will require hospital policies and procedures to be changed.

If the Department appoints a Scope of Practice Review Committee, CHA respectfully requests an appointment to the Committee.

KMB:mb
By e-mail

October 1, 2016

Karen G. Wilson, HPA
Practitioner Licensing and Investigations Section
Department of Public Health
410 Capitol Avenue, MS#12APP
P.O. Box 340308
Hartford, CT 06134

Dear Ms. Wilson:

The Connecticut Society for Respiratory Care has reviewed a scope of practice proposal submitted by the American College of Surgeons relative to a definition of surgery.

CTSRC is concerned that the proposal could affect our practice act and the care we provide to our patients. In the event this proposal is selected for a full Scope of Practice Review Committee, CTSRC would like to request that we be included in the process and have two members on the panel. Thank you.

Sincerely,

Connie Dills, MBA, RRT, RPFT
President

Division of Health Sciences

David M. Brady, ND, DC, CCN, DACBN
Vice President for Health Sciences

October 01, 2016

Ms. Karen G. Wilson, HPA
Practitioner Licensing and Investigations Section
Department of Public Health
410 Capitol Avenue, MS 12APP
P.O. Box 340308
Hartford, CT 06134

Dear Ms. Wilson:

I am Vice President for Health Sciences at the University of Bridgeport. Collectively, we educate students in schools, colleges and institutes of Nursing, Dental Hygiene, Clinical Laboratory Sciences, Nutrition, Physician Assistant, Acupuncture/TCM, Naturopathic Medicine, Chiropractic and Doctorate in Health Sciences. In general, we believe Connecticut laws should permit each profession to treat patients to the full extent of their contemporary education and training and that practice acts should be reviewed periodically to reflect the latest developments in medicine and the competencies of specific professions to best meet the needs of an evolving healthcare system.

I understand that a Scope of Practice proposal has been submitted to update the Physician Assistant practice act. Any discussions and potential changes will have ramifications for our Physician Assistant program. As such, if the Commissioner decides to accept this proposal, the University of Bridgeport-Division of Health Sciences would like to have two members of the Scope of Practice Review Committee, to include myself as the representative of senior University administration and Theresa V. Horvath, PA-C, MPH, as director of the Physician Assistant Institute. Please contact me with any questions that you might have.

Sincerely,

David M. Brady, ND, DC, CCN, DACBN
Vice President for Health Sciences
Director, Human Nutrition Institute
Associate Professor of Clinical Sciences
University of Bridgeport

Connecticut Coalition of Advanced Practice Nurses

American College of Nurse-Midwives (ACNM), Region I, Chapter 2
Connecticut Advanced Practice Registered Nurses Society (CTAPRNS)
Connecticut Association of Nurse Anesthetists (CANA)
Connecticut Nurses' Association (CNA)
Connecticut Chapter of the American Psychiatric Nurses Association (APNA-CT)
National Association of Pediatric Nurse Practitioners (NAPNAP), Connecticut Chapter
The Northwest Nurse Practitioner Group

October 2, 2016
Karen G. Wilson, HPA
Practitioner Licensing & Investigations
Connecticut Department of Public Health
410 Capitol Avenue, MS#12 APP
P.O. Box 340308
Hartford, CT 06134

Dear Ms. Wilson,

I am writing on behalf of the Connecticut Coalition of Advanced Practice Nurses in opposition to the scope of practice request submitted by the Connecticut Chapter of the American College of Surgeons Professional Association for a definition of surgery as written by the American College of Surgeons and adopted by the American Medical Association which states:

(A) A plain language description of the request;

> H-475.983 Definition of Surgery Based upon the AMA adopted definition of "surgery" as taken from American College of Surgeons Statement ST-11 (please see exhibit 6 for the full Statement): "Surgery" is defined as the structural alteration of the human body by incision or destruction of tissue or the diagnostic or therapeutic treatment of conditions or disease processes using any instrument causing localized alteration or transposition of live human tissue, including, but not limited to, lasers, ultrasound, ionizing radiation, scalpels, probes and needles, used to cut, burn vaporize, freeze, suture, probe, or otherwise alter by mechanical, thermal, light-based, electromagnetic, or chemical means, or manipulation by closed reductions for major dislocations or fractures, or the injection of diagnostic or therapeutic substances into body cavities, internal organs, joints, sensory organs and the central nervous system.
>
> Patient safety and quality of care are paramount and, therefore, patients should be assured that individuals who perform these types of surgery are licensed physicians (defined as doctors of medicine or osteopathy) who meet appropriate professional standards. (Res. 212; A-07)" The definition of surgery, as proposed, should not limit procedures currently allowed to be performed by allied health professions under statute nor should it limit or attempt to define procedures performed by different physicians practicing within their professionally accepted

scope at the time of its inception or in the future. The definition should limit the performance of surgery in Connecticut to physicians, dentists and podiatrists licensed by their respective Boards. In addition we propose that no other board or agency should regulate the performance of surgery.

This request does NOT indicate any SOP change for the requestor and, therefore, raises the question as to what SOP is being sought. The statement is not clear.

(B) Public health and safety benefits that the requestor believes will be achieved should the request be implemented and, if applicable, a description of any harm to public health and safety should the request not be implemented;

The authors failed to provide any documentation or data to support the claim, not having a definition has harmed the public. In fact, admits that "public health and safety will not technically be harmed without implementation ___".

However, although surgical privileges are granted to several classes of licensed professionals, no one specific definition of surgery exists in state statute. A strong definition will ensure trained professionals are practicing to the highest standards and will provide the essential guidance that health care examining boards require to assess and ensure that the public is not exposed to providers who are practicing outside their scope of practice and beyond their training and capability.

We are not clear what is meant by this statement. The scope of practice of professions overlap. By defining surgery in such broad terms, the scope of practice of many other professions will be affected if not exempt when practicing within their SOP. This application does not make it clear that other professions practicing within their scope of practice would be affected. However, the requestor seems to be asking OTHER Examining Boards to restrict their guidance to this definition as if to restrict existing Scopes of Practice of other licensed professionals?

(C) The impact that the request will have on public access to health care;

It will harm the public by reducing access to care by restricting the current scope of practice of many professions. All professions have standards of care and practice and the physicians and surgeons employ such standards. Nowhere is there a clear documentation of a public health threat by NOT having a definition of surgery. Patient access would be severely impacted if this definition were considered. Certainly not taken into consideration is the current state of the physician shortage and the impact this definition would have on those who currently provide care which will now be restricted only to a physician.

(D) A brief summary of state or federal laws that govern the health care profession making the request;

This area is confusing. Are the surgeons requesting a scope of practice change for themselves? They again document their standards and professional compliance. The statues they cite do not indicate any areas where the public can be harmed or give the appearance of potential harm. There is no clear issue there is any state or federal law violation which a definition of surgery would satisfy.

(E) The state's current regulatory oversight of the health care profession making the request;

The Department of Public Health regulates the oversight of professions. Complaints about entities performing out of their respective scope of practice, DPH has a system in place to address such concerns. If the surgeons have a specific concern regarding the public's potential harm, the department of public health should be notified and an investigation undertaken. This process has proven effective at thwarting perceived, potential or actual perpetrators.

(F) All current education, training and examination requirements and any relevant certification requirements applicable to the health care profession making the request;

We respect our physician and surgeon colleague's education and training. They have provided no data to support any reason a definition is required when other professions clearly can deliver care within their scope of practice.

(G) A summary of known scope of practice changes either requested or enacted concerning the health care profession in the five-year period preceding the date of the request;

This request has been put forth multiple times by the physicians and surgeons. It is a clear mandate by the American Medical Association to define and limit other professions Scope of practice, (AMA Scope of Practice Data Series :Nurse Practitioners , October 2009)

(H) The extent to which the request directly impacts existing relationships within the health care delivery system;

This section provides no information about relationships and refers to "fights" without any explanation as to the issues involved or the entities involved and whether or not DPH was properly involved. This is inflammatory and without substance.

(I) The anticipated economic impact of the request on the health care delivery system;

By codifying the definition of surgery in the CGS we believe that we will, over time, see a reduction in medical errors and a concurrent improvement in the quality of surgical care in the state as surgical procedures will be performed by those physicians who are properly trained and/or certified.

If there are knowledge of issues regarding medical errors and quality of surgical care, it is lacking in this application. Again there is no data or studies to show who or what harm the public has endured by NOT having a definition. Furthermore, this request will clearly impact health care delivery by reducing access

through manipulation of other professions scope of practice and increasing costs by only allowing the highest cost provider to perform any of the services listed.

(J) Regional and national trends concerning licensure of the health care profession making the request and a summary of relevant scope of practice provisions enacted in other states;

In addition, practitioners who practice by statute under physician supervision would continue to be able to do so.
The definition of surgery, as proposed, should not limit procedures currently allowed to be performed by allied health professions under statute nor should it limit or attempt to define procedures performed by different physicians practicing within their professionally accepted scope at the time of its inception or in the future.

This statement requires clarification as to whom the requester is referring. An attempt to define procedures with the Medical Spa task force proved quite challenging. We know health care is constantly evolving so any attempt to quantify specific tasks could paralyze the process and thus impact patient access and safety. State of CT relies on its licensed health care professionals to perform within their scopes of practice and makes it clear that unlicensed personnel do NOT have equal standing. The requestor does not indicate an understanding of other scopes of practice nor does it address any issue with unlicensed personnel leaving one to wonder exactly what SOP issue they are trying to address. If other health care professionals properly licensed and practicing in CT are intended to be exempt from this proposed definition, the applicant needs to clearly state such and make it part of the definition, similar to other states. One might conclude, based on the application, there is NO SOP issue for the application does not properly set forth a SOP request.

(K) Identification of any health care professions that can reasonably be anticipated to be directly impacted by the request, the nature of the impact and efforts made by the requestor to discuss the request with such health care professions;

The requester does not list any other professions affected by this request, when in fact, the request is all about other professions' scopes of practice. There has been a meeting with the Connecticut Coalition of Advanced Practice Nurses and other professions affected by this request to attempt consensus. Though there was thoughtful discussion, consensus could not be attained.

(L) A description of how the request relates to the health care profession's ability to practice to the full extent of the profession's education and training.

Very succinctly, we believe that the adoption of the above Definition of Surgery into the CGS allows each and every surgical health care practitioner in Connecticut to provide quality patient care to the fullest extent of their individual education, training, certification, and licensure.

All health care providers should be allowed to practice to the full extent of the profession's level of education and training. We disagree that this definition would have any impact on CT Surgeons ability to continue to fully utilize their talents and provide quality safe care.

This request fails to adhere to the 4 Pillars of Health Care Policy: Quality, Access, Cost and Safety. This request is not about a change to the surgeon's scope of practice. This request is to clearly inhibit the scope of practice of other health care providers who deliver high quality, cost-effective care. Nowhere in this request do the surgeons provide any data where the public has been harmed by not having a definition of surgery. Additionally, defining surgery would hurt access to those seeking care mainly by restricting to a physician which can have a profound effect on the care they seek and in a timely fashion. This scope request sets health care back twenty years. Today, there is an inherent overlap of professions scope of practice. Evolving health care and technologies fuel this fluidity.

This scope request is unrealistic in today's' health care environment where we need all health care providers delivering care to their highest level of education and training.

Lynn Rapsilber DNP APRN ANP-BC FAANP
Chair Connecticut Coalition of Advanced Practice Nurses
253 Fairlawn Drive
Torrington, Connecticut 06790

Karen G. Wilson, HPA
Practitioner Licensing and Investigations Section
Department of Pubic Health
410 Capitol Ave, MS #12APP
P.O. Box 340308
Hartford, CT 06134
Email: Karen.Wilson@ct.gov

10/03/16

Dear Ms. Wilson,

ConnOTA would like to take this opportunity to respond to the proposed scope of practice revisions being proposed by the Connecticut Chapter of the American College of Surgeons Professional Association, Inc. ("CTACSPA") for 2016.

Let me start my providing a brief explanation of Occupational Therapy. As of September 30, 2016 , there were 2450 licensed Occupational Therapists and 948 licensed Certified Occupational Therapy Assistants in the state of CT.

Occupational Therapy is a science-driven, evidence based profession that enables people of all ages to live life to its fullest by helping them promote health and prevent – or live better with their illness, injury or disability. Patients (clients) who receive our services range in age from the pre-mature infant to the geriatric patient and all ages in-between. When we evaluate a patient (client) we take into account the complete person including his or her psychological, physical, emotional and social makeup so they can function at the highest possible level.

As outlined on the AOTA website, "Common occupational therapy interventions include helping children with disabilities to participate fully in school and social situations, helping people recovering from injury to regain skills, and providing supports for older adults experiencing physical and cognitive changes. Occupational therapy services typically include:

- an individualized evaluation, during which the client/family and occupational therapist determine the person's goals,
- customized intervention to improve the person's ability to perform daily activities and reach the goals, and
- an outcomes evaluation to ensure that the goals are being met and/or make changes to the intervention plan.

Occupational therapy services may include comprehensive evaluations of the client's home and other environments (e.g., workplace, school), recommendations for adaptive equipment and training in its use,

and guidance and education for family members and caregivers. Occupational therapy practitioners have a holistic perspective, in which the focus is on adapting the environment to fit the person, and the person is an integral part of the therapy team.

In regards to the proposed scope changes submitted by the CTACSPA, ConnOTA expresses serious concern regarding specific language used to define surgery, please note that the same concerns were submitted February 2015 to the Committee on Public Health regarding HB 5625:

"Surgery" may be performed by mechanical instruments such as scalpels, probes, and needles, or by instruments that use thermal or light based energies, electromagnetic or chemical means, and high pressure water jets to cut, burn, vaporize, freeze, probe or re-approximate living tissue.

This section of the proposed changes to the definition of surgery should not be expanded to be exclusive of being performed by a surgeon, as there are treatment modalities performed by Occupational Therapists where mechanical instruments that use thermal or light based energies and chemical means to re-approximate living tissue in the healing process.

- Occupational Therapists utilize ultrasound to treat joint stiffness, pain and inflammation in an effort to improve anatomical or physiological symptoms that impact an individuals ability to successfully care for themselves, their environment and engage in the roles they value.
- Occupational Therapists utilize therapeutic modalities iontophoresis and phonophoresis to provide pain management in an effort to improve anatomical or physiological symptoms that impact an individuals ability to successfully care for themselves, their environment and engage in the roles they value.
- Certified Occupational Therapy Hand Therapists (CHT) engage in the practice of wound care, wound debridement and suture removal - all of which are within the scope of practice for a CHT and would be significantly impacted by the proposed scope of practice changes regarding the definition of surgery on behalf of the CTACSPA.

Due to the nature of the language in the proposed scope of practice and the imminent impact this could have on the Occupational Therapy profession and recipients of Occupational Therapy services in Connecticut we respectfully request further dialogue with the CTACSPA prior to the proposed scope of practice submission being approved by DPH.

Sincerely,

Judith Sheehan, OTR/L

ConnOTA President

Morgan Villano, MPA/MSPS, OTR/L

ConnOTA Member for Government Affairs

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Pursuant to Public Act 11-209 we are writing to notify you of the positive impact defining surgery as submitted by the CT Chapter of the American College of Surgeons would have on the medical delivery system in Connecticut.
Our organizations support the American College of Surgeons attempt to clarity and codify a standard definition of surgery. We too, believe while there are several places in the Connecticut General Statutes ("CGS") where the word "surgery" is referenced, there is no place where surgery is formally defined. Of great import, the American Medical Association ("AMA") with the approval of various national specialty societies has formally adopted a Definition of Surgery.

We are requesting that the Connecticut General Assembly ("CGA") adopt the same definition in the CGS. All of the information supplied to you by the CT Chapter of the American College of Surgeons is endorsed by these four organizations and should be duplicated and attached to this letter of impact. In closing, all four of these organizations would like to be part of any Definition of Surgery discussions if this issue is considered for the 2017 legislative session.

Please contact Debbie Osborn at 860-459-4377 or by email at debbieosborn36@yahoo.com , if you have any questions about this statement.

Sincerely,

David McCullough, M.D. President CSEP
Ray Winicki, M.D. President CT ENT Society
Frank Castiglione, M.D. President CT Dermatology and Dermatologic Surgery Society
Marlene Murphy-Setzko, M.D. President of CT Urology Society

INTERNATIONAL AESTHETIC & LASER ASSOCIATION

Impact Statement of International Aesthetic & Laser Association in Opposition to the Scope of Practice Request of the Connecticut Chapter of the American College of Surgeons Professional Association, Inc.

This Impact Statement is made by the International Aesthetic & Laser Association ("IALA") in opposition to the Scope of Practice Request ("SOP Request") submitted by the Connecticut Chapter of the American College of Surgeons Professional Association, Inc. ("CTACSPA").

Description of Request:

The CTACSPA requests the adoption of the American Medical Association's definition of the term "surgery." IALA requests that, if a definition of surgery is adopted, the definition be amended to provide unambiguously that cosmetic-type procedures, such as laser treatments including hair, age and sunspot removal, capillary removal, intense pulse light, cell sculpting, and certain injectables, e.g. Botox (collectively, "Cosmetic Procedures"), can be performed by physician assistants ("PAs") and advanced practice registered nurses ("APRNs").

Public Health and Safety Benefits and Risks:

The CTACSPA states that public health and safety will not technically be harmed without implementation. They maintain that a definition of surgery will ensure trained professionals practice to the highest standards and benefit public health and safety. However, unless the definition includes training that is not already included in the education and training of surgeons, educational standards will remain the same as they are currently.

Furthermore, because APRNs and PAs currently perform Cosmetic Procedures (and other procedures, as more fully discussed below), the definition of surgery that the CTACSPA proposes requires an additional statement clarifying that procedures already provided by these mid-level practitioners would not be affected. The CTACSPA definition, without more, is insufficient because it does not take into account the authority these practitioners already have under Connecticut law.

As the CTACSPA notes in the SOP Request, public health and safety will not technically be harmed if the request of CTASPCA is not granted. IALA agrees.

Impact of Request on Public Access to Health Care:

The CTACSPA states that public access to health care will not be impacted by a definition of surgery. IALA does not concur. The proposed definition of surgery will have a negative impact on those who already provide such services. As discussed more fully below, APRNs have already been unambiguously authorized by the Connecticut Board of Examiners for Nursing to provide a number of

Cosmetic Procedures (as well as additional treatments, such as Botox injections and Restyline). Adoption of the CTACSPA's definition of surgery, without any clarification as to how the definition would accommodate the previously-authorized ability of APRNs to perform Cosmetic Procedures, or how the definition would affect how PAs carry out their responsibilities under their delegation agreements, would add uncertainty and confusion to this area of medicine and would negatively impact public access to health care.

Brief Summary of State or Federal Laws Governing the Profession:

The SOP Request clearly outlines the laws governing the profession. IALA is in full support of this.

Current State Regulatory Oversight of the Profession:

The SOP Request outlines the oversight of the profession. IALA is in full support of this.

All Current Education, Training, and Examination Requirements and Any Relevant Certification Requirements Applicable to the Profession:

The SOP Request clearly outlines the aspects of this section in their application. IALA is in full support of this.

Summary of Known Scope of Practice Changes Requested or Enacted Concerning the Profession in the Five Years Preceding the Request:

The SOP Request application clearly outlines the past requests for SOP changes. IALA is in full agreement with this review.

Extent to Which the Request Directly Affects Existing Relationships within the Health Care Delivery System:

The SOP Request completely ignores the scope of practice of other independently licensed practitioners such as APRNs and PAs. The definition of "surgery" includes "structural alteration of the human body by incision or destruction of tissue or the diagnostic or therapeutic treatment of conditions or disease processes using any instrument causing localized alteration or transposition of live human tissue, including, but not limited to, lasers, ultrasound, ionizing radiation, scalpels, probes and needles, used to cut, burn vaporize, freeze, suture, probe, or otherwise alter by mechanical, thermal, light-based, electromagnetic, or chemical means, or manipulation by closed reductions for major dislocations or fractures, or the injection of diagnostic or therapeutic substances into body cavities, internal organs, joints, sensory organs and the central nervous system."

Currently, APRNs perform biopsies, PAP smears, remove warts, debride wounds and countless other procedures that would be affected by this definition. APRNs safely provide these services which do require 'structural alteration of the human body by incision or destruction of tissue or the diagnostic or therapeutic treatment of conditions...' In addition, the CTACSPA acknowledges that the public health will not be harmed without implementation of the definition. However, with implementation of this definition, access to care for many patients will be decreased. If the definition of surgery includes simple procedures that are currently within the scope of practice of APRNs and/or PAs, then many

patients will not have access to those procedures. One important example is women's health for which PAP smears and biopsies would fall under the definition of surgery.

Furthermore, at a minimum, the proposed definition of "surgery" will likely cause confusion for APRNs and PAs who safely perform Cosmetic Procedures to the benefit of patients. Specifically, the Connecticut Board of Examiners for Nursing has already clearly established, in its decision dated May 11, 2005, that APRNs and RNs who have received the appropriate training, demonstrated skill/competency and have resources available to them for consultation and supervision may perform certain treatments, including laser treatments (such as hair, age and sun spot removal, capillary removal and impulse light treatments); collagen injections; facials; and Botox injections and Restyline. Adopting the CTACSPA's proposed definition of "surgery" without clarifying how the definition would relate to the standards already set by the Board would only add confusion and uncertainty to an area that is clear. Since PAs in Connecticut receive even more extensive training than APRNs, it logically follows that PAs should be able to provide the same treatments as APRNs do. Adopting the CTACSPA's definition without clarification would muddy the waters and could, as described elsewhere in this Impact Statement, negatively affect patients' access to these treatments.
Finally, Governor Malloy, in his veto message regarding substitute Senate Bill 1067, An Act Concerning Medical Spa Facilities, himself made clear that, among his reasons for vetoing the bill was his belief that requiring physicians "to perform or supervise and control all cosmetic procedures may unnecessarily limit the scope of practice of Advanced Practice Registered Nurses (APRNs) and other licensed medical professionals."

Anticipated Economic Impact of the Request on the Health Care Delivery System:

The SOP Request states that healthcare costs will not increase due to the request. However, public access to services will decrease due to the broad definition of surgery and the possible limitation on APRNs and PAs delivering services to the extent they currently do so.

Regional and National Trends in Licensing of the Health Profession Making the Request and a Summary of Relevant Scope of Practice Provisions Enacted in Other States:

The SOP Request states that twenty-three states have defined "surgery." They also state that this request will not impact other physicians, but do not consider any other professions who perform minor cutting of live tissue. For example, New Hampshire's definition found in Title XXX, section 329.1 avoids this ambiguity by stating: '"Surgery" means any procedure, including but not limited to laser, in which human tissue is cut, shaped, burned, vaporized, or otherwise structurally altered, except that this section shall not apply to any person to whom authority is given by any other statute to perform acts which might otherwise be deemed the practice of medicine." This definition avoids the ambiguity associated with only referring to physicians.
Similarly, the Illinois regulation addressing the use of light emitting devices makes it clear that the language is not meant to prevent other providers from practicing within their scope. The statute states: "Nothing in this Section shall be deemed or construed to prevent any person licensed in this State under the Illinois Dental Practice Act as a dentist, the Podiatric Medical Practice Act of 1987, the Nurse Practice Act as an advanced practice nurse as specifically authorized by a written collaborative agreement with a physician licensed to practice medicine in all its branches, or the Physician Assistant Practice Act of 1987 as specifically authorized by written guidelines with a physician licensed to practice medicine in all its branches from engaging in the practice for which he or she is licensed." 68 Ill. Admin. Code 1285.336(c).

Clearly, other states have recognized that defining "surgery" can give rise to potential conflict for providers other than physicians and have taken steps to resolve such conflict. Connecticut should do likewise.

Identification of Any Health Care Professions that can Reasonably be Anticipated to be Directly Affected by the Request, the Nature of the Impact, and Efforts Made by the Requestor to Discuss It with Such Health Care Professions:

The SOP Request states that the definition of surgery has been discussed among physicians and surgeons in varied specialties. There is no identified effort to discuss the definition of surgery with non-physician providers, such as APRNs or PAs. The intent may be to protect the public, but in doing so, the public is actually harmed if the proposed definition curtails access to APRNs and PAs.

Description of How the Request Relates to the Health Care Profession's Ability to Practice to the Full Extent of the Profession's Education and Training:

The SOP Request states that the adoption of the definition of surgery would allow them 'to provide quality patient care to the fullest extent of their individual education, training, certification, and licensure.' However, they have also stated that lack of implementation of this definition would not harm the public. IALA maintains that surgeons already work to the fullest extent of their practice and should be providing quality patient care to the fullest extent of their education, training, certification and licensure. In essence, adopting the definition of surgery would not improve practice, but it would decrease public choice of providers and access to non-physician providers who are competent to perform Cosmetic Procedures, biopsies and other minor procedures.

Respectfully submitted,
International Aesthetic & Laser Association

Nicole Strothman

Podiatry position of proposed definition of surgery

Submitted by Joseph Treadwell, DPM

The Connecticut Podiatric Medical Association (CPMA) does not support the definition of surgery as proposed by the CT chapter of the American College of Surgeons Professional Association (CTASCPA).

The proposed definition will not improve the quality of patient care, it will not impact patient treatment outcomes and it will not improve access to care.

Various responses submitted by the CTASCPA to the DPH are inaccurate and misleading and should be reviewed by the committee.

The CTASCPA acknowledges that failure to implement their definition of surgery will not harm public health and safety.

The CTASCPA in their initial proposal desired to attach the definition of surgery to MD and DO providers as cited in section **(10) regional and national trends in licensing of the health profession making the request and a summary of relevant scope of practice provisions enacted in other states;**

"As proposed, the Definition of Surgery applies to all Doctors of Medicine (M.D.) and Doctors of Osteopathic Medicine (D.O.) who are already licensed by the state of Connecticut to perform surgery as the practice of medicine."

This stipulation regardless of current statutes has the potential to have a negative impact on non-physician providers, specifically podiatrists, not only from insurance payors but also creating confusion and biasing public perception.

During the November 22nd, 2016 meeting the CTASCPA stated their intent is not to impact any scope of practice now or in the future or any non-physician provider.

While the CPMA does not support this definition moving forward, if the DPH does present language to the legislature we would like to see the definition of surgery preceded directly by some language communicating the following concept:

> Surgery, as defined below, can be performed by physician and non-physician providers licensed by the Department of Public Health.

In the absence of the CTASCPA proving any benefit from adopting this definition, the potential negative impact on any non-physician provider group should warrant refusal of passage at the legislative level.

Impact Statement for the Connecticut Advanced Practice Registered Nurse Society (CTAPRN Society) regarding the Definition of Surgery Scope of Practice Request

1. Plain Language Description of the Request:

The Connecticut Chapter of the American College of Surgeons Professional Association, Inc. (CTACSPA) has submitted a scope of practice request to define surgery. This request defines surgery in very broad terms to reflect any alteration of tissue for both diagnostic or therapeutic purposes. This definition of surgery would limit procedures routinely performed by non-physician health care providers including APRNs. Some of those procedures which are commonly performed include wound debridement, joint injections, and skin tag removal. The CT APRN Society does not agree with the scope of practice change as requested.

2. Public Health and Safety Benefits and Risks

The intent of this request is to clarify surgery for the public. However, the definition of surgery to include alteration of tissue applies broadly to many professions. The proposed definition would confuse the public by making it more difficult for them to understand which health care providers can given them the services that they need.

3. Impact on Public Access to Health Care:

The CTACSPA states that defining surgery will not impact access to care, but improve the quality of care. However, the proposed definition would prevent non-physician health care providers from performing common procedures including skin biopsies, joint injections, colposcopies, wound debridement and wound care. The public would have decreased access to many services that they currently receive from non-physician providers.

4. Brief Summary of State or Federal Laws Governing the Profession:

The CT APRN Society concurs with the review of the State or Federal laws governing physicians.

5. Current State Regulatory Oversight of the Profession:

The CT APRN Society concurs with the review of State regulatory oversight of physicians.

6. All Current Education, Training, and Examination Requirements and Any Relevant Certification Requirements Applicable to the Profession:

The CT APRN Society concurs with the review of education, training and examination requirements for physicians.

7. Summary of Known Scope of Practice Changes Requested or Enacted Concerning the Profession in the Five Years Preceding the Request:

The CTACSPA submitted the same scope of practice request for the definition of surgery in 2015 as well.

8. Extent to Which the Request Directly Affects Existing Relationships within the Health Care Delivery System:

The broad definition of surgery will impact the procedures performed by health professions other than surgeons. Nurses and nurse practitioners (NPs) may be certified to debride wounds in order to promote healing. NPs perform simple biopsies, colposcopies and other procedures that alter tissue. This definition includes more than the surgical procedures commonly thought of as "surgery" that only surgeons are qualified to perform. Common office procedures will be considered "surgery" by this definition, and therefore not able to be performed by health care providers that aren't surgeons.

9. Anticipated Economic Impact of the Request on the Health Care Delivery System:

Health care costs will increase dramatically if only surgeons are able to perform common, office procedures rather than health care professionals, such as nurses and nurse practitioners.

10. Regional and National Trends in Licensing of the Health Profession Making the Request and a Summary of Relevant Scope of Practice Provisions Enacted in Other States

There are trends to define surgery in other states in the country. In New England, only Rhode Island and Vermont have defined surgery. However, CTACSPA limits the ability to perform surgical procedures (defined as altering tissue) to physicians and physician delegated practitioners. Nurse practitioners are independently licensed and, after two years and 2000 hours of practice, may practice without a collaborative agreement with a physician. Therefore, this scope of practice request will, in reality, limit the scope of practice for at least one other health care profession.

11. Identification of Any Health Care Professions that can Reasonably be Anticipated to be Directly Affected by the Request, the Nature of the Impact, and Efforts Made by the Requestor to Discuss It with Such Health Care Professions

CTACSPA discusses the developments within the physician profession that brought about this definition of surgery. They held one meeting in 2015 regarding the definition of surgery that included CT APRN Society. However, the CTACSPA was unable to provide any examples how

not having surgery defined impacted public health or resulted in other providers working outside of their training.

12. Description of How the Request Relates to the Health Care Profession's Ability to Practice to the Full Extent of the Profession's Education and Training:

The scope of practice request does not limit or extend practice for surgeons. Surgeons currently can practice to the fullest extent of their education and training. The scope of practice request does attempt to limit procedures performed by other trained health care providers, thereby limiting their scopes of practice.

Respectfully submitted by
Christina Morrissey DNP NP-C FNP
CT APRN Society
Health Policy Committee Co-Chair

Division of Health Sciences

David M. Brady, ND, DC, CCN, DACBN
Vice President for Health Sciences

Date: November 28, 2016

To: Connecticut Department of Public Health

RE: Definition of Surgery Impact Statement

Dear DPH Representatives and Committee Members:

The following represents the concerns of the University of Bridgeport, Division of Health Sciences regarding the proposed Definition of Surgery.

After review of the submitted proposal, and through discussions at the initial committee meeting on the issue, we simply see no compelling reasons why this definition, or any other, should be placed in statute. It does not provide any greater measure of public safety and does not remove any identifiable threat to patients, as is reflected by the lack of any known adverse events attributed to the current state of the statues which have been in-effect for many years.

Of considerable concern is the potential for unforeseen or unintended negative consequences to one or more of the various allied health professions licensed to practice under their current scope in the State. Such negative consequences may emerge related to how any new definition may be used by third-party payers as a mechanism to deny claims from non-MD/DO providers for services currently being provided them and reimbursed for. We are also very concerned that this definition attempt is actually part of a national campaign and strategy by organized political medicine to find an alternate mechanisms to essentially freeze in-place the current scope of practice of non-MD/DO providers. Why such worry you may ask? Well, primarily because the medical associations and organizations have stated as much in their own internal documents. Two examples are provided below:

From the document, State of the states: Defining surgery (American College of Surgeons-2012) the following quote can be found; "… *considerable attention and many advocacy efforts are being directed toward defeating legislation that expands non-surgeon health care practitioners' scope of practice.*"

From the document, Physicians Foundation Accept No Substitute. A Report on Scope of Practice 2012 (AMA House of Delegates) provides a roadmap for state medical associations to oppose licensure expansion across the country at all cost for all non-MD/DO providers. Quoting from this document, "… *there has been a lack of hard evidence that physicians do in fact provide higher quality care than non-physician providers*" while also stating that efforts to squelch scope of practice expansion should focus solely and relentlessly on patient safety. It is clear from the initial committee meeting that ACS and the CSMS is following the script and trying to use patient safety to push this effort, while not being able to point to one patient safety issue that has occurred.

Division of Health Sciences

David M. Brady, ND, DC, CCN, DACBN
Vice President for Health Sciences

Below please see a directly copied excerpt from the document Physicians Foundation Accept No Substitute. A Report on Scope of Practice 2012 (AMA House of Delegates)

> ***The evidence gap***
>
> Finally, one other key "driving force" behind the recent scope of practice expansions has been the lack of evidence that physicians provide higher quality care than non-physician providers. A number of the state medical society executives we spoke with expressed concern that they had very little hard data and few, if any, empirical studies with which to refute the growing body of research presented by non-physicians and their advocates—research that tends to show that their clinical outcomes are at least as good as those of physicians. Among the executives' comments:
>
> - "I don't think we can hold back scope of practice much longer without data. If there's no data, we're on thin ice."
> - "The CRNAs have data [showing favorable outcomes], but we don't have any data showing that physician outcomes are better."
> - "We don't have a strong policy argument [against allowing optometrists to prescribe oral medications] because we don't have any data showing that there's a problem in the other 46 states that *allow* prescriptions."
> - "We just don't have the outcome data."
> - "The doctors tell me anecdotally that they see a lot of patients from the [nurse-run] clinics with adverse outcomes, but there's no systematic data."

Finally, the definition that has been proposed is extremely broad and subjective and can be interpreted and twisted in many directions going forward. The definition as proposed, for instance, could be used to argue that doctors of chiropractic could not do spinal manipulation or apply laser or ultrasound therapy, that acupuncturists could not insert needles or use moxibustion, that a naturopathic physician could not use infrared sauna therapy, or that a physician assistant or APRN could not assist in many aspects of in-office and in-patient surgical and non-surgical procedures that they now engage in safely. The potential scenarios by which this proposed definition could potentially negatively affect a long list of perfectly qualified health care providers from doing what they have been trained to do, and from providing therapies which they currently provide safely every day, is endless and too long to try and list.

For all of these reasons, and more, we respectfully and strongly encourage the Department of Public Health to not adopt this, or any other new formal definition of surgery.

Division of Health Sciences

David M. Brady, ND, DC, CCN, DACBN
Vice President for Health Sciences

Sincerely,

David M. Brady, ND, DC, CCN, DACBN
Vice President for Health Sciences
Director, Human Nutrition Institute
Associate Professor of Clinical Sciences
University of Bridgeport

AMERICAN SOCIETY OF PLASTIC SURGEONS ®
THE PLASTIC SURGERY FOUNDATION ®

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December 5, 2016

Karen G. Wilson, HPA
Practitioner Licensing and Investigations Section
Connecticut Department of Public Health
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Hartford, CT 06134

Dear Ms. Wilson:

In advance of the 2016 Connecticut legislative session, the American Society of Plastic Surgeons (ASPS) submitted an impact statement as part of the Connecticut Department of Public Health's (Department) Scope of Practice Review related to the definition of surgery, as requested by the Connecticut Chapter of the American College of Surgeons Professional Association (ACS) in August of 2015. ASPS understands that the ACS re-requested the review of the definition of surgery for the 2017 Connecticut legislative session, and that the period for formally submitting impact statements is currently closed. However, immediately below please find ASPS's 2015 impact statement that reflects our organizations positions on this issue. Additionally, we look forward to the report that the Department is authoring on this topic.

Over the years, Connecticut has experienced ongoing changes to numerous medical scopes of practice and the American Society of Plastic Surgeons strongly believes that the scope and definition of surgery must be evaluated and codified in a manner that ensures the practice of surgery is limited to trained surgeons. Founded in 1931, ASPS is the largest association of plastic surgeons in the world, representing more than 7,000 members and 94 percent of all American Board of Plastic Surgery board-certified plastic surgeons in the United States. Because ASPS's mission includes advancing the highest standards of training, ethics and physician practice, we believe that a specified definition of surgery will be beneficial to all providers and patients, increasing the level of care and patient safety provided to the people of Connecticut.

Per your request, below please find responses to your specified questions regarding the impact of defining surgery in Connecticut:

1) A plain language description of the request:
   On August 17, 2015, [*and again on August 9, 2016*] the Connecticut Chapter of the American College of Surgeons Professional Association requested that the Department review and recommend a definition of surgery to the Connecticut General Assembly so that the Assembly may take this definition under consideration for adoption within the Connecticut General Statues. The American Society of Plastic Surgeons supports this request, urges the Department

to move forward with this review, and recommends that the American Medical Association's definition of surgery, widely accepted by organized medical specialty organizations and detailed below, be adopted.

2) Public health and safety benefits that the requestor believes will occur if the request is implemented and, if applicable, a description of any harm to public health and safety if it is not implemented:

While "surgery" is referenced through the Connecticut General Statutes, the term has never been formally defined by the legislature or the Department. This can cause confusion among patients, providers and legislators as issues arise. The creation of a clear definition of surgery will remove any future misunderstandings or varying interpretations of this term.

The American Medical Association adopted the following definition of surgery, which the American Society of Plastic Surgeons fully supports and encourages the Department to adopt in the course of this scope of practice review and advance to the Assembly for adoption:

> *Surgery is performed for the purpose of structurally altering the human body by the incision or destruction of tissues and is part of the practice of medicine. Surgery also is the diagnostic or therapeutic treatment of conditions or disease processes by any instruments causing localized alteration or transposition of live human tissue which include lasers, ultrasound, ionizing radiation, scalpels, probes, and needles. The tissue can be cut, burned, vaporized, frozen, sutured, probed, or manipulated by closed reductions for major dislocations or fractures, or otherwise altered by mechanical, thermal, light-based, electromagnetic, or chemical means. Injection of diagnostic or therapeutic substances into body cavities, internal organs, joints, sensory organs, and the central nervous system also is considered to be surgery (this does not include the administration by nursing personnel of some injections, subcutaneous, intramuscular, and intravenous, when ordered by a physician). All of these surgical procedures are invasive, including those that are performed with lasers, and the risks of any surgical procedure are not eliminated by using a light knife or laser in place of a metal knife, or scalpel.*
>
> *Patient safety and quality of care are paramount and, therefore, patients should be assured that individuals who perform these types of surgery are licensed physicians (defined as doctors of medicine or osteopathy) who meet appropriate professional standards. (Res. 212; A-07; Reaffirmed: BOT Rep. 16, A-13)*

This definition will ensure that all providers are held to the same, high standards and that patients are served by trained professionals who do not practice outside of a scope of practice appropriate for their training. The ambiguity that currently exists in Connecticut does not support efforts to prevent unqualified, untrained providers from performing certain surgical procedures. A clear definition of surgery will remove any uncertainty that currently exists, while improving patient safety and the level of care provided to patients throughout your state.

3) The impact of the request on public access to health care:

By adopting a clear definition of surgery, public access to health services will remain the same, but patient safety and quality of care will be positively impacted. The American Society of Plastic Surgeons is committed to the highest quality of care and practice standards. So, for ASPS this is

not simply a question of access to care. Instead, it is also a question of access to high-quality care.

4) A brief summary of state or federal laws governing the profession:

Physicians are currently regulated by both government and non-government bodies, all working to ensure that safety and training standards are maintained and that patients are provided with the best quality of care. Members of the American Society of Plastic Surgeons must:

- Complete at least five years of surgical training with a minimum of two years in plastic surgery
- Be trained and experienced in all plastic surgery procedures, including breast, body, face and reconstruction
- Operate only in accredited medical facilities
- Adhere to a strict code of ethics
- Fulfill continuing medical education requirements, including standards and innovations in patient safety
- Be board certified by The American Board of Plastic Surgery or in Canada by the Royal College of Physicians and Surgeons of Canada®

ASPS members in Connecticut must also abide by the high standards set in place by 1) the accredited medical facilities (hospitals, ambulatory surgery centers, etc.) where they perform procedures, 2) The American Board of Plastic Surgery, 3) the Accreditation Council for Graduate Medical Education (ACGME), 4) The American Board of Medical Specialties, 5) the Centers for Medicare & Medicaid Services, and 6) the Connecticut Medical Examining Board. Furthermore, the Connecticut General Statutes, Chapter 379, licenses and regulates physicians in the state. These provisions outline requirements for licensure and continuing medical education. The statue provides additional levels of oversight by requiring physicians who practice office based surgery to obtain both a Certificate of Need and a license from the Department of Public Health.

5) The state's current regulatory oversight of the profession:

Physicians in Connecticut are overseen by the Department of Public Health, as well as the Department of Consumer Protection (if prescribing).

6) All current education, training, and examination requirements and any relevant certification requirements applicable to the profession:

Education and Training

The Accreditation Council of Graduate Medical Education (ACGME), an independent, non-governmental accreditation body for graduate and medical education, recognizes two training models for plastic surgery. Both the independent and the integrated model require a minimum of six years of clinical surgery education in which a minimum of three years are concentrated in plastic surgery education. Through the independent model, residents complete their prerequisite training outside of the plastic surgery residency process in a surgical program accredited by the ACGME, the Royal College of Physicians and Surgeons of Canada, or the American Dental Association. Residents complete core surgical training and the plastic surgery specific training under the authority and direction of the plastic surgery program director. In the

integrated model, residents complete six years of ACGME-accredited plastic surgery training following receipt of an M.D. or D.O. degree from an institution accredited by the Liaison Committee on Medical Education or the American Osteopathic Association.

Fellowships
Fellowships in plastic surgery offer the surgeon an opportunity to pursue additional experiences in the basic science and clinical practice of plastic surgery. These fellowships cover a wide variety of topical areas and – except for hand surgery – are not required to follow any generally recognized format or any approved curriculum. Fellowship training experiences can be of variable lengths, ranging from three to twelve months in duration, and may take place in either an institutional setting or with an individual preceptor.

Continuing Medical Education
ASPS members must earn 150 credits of Continuing Medical Education during a consecutive three-year period. Of these 150 credits, no fewer than 60 must be AMA PRA Category 1 Credits and 50 credits must be earned in patient safety related topics and may be either Category 1 or Category 2.

The American Board of Plastic Surgery
An important qualifier for granting plastic surgery privileges is that the surgeon is certified by the American Board of Plastic Surgery (ABPS) or admissible to the ABPS examination process. ABPS is one of only 24 accredited specialty boards recognized by the American Board of Medical Specialties (ABMS). ABMS certification includes initial specialty certification and maintenance of certification through the physician's career, which are intended to provide assurance to the public that the physician specialist certified by a member board of ABMS (i.e. ABPS) has successfully complete an approved educational program and evaluation process which includes components designed to assess the physician's medical knowledge, clinical judgment, professionalism and communication skills required to provide quality patient care in that specialty.

Maintenance of Certification in Plastic Surgery
The key components of the Maintenance of Certification in Plastic Surgery (MOC-PS) Program include documented professionalism, lifelong learning, cognitive evaluation, and practice assessment and continual improvement. Lifelong learning is achieved through participation in CME activities throughout the 10-year cycle. Professionalism evaluations and Practice assessment and improvement are performed every three years. A sub-specialty exam is completed at the end of the cycle.

7) A summary of known scope of practice changes requested or enacted concerning the profession in the five years preceding the request:
There have been no requests by the American Society of Plastic Surgeons to alter the scope of practice of physicians in Connecticut.

8) The extent to which the request directly affects existing relationships within the health care delivery system:

ASPS believes that a clearly defined definition of surgery will maintain, if not improve, current relationships within the health care delivery system. As proposed by the American College of Surgeons, the definition of surgery will apply to all M.D. and D.O.s who are currently licensed by the state to perform surgery as a practice of medicine. The definition should not negatively impact other physicians in the state as they are not licensed to perform surgery under their current scope. Other health care providers who practice under physician supervision will not be impacted by this definition.

A definition of surgery will allow for future scope of practice questions to be definitively answered, thus removing any potential conflicts between providers. By accepting the nationally approved standards set forth by the American Medical Association, all providers will have clear guidance regarding their surgical scope.

9) The anticipated economic impact of the request on the health care delivery system:
ASPS supports the findings of the American College of Surgeon's NSQIP risk-adjustment quality database tool, which indicates that the quality of health care will improve, the number of errors will be reduced, and that, over time, meaningful cost savings will be achieved by adopting a definition of surgery.

10) Regional and national trends in licensing of the health profession making the request and a summary of relevant scope of practice provisions enacted in other states:
Twenty-three states have defined surgery through statue or regulation, including:

Alabama	Maine	Ohio
Arizona	Maryland	Pennsylvania
Arkansas	Minnesota	Rhode Island
Florida	Mississippi	Virginia
Illinois	Montana	West Virginia
Indiana	Nevada	Wisconsin
Kansas	New Hampshire	Wyoming
Louisiana	New Jersey	

11) Identification of any health care professions that can reasonably be anticipated to be directly affected by the request, the nature of the impact, and efforts made by the requestor to discuss it with such health care professions:
The American Society of Plastic Surgeons has participated in a task force created by the American College of Surgeons to further examine their statement on the use of laser surgery. The American Academy of Ophthalmology, American Academy of Otolaryngology-Head and Neck Surgery, and the American Academy of Facial Plastic and Reconstructive Surgeons all participated in this task force. The group collectively agreed to revisions of the original statement, which was later brought before and approved by the American Medical Association House of Delegates as a formal definition of surgery. The House of Delegates is the principal policy-making body of the American Medical Association, which is comprised of individuals from all fifty states, US territories, federal departments, national medical specialty societies and other professional interest. As this definition was widely adopted by major stakeholders in physician medical care, we do not foresee future conflicts within this group.

12) A description of how the request relates to the health care profession's ability to practice to the full extent of the profession's education and training:

As previously described in Question 6, ASPS physician members are highly qualified, highly educated and highly trained individuals. The American Society of Plastic Surgeons fully supports defining surgery as it will remove all ambiguity regarding the necessary qualifications to perform surgical procedures in the state of Connecticut. By removing this uncertainty, patients throughout the state will be better served by trained and qualified medical professionals.

Thank you for your consideration of our comments. If you have any questions or need further assistance, please feel free to contact Patrick Hermes, Senior Manager of Advocacy and Government Affairs at phermes@plasticsurgery.org.

Sincerely,

Debra Johnson, MD
President, American Society of Plastic Surgeons

Appendix E

Response to Impact Statements

American College of Surgeons
Inspiring Quality:
Highest Standards, Better Outcomes

Connecticut Chapter
of the American College of Surgeons
Professional Association, Inc.

17 October 2016

Connecticut Association of Nurse Anesthetists
Donna Sanchez, MS, CRNA, APRN

Dear Ms. Sanchez,

The Connecticut Chapter of the American College of Surgeons Professional Association, Inc. submits this response to your letter with respect to our proposal to define surgery based upon the American Medical Association adopted Definition of Surgery, as authored by the American College of Surgeons in the Connecticut General Statutes.

Our objective in proposing to codify the American Medical Association's House of Delegates approved Definition of Surgery is to provide the State of Connecticut with a clear and accurate understanding of what medical treatment is and is not considered to be surgery.

Our proposal is guided by the following parameters:

- The proposed Definition of Surgery limit surgery to physicians, dentists and podiatrists licensed by the Board of Medicine or Board of Dentistry.
- No other board or agency should regulate performance of surgery.
- The definition should not limit currently allowed or legal procedures performed by allied health professions.
- It should not limit or attempt to define procedures performed by different physicians practicing within their professionally accepted scope.

In December, 2015, we convened a meeting of many stakeholders that might be impacted by this proposal. Based on feedback from the meeting we made meaningful changes to the language of the current proposed definition.

The delivery of healthcare is changing rapidly in Connecticut. APRNs successfully used the legislative process to gain a significant expansion in their scope of practice. Concurrent with our submission this year, the Physicians Assistants' have submitted a proposal to significantly expand their scope. While disagreements may exist amongst physicians and healthcare professionals about these proposals I firmly believe that we are all agreement that patient safety is our primary and most important concern. In addition, I believe that we all want patients to have a simple and transparent understanding of the individual roles we play in the continuum of care.

As we have stated in our proposal, in public testimony and reiterated in this letter, our intent is not to change or limit any existing scope nor prevent any professional from performing to the maximum extent of their scope. Our goal is to clarify what we believe to be a meaningful issue in our statutes, namely the lack of a clear definition of a term that appears over 175 times, "surgery".

We respect the care that nurse anesthetists provide for patients however based on your impact statement, we do not fully understand how the work you perform will be limited by the proposed definition of surgery. Our intention is and always has been not to limit or restrict any care that is currently provided under your scope of practice.

We look forward to your productive participation on a committee, should one be formed.

Sincerely,

KLaVorgna MD

Kathleen LaVorgna, MD, FACS
Vice President, Legislative

cc: Karen Wilson, HPA, CT Department of Public Health

American College of Surgeons
Inspiring Quality:
Highest Standards, Better Outcomes

Connecticut Chapter
of the American College of Surgeons
Professional Association, Inc.

17 October 2016

Connecticut Advanced Practice Registered Nurse Society
Christine Morrissey, DNP, NP-C, FNP

Dear Ms. Morrissey,

The Connecticut Chapter of the American College of Surgeons Professional Association, Inc. submits this response to your letter with respect to our proposal to define surgery based upon the American Medical Association adopted Definition of Surgery, as authored by the American College of Surgeons in the Connecticut General Statutes.

Our objective in proposing to codify the American Medical Association's House of Delegates approved Definition of Surgery is to provide the State of Connecticut with a clear and accurate understanding of what medical treatment is and is not considered to be surgery.

Our proposal is guided by the following parameters:

- The proposed Definition of Surgery limit surgery to physicians, dentists and podiatrists licensed by the Board of Medicine or Board of Dentistry.
- No other board or agency should regulate performance of surgery.
- The definition should not limit currently allowed or legal procedures performed by allied health professions.
- It should not limit or attempt to define procedures performed by different physicians practicing within their professionally accepted scope.

In 2013. In December, 2015, we convened a meeting of many stakeholders that might be impacted by this proposal. Based on feedback from the meeting we made meaningful changes to the language of the current proposed definition.

The delivery of healthcare is changing rapidly in Connecticut. APRNs successfully used the legislative process to gain a significant expansion in its scope of practice. Concurrent with our submission this year, the Physicians Assistants' have submitted a proposal to significantly expand their scope. While disagreements may exist amongst physicians and healthcare professionals about these proposals I firmly believe that we are all agreement that patient safety is our primary and most important concern. In addition, I believe that we all want patients to have a simple and transparent understanding of the individual roles we play in the continuum of care.

As we have stated in our proposal, in public testimony and reiterated in this letter, our intent is not to change or limit any existing scope nor prevent any professional from performing to the maximum extent of their scope. Our goal is to clarify what we believe to be a meaningful issue in our statutes, namely the lack of a clear definition of a term that appears over 175 times, "surgery".

We respect the care that you provide and look forward to your productive participation on a committee, should one be formed.

Sincerely,

KLaVorgna MD

Kathleen LaVorgna, MD, FACS
Vice President, Legislative

cc: Karen Wilson, HPA, CT Department of Public Health

AMERICAN COLLEGE OF SURGEONS
Inspiring Quality:
Highest Standards, Better Outcomes

CONNECTICUT CHAPTER
of the American College of Surgeons
Professional Association, Inc.

17 October 2016

Brian T. Lynch, O.D., Legislative Chair
Connecticut Association of Optometrists
35 Cold Spring Road
Suite 211
Rocky Hill, CT 06067

Dear Dr. Lynch,

The Connecticut Chapter of the American College of Surgeons Professional Association, Inc. submits this response to your letter with respect to our proposal to define surgery based upon the American Medical Association adopted Definition of Surgery, as authored by the American College of Surgeons in the Connecticut General Statutes.

Our objective in proposing to codify the American Medical Association's House of Delegates approved Definition of Surgery is to provide the State of Connecticut with a clear and accurate understanding of what medical treatment is and is not considered to be surgery.

Our proposal is guided by the following principles:

- The proposed Definition of Surgery limits surgery to physicians, dentists and podiatrists regulated by the Boards of Medicine, Dentistry, and Podiatry in accordance with current Connecticut statute.
- No other boards or agencies should regulate the performance of surgery.
- The Definition of Surgery should not limit those procedures performed by the allied health professions that are currently allowed by statute.
- It should not limit or attempt to define procedures performed by different physicians practicing within their professionally accepted scope.

We disagree with the arguments that you proposed and will allow the Department of Public Health to opine on the issues you raised. However, we do agree with your statement that ultimately the Connecticut General Assembly will be required to pass legislation regarding the issue. PA 11-209 was passed by the General assembly as a means for a comprehensive and collegial review of objective and concrete proposals that impact scopes of practice prior to legislative debate. Our complete and appropriate proposal allows that opportunity.

However, based on information you provided regarding the existing scope of practice for optometrists, we offer that none of the procedures involves incision or injection.

Therefore, based on the concerns expressed in your letter we find no basis for your objection to our proposal. Our submission is complete and the Definition of Surgery we are proposing is clear and concise. It does not impact the practice of optometry. The Commissioner of the Department of Public Health and the Public Health Committee have endorsed the scope committee hearings

and have specifically asked that this scope request be resubmitted to examine the issues before they are brought before the state legislature.

Scope expansion or even the re-interpretation of scope already defined in statute has significant impact on the public. It deserves the full light of day whenever it has the potential to change the way that health care providers deliver care. The needs of the citizens of this state are best served when changes in scope are thoroughly vetted through processes that are open, accessible and transparent. That was the goal of the legislature when they created Public Act 11-209; that was our goal in 2012 when we first asked for a scope committee, and that is our goal now.

A definition of surgery has been statutorily established in 23 other states and functions to reduce confusion, conflict and the enmity that can occur when disputes arise over issues of scope. When everybody is on the same page disagreements are much less likely to occur. Although we fail to see any possible negative impact that a clear, statutory definition of surgery would have on optometrists practicing within their current scope in Connecticut, we recognize your concern, and in the spirit of openness and transparency invite you to participate in this scope expansion committee hearing, should it be granted by the state of Connecticut.

Sincerely,

Kathleen LaVorgna, MD, FACS
Vice President, Legislative

cc: Karen Wilson, HPA, CT Department of Public Health

AMERICAN COLLEGE OF SURGEONS
Inspiring Quality:
Highest Standards, Better Outcomes

CONNECTICUT CHAPTER
of the American College of Surgeons
Professional Association, Inc.

19 October 2016

Karen Buckley
Vice President, Advocacy
Connecticut Hospital Association
110 Barnes Road
PO Box 90
Wallingford, CT 06492-0090

Dear Ms. Buckley:

The Connecticut Chapter of the American College of Surgeons Professional Association, Inc. submits this response to your letter with respect to our proposal to define surgery based upon the American Medical Association adopted Definition of Surgery, as authored by the American College of Surgeons in the Connecticut General Statutes.

Our objective in proposing to codify the American Medical Association's House of Delegates approved Definition of Surgery is to provide the State of Connecticut with a clear and accurate understanding of what medical treatment is and is not considered to be surgery.

Our proposal is guided by the following principles:

- The proposed Definition of Surgery limits surgery to physicians, dentists and podiatrists regulated by the Boards of Medicine, Dentistry, and Podiatry in accordance with current Connecticut statute.
- No other boards or agencies should regulate the performance of surgery.
- The Definition of Surgery should not limit those procedures performed by the allied health professions that are currently allowed by statute.
- It should not limit or attempt to define procedures performed by different physicians practicing within their professionally accepted scope.

In your impact statement you indicate that *"A change to the definition of surgery along the lines suggested in the proponent's filing would cause a significant, if not extreme, shift in the healthcare delivery system in Connecticut, and potentially across the region. It would drastically affect all hospital and outpatient surgical facility personnel and staff. More importantly, patients and the community would be substantially affected."* We note that this definition has already been adopted over 23 other states and, to our knowledge, it has caused no disruption or meaningful change to the delivery of care in those states nor their regions.

Your letter does not cite any specific impact or harm that would be caused by this proposal. Instead, it suggests extremely broad and unlikely consequences that we believe, by their own nature, dramatically reduce the relevance of your impact statement. We believe that the purpose of this phase of the process is to highlight how proposals would specifically impact healthcare practitioners in Connecticut. We are unclear from your letter how our proposal specifically impacts your members, however we do believe that codifying the definition of surgery will have a positive impact on the safety of the patients for whom we all care.

As such, we find no merit to your concerns and ask that if a committee is convened that DPH not include you as you have not set forth a cogent nor specific manner in which our proposal would impact any specific practitioners or the health care delivery system in Connecticut.

Sincerely,

Sincerely,

LaVorgna MD

Kathleen LaVorgna, MD, FACS
Vice President, Legislative

cc: Karen Wilson, HPA, CT Department of Public Health

Appendix F

State of the States: Defining Surgery, American College of Surgeons, 2012

State of the states: Defining surgery

By **Charlotte Grill**
PUBLISHED May 1, 2012

The state legislatures started their sessions in early January and are now considering thousands of bills that could impact patients, physicians, nonphysician health care providers, and virtually the entire health care system. Generally speaking, the American College of Surgeons (ACS) State Affairs area of the Division of Advocacy and Health Policy monitors and tracks more than 1,000 pieces of state legislation per year, with a focus on four main issues:

- Medical liability reform, including caps on noneconomic damages, alternative dispute resolution, expert witness qualifications, standards of evidence, statute of limitations, and so on
- Quality/patient safety, which includes scope of practice and injury prevention issues
- Workforce/surgical practice, including the Uniform Emergency Volunteer Health Practitioners Act (UEVHPA) model and trauma system funding and development
- Physician payment, including provider taxes

Of these four areas, considerable attention and many advocacy efforts are being directed toward defeating legislation that expands nonsurgeon health care practitioners' scope of practice. Working in collaboration with a larger coalition of state medical societies and national surgical specialty societies is essential to ensure that health care professionals performing surgical procedures have the proper education, licensing, and training to do so.

It has become an all-too-common occurrence in state legislatures for one group of licensed health care professionals to seek modifications in their licensing acts in an effort to expand their scope of practice. Additional practice privileges may be reasonable in some cases if the health care professionals have the education, training, and experience necessary to gain these privileges. However, more frequently, these practitioners do not have the necessary medical/surgical training and experience that surgeons receive during medical school, residency training, and specialty fellowships. Patient safety and quality care are of vital importance in the debate over whether legislators should broaden scope of practice, especially when that expansion includes performing surgery.

Definition of surgery

A statutory definition of surgery at the state level can help to limit nonphysicians' attempts to expand their scope into the performance of surgery. To this end, the College collaborated with a number of surgical specialty societies to enhance an existing ACS statement on laser surgery to include a definition of surgery. As described in ST-11, Statement on Surgery Using Lasers, Pulsed Light, Radiofrequency Devices, or Other Techniques, the College's definition of surgery is as follows:

Surgery is performed for the purpose of structurally altering the human body by incision or destruction of tissues and is part of the practice of medicine. Surgery also is the diagnostic or therapeutic treatment of conditions or disease processes by any instruments causing localized alteration or transportation of live human tissue, which include lasers, ultrasound, ionizing, radiation, scalpels, probes, and needles. The tissue can be cut, burned, vaporized, frozen, sutured, probed, or manipulated by closed reduction for major dislocations and fractures, or otherwise altered by any mechanical, thermal, light-based, electromagnetic, or chemical means. Injection of diagnostic or therapeutic substances into body cavities, internal organs, joints, sensory organs, and the central nervous system is also considered to be surgery (this does not include administration by nursing personnel of some injections, such as subcutaneous, intramuscular, and intravenous when ordered by a physician). All of these surgical procedures are invasive, including those that are performed with lasers, and

the risks of any surgical intervention are not eliminated by using a light knife or laser in place of a metal knife or scalpel. Patient safety and quality of care are paramount, and the College therefore believes that patients should be assured that individuals who perform these types of surgery are licensed physicians (defined as doctors of medicine or osteopathy) who meet appropriate professional standards.

Following the College's adoption of ST-11—which was revised in April 2007—a resolution was introduced in the American Medical Association (AMA) House of Delegates (HOD) calling on the AMA to adopt the definition of surgery as created by the College. After considerable and thoughtful discussion, the HOD adopted this definition as stated in ST-11, providing uniformity within the house of medicine and surgery.

To see the full statement, go to **http://www.facs.org/fellows_info/statements/st-11.html**.

Status of related legislation

Proponents of legislation that establishes a definition of surgery have a lot of work to do on the state level because the majority of states do not have a regulatory definition of surgery in place. Of the 50 states, only 25 have defined surgery in laws or regulations. Ten of those states have definitions that include a form of the word "incision" (Alabama, Arkansas, Arizona, Florida, Indiana, Kansas, Louisiana, Maine, Ohio, Rhode Island). Nine states included "diagnosis" as a part of the definition of surgery, which closely mirrors the ACS statement (Arizona, Kansas, Maryland, Mississippi, Nevada, Ohio, Pennsylvania, West Virginia, Wisconsin). Three states specifically define surgery to start at the point of incision and end at the close of the incision or when all operative devices have been removed (Indiana, Maine, New Jersey). Other states specifically define types of surgeries, such as elective, cosmetic, minor, major, or ophthalmic surgery.

AMA definitions to consider

As noted earlier, the AMA adopted the College's definition of surgery and specifically references ST-11 in their policy. Although this definition is broader in scope, it may not always be feasible to enact such a definition the first time related legislation is considered. In fact, some states start with a definition of cosmetic or reconstructive surgery to protect patients undergoing those specific types of surgical procedures from receiving care from other health care providers. The AMA HOD passed two policies regarding cosmetic and reconstructive surgery that would be important to consider and incorporate if this type of legislation is being pursued at the state level, and they are as follows:

- *Cosmetic Surgery (H-475.992)*. This surgery is performed to reshape normal structures of the body in order to improve the patient's appearance and self-esteem. Reconstructive surgery is performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease. It is generally performed to improve function, but may also be done to approximate a normal appearance. This statement can be viewed on the AMA website.
- *Laser Surgery (H-475.988)*. The AMA supports the position that revision, destruction, incision, or other structural alteration of human tissue using a laser is surgery. This statement can be viewed on the AMA website.

2012 legislation

The ACS—along with the AMA Scope of Practice Partnership and other key state stakeholders—are currently tracking a number of bills that have been introduced during the 2012 session that address and define surgery in some capacity. These bills are as follows:

- *Pennsylvania bill, HB 838*. This legislation amends the bill known as the Optometric Practice and Licensure Act and defines optometry and ophthalmic surgery while clearly prohibiting optometrists from performing ophthalmic surgery. The AMA Scope of Practice Partnership is working with the

Pennsylvania Medical Society in the efforts to get this bill passed. It passed through the House in June 2011, and at press time was awaiting a vote in the Senate Consumer Protection and Professional Licensure committee.

- *Utah bill, SB 40*. The Medical and Osteopathic Act defines cosmetic medical laser procedures to be the practice of medicine and osteopathy. It permits the delegation of certain cosmetic medical laser procedures by a physician; requires supervision by a physician if the cosmetic laser procedure is delegated; and prohibits the delegation of supervision when supervision is required. On March 2, 2012, this bill was approved by the Senate.
- *Virginia bill, HB 266*. This bill was introduced due to the efforts of the Medical Society of Virginia. The bill states that surgery is defined as the structural alteration of the human body by the incision or cutting into of tissue for the purpose of diagnostic or therapeutic treatment of conditions or disease process by any instrument causing localized alteration or transposition of live human tissue, but does not include procedures for the removal of superficial foreign bodies from the human body, punctures, injections, dry needling, acupuncture, or removal of dead tissue. The bill also states that no person shall perform surgery unless they are licensed by the board of medicine as a doctor of medicine, osteopathy, or podiatry, and so on. This bill was signed by the governor on February 28, 2012, and will take effect July 1, 2012.

Future action

Legislation that defines surgery and its scope is a preventive and proactive means for state medical societies, ACS state chapters, and the AMA to ensure that patients are protected and treated with the highest level of care. The College encourages ACS chapters to participate in collaborative state advocacy initiatives to assist in the passage of definition of surgery legislation, specifically containing the ACS definition. For more information on the legislation discussed in this article contact Charlotte Grill at **cgrill@facs.org**.

Appendix G

Letter from the Executive Director of the American College of Surgeons

AMERICAN COLLEGE OF SURGEONS
Inspiring Quality:
Highest Standards, Better Outcomes
100+*years*

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November 28, 2016

Mr. Christian D. Andresen, Section Chief
Practitioner Licensing & Investigations
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134

Dear Mr. Andresen:

It has come to our attention that during the meeting of the Department of Public Health to discuss the proposal to establish a "Definition of Surgery" questions were raised regarding the American College of Surgeons' (ACS) position and intent for supporting legislative efforts to enact a definition of surgery including the proposal by the Connecticut Chapter of the American College of Surgeons. The ACS has held and continues to hold that the purpose of adopting a definition of surgery by a state is to ensure that patients are protected and treated with the highest level of care and, rather, not for the purpose of unduly restricting the professional ability of healthcare professionals from providing services consistent with their legal scope of practice as defined by state legislative and regulatory bodies.

It was indicated that during the November 22nd meeting, a sentence in an informational article published by the American College of Surgeons in 2012 was referenced by several groups as to indicate that the ACS' intent is to limit the scope of practice of non-physician healthcare providers. A complete reading of the article will demonstrate that the intent is to rather clarify the role of all healthcare providers engaged in surgical procedures to ensure patient safety.

Surgeons are held to very high standards by regulatory agencies for education, continued training, and quality to maintain safe surgical settings and processes for performing surgical procedures. Patients have come to expect such standards of care when undergoing complex and high risk procedures. Any and all medical professionals performing a surgical procedure that transforms living tissue in an irreversible way should be held to the same standards for training and quality to ensure the highest level of patient safety.

Currently, there are 140 references to "surgery" the Connecticut General Statutes and is included in multiple scopes of practice for differing healthcare professionals. As can

be the case when examining a specific scope of practice outside of the other scopes, the meaning and interpretation of what "surgery" means can be something different than what is understood and interpreted in other parts of the code. A clear and concise definition for surgery provides a standard marker for the practice of medicine and surgery in Connecticut.

Establishing a definition for surgery should in no way impede the ability of healthcare providers from performing their services as defined in the Connecticut General Statutes. In addition, as new technologies, trainings and advanced procedures are developed, and as certain healthcare providers seek to expand their service capabilities, the Connecticut Department of Health will continue to be able to utilize the existing scope of practice review process to determine the qualifications of a petitioning provider so that they meet the high standards for education, training and quality to ensure surgical patient safety.

The American College of Surgeons firmly maintains its belief that establishing a definition of surgery is in the best interest of patient quality and safety.

Sincerely,

David B. Hoyt

David B. Hoyt, MD, FACS
Executive Director

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Appendix H

Revised Definition of Surgery Submitted by CCACS Prior to First Committee Meeting

21 November 2016

Updated Definition

The following definition was developed in two phases. The Chapter and CSMS hosted a "meeting of concerned parties" in December of 2015 to talk more about the proposed Definition of Surgery and their concerns about its impact. We modified the language in the definition we submitted in August based on that feedback.

After reviewing the submitted impact statements we added the final paragraph beginning with the word "Nothing". This was added after our submission to the scope process to address the concerns that this definition would cause any loss of scope for any practitioners.

"Surgery" is defined as the structural alteration of the human body by cutting into, destroying, transposing, adding or removing live human tissue for the diagnosis and/or treatment of medical conditions.

"Surgery" may be performed by mechanical instruments such as scalpels, probes, and needles, or by instruments that use thermal or light based energies, electromagnetic or chemical means, and high pressure water jets to cut, burn, vaporize, freeze, probe or re-approximate living tissue.

"Surgery" includes the injection of diagnostic or therapeutic products into body cavities, joints, internal organs, the central nervous system, and the sensory organs, excluding the skin. It also includes the closed reduction of dislocations and/or fractures that require anesthesia.

Nothing in this definition shall be construed to restrict, limit, change, or expand the scope of practice in effect on <date of adoption>, of any profession licensed by any of the health regulatory boards within the Department of Public Health.

States with a Definition of Surgery

Alabama	Maryland	Rhode Island
Alaska	Minnesota	Virginia
Arizona	Mississippi	West Virginia
Florida	Montana	Wisconsin
Illinois	Nevada	Wyoming
Indiana	New Hampshire	
Kansas	New Jersey	
Louisiana	Ohio	
Maine	Pennsylvania	