

KANSAS LAW RELATING TO HEALTH INFORMATION PRIVACY JUNE 2008

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I. Introduction

The new federal health information privacy regulation, 45 C.F.R. Parts 160 and 164 (referred to herein as “the HIPAA Privacy Rule”) sets a federal floor for health information privacy rights. To the extent there is a state law (statute, regulation, or case law) that imposes more stringent protections of health information privacy, health care providers in that state must continue to comply with those requirements. In addition, the HIPAA Privacy Rule also defers to state law with respect to disclosures of information required by law. The purpose of this outline is to provide a summary of the provisions of Kansas law relating to health information privacy. This outline does not address *all* of the statutes, regulations, and case law relating to this subject; instead, we focus on the most important provisions.

II. Who Owns the Record, and How Long Must the Record Be Maintained?

- A.** The health care provider who generates a record of patient care owns the record unless that provider is employed by another individual or business entity; then the record belongs to the employer.
- B.** The patient “owns” the information contained in the record, and thus may request a copy of his/her record be provided to a third party. The patient, however, does not have the right to obtain the original record.
- C.** A patient record should include any writing intended to be a final record, but rough drafts, and notes need not be included once converted to final form.
- D.** If a provider receives records from a third party concerning a patient, those records should be included in the patient’s chart to the extent the provider relies on the information in caring for the patient. If a provider is asked to provide a copy of a patient’s file, the provider should include records provided by a third party in which the provider relied, but should note in a cover letter that the provider is not responsible for the accuracy or completeness of records generated by third parties.

- E. As a practical matter, a provider should maintain records for ten years from the last date the provider treated the patient or, in the case of a minor, until the minor turns nineteen, if that would be longer than ten years.
- F. If a paper record is converted to electronic form, the paper record may be destroyed if the electronic record cannot be altered.

III. The State Law Basis for Health Information Privacy Rights.

Unlike other states, Kansas does not have a general, comprehensive statute granting a patient access to medical records or prohibiting the disclosure of confidential medical information. Rather, these privacy protections are addressed in statutes governing specific entities or medical conditions.

A. K.S.A. 60-427 is the statutory source for the Physician-Patient Privilege in Kansas (strictly read, it only protects certain communications from disclosure in a civil action or a misdemeanor prosecution).

1. The scope of this privilege is limited to confidential communications between a physician and a patient.
 - a. A physician is “a person licensed or reasonably believed by the patient to be licensed to practice medicine” in the state where the consultation or examination occurs. K.S.A. 60-427(b). Physicians include those who practice the healing arts, which includes “the practice of medicine and surgery; the practice of osteopathic medicine and surgery; and the practice of chiropractic.” K.S.A. 65-2802.
 - b. A patient is one “who, for the sole purpose of securing preventive, palliative, or curative treatment, or a diagnosis preliminary to such treatment, of such person’s physical or mental condition, consults a physician, or submits to an examination by a physician.” K.S.A. 60-427(a). A patient includes one who receives medical assistance while unconscious, without giving consent, or even while objecting to being treated. See *State v. Pitchford*, 10 Kan. App. 2d 293, 298, 697 P.2d 896 (1985).
 - c. The privilege serves only to protect a confidential communication, which is “information transmitted between physician and patient, including information obtained by an examination of the patient, as is transmitted in confidence and by a means which, so far as the patient is aware, discloses the

information to no third persons other than those reasonably necessary for the transmission of the information or the accomplishment of the purpose for which it is transmitted.” K.S.A. 60-427(a)(4).

- d. Information that is not related to the patient’s condition and is unnecessary for treatment is not privileged. See Pitchford, 10 Kan. App. 2d at 296-97.
 - e. A communication from a patient of false information in order to get a prescription-only drug is not a confidential communication, and there is no privilege against disclosure in a prosecution for obtaining a prescription-only drug by fraudulent means. K.S.A. 60-427(h).
 - f. No privilege exists if the physician is a “disinterested physician,” i.e., “a doctor who examines a person without intending to offer treatment or advice.” Pitchford, 10 Kan. App. 2d at 297; Williams v. Hendrickson, 189 Kan. 673, 676-77, 371 P.2d 188 (1962) (holding that when physician merely drew blood of individual, then turned the blood over for analysis, there was no physician-patient relationship).
- 2. The policy behind the physician-patient privilege is “to encourage confidence in the doctor-patient relationship” and “is grounded upon the advantage to all concerned in the full disclosure of all facts which may have a bearing upon diagnosis and treatment of the patient.” 61 Am. Jur. 2d Physicians, Surgeons, and Other Healers § 169 (2000); see also Pitchford, 10 Kan. App. 2d at 296 (noting that “[t]he purpose of the privilege is to ‘encourage persons needing medical aid to seek it without fear of betrayal.’”).
 - 3. The physician-patient privilege may only be invoked by the holder of the privilege. The patient is usually the holder of the privilege, however, if the patient is under a guardianship or conservatorship, the guardian or conservator is the holder. If the patient is dead, the patient’s personal representative is the holder. K.S.A. 60-427(c).
 - 4. Certain communications are specifically excepted by statute from protection by the physician-patient privilege. The privilege does not apply in the following situations:
 - a. In an action to commit the patient on the grounds of incapacity or mental illness are not protected. K.S.A. 60-427(c)(1).

- b. In an action in which the patient seeks to establish his or her competency. K.S.A. 60-427(c)(1).
 - c. In an action to recover damages because of the patient's conduct that constitutes a criminal offense other than a misdemeanor. K.S.A. 60-427(c)(1).
 - d. To issues regarding the validity of the patient's alleged will or to issues between parties claiming by testate or intestate succession from a deceased patient. K.S.A. 60-427(c)(2)-(3).
 - e. When the patient's condition is a factor of the patient's claim or defense. K.S.A. 60-427(d).
 - f. When blood is drawn at the proper request of a law enforcement officer. K.S.A. 60-247(e)(1).
 - g. When information is required to be reported by the physician or the patient to a public official or when information is required to be recorded in a public office, unless the statute requiring such reporting states that the information shall not be disclosed. K.S.A. 60-427(e)(2).
 - h. In a misdemeanor prosecution for driving under the influence of alcohol or drugs. K.S.A. 60-427(b), 8-1567.
 - i. If the court finds that sufficient evidence (other than the communication) warrants a finding that the patient sought or obtained the physician's services in order to commit a crime or a tort, or to escape detection after the commission of a crime or a tort. K.S.A. 60-427(f).
5. In summary, the physician-patient privilege serves to protect information from disclosure in a civil action or in a criminal prosecution for a misdemeanor if the court finds that:
- a. the Communication was a confidential communication between a physician and a patient;
 - b. "the patient or the physician reasonably believed the communication was necessary or helpful to enable the physician to make a diagnosis of the condition of the patient or to prescribe or render treatment therefore;"

- c. the witness is either the holder of the privilege, was the patient's physician at the time of the confidential communication was made, or is a person who obtained knowledge of the communication from the physician's intentional breach of his or her duty of nondisclosure; and
- d. the person claiming the privilege is the holder of the privilege. K.S.A. 60-427(b).

B. Physicians also have a professional duty to maintain the confidentiality of patient information apart from the evidentiary privilege provided by statute.

1. The ethical codes by which physicians are governed provide for a common law basis for the physician-patient privilege. "The Hippocratic Oath, for example, states: 'Whatever . . . I see or hear . . . which ought not to be spoken of abroad, I will not divulge.'" Note, *Perspectives on Patient Confidentiality in the Age of AIDS*, 44 Syracuse L. Rev. 967, 983 (1993) (footnote and citation omitted). The American Medical Association also recognizes the physician-patient privilege. The policy behind such a common law privilege is similar to the policy behind the statutory privilege.
2. The Kansas Attorney General's Office has stated that a trust relationship "exists between physicians and patients which may require that disclosure not be made to others" outside of the courtroom. Kansas Att'y Gen. Op. No. 87-139, 1987 Kan. AG LEXIS 54 (Sept. 19, 1987).
3. Physicians are duty-bound to maintain the confidentiality of patient information and communications unless compelled to disclose such information by law or the court. K.S.A. 65-2837(b)(6) (stating that unprofessional conduct includes the "willful betrayal of confidential information.").

C. People licensed under the Board of Healing Arts commit unprofessional conduct if they willfully betray confidential information. K.S.A. 65-2837(b)(6).

D. Mental Health Technicians, Professional Nurses, and Practical Nurses commit unprofessional conduct by violating the confidentiality of information or knowledge concerning any patient. K.S.A. 60-7-106, 60-3-110(g).

E. Optometrists commit unprofessional conduct if they willfully betray a patient's confidence. K.S.A. 65-1516(b)(22).

F. Pharmacists commit unprofessional conduct if they willing betray confidential information. K.S.A. 65-1626(hh)(6).

Confidential information includes privileged communications between a pharmacist and the pharmacist's patient and records of prescription orders filled by a pharmacist, which "are placed on the same basis of confidentiality as provided by law for communications between a physician and the physician's patient and records of prescriptions dispensed by a physician." K.S.A. 65-1654.

G. A Podiatrist's license may be revoked, suspended, or limited because of unprofessional conduct as described in K.S.A. 65-2837(b)(6) (willful betrayal of confidential information). K.S.A. 65-2006(a)(2).

H. Physical Therapists, Occupational Therapists, and Respiratory Therapists commit professional misconduct by willfully betraying confidential information. K.A.R. 100-29-12(a)(15), 100-54-5(m), 100-55-5(n).

I. An Athletic Trainer's registration may be revoked, suspended, or limited because of a violation of any professional trust or confidence. K.S.A. 65-6911(a)(9).

J. Information received by the Department of Health and Environment from Adult Care Homes through filed reports and inspections shall not be disclosed publicly in a manner that would identify individuals. K.S.A. 39-934.

K. Professional Counselors commit unprofessional conduct by violating any professional trust or confidence. K.S.A. 65-5809(l).

Confidential relations and communications between a licensed professional counselor or a licensed clinical professional counselor and his or her patient "are placed on the same basis as provided by law for those between an attorney and an attorney's client." K.S.A. 65-5810(a)-(b).

L. Privileged communications between a Licensed Psychologist and his or her patient are placed on the same basis as communications between an attorney and an attorney's client.

M. No Licensed Social Worker, anyone who participates in the delivery of social work services, nor anyone who works under the supervision of a Licensed Social Worker may disclose any information acquired from a patient in the course of consulting the patient in a professional capacity. K.S.A. 65-6315.

1. The rule does not apply in the following situations:
 - a. when the professional obtains the written consent of the patient;
 - b. when the patient is a child under the age of 18 and is the victim of a crime to which the professional is testifying; or
 - c. when the patient waives the privilege because he or she has brought an action against the professional. K.S.A. 65-6315.
2. The privilege is on the same basis as that between an attorney and an attorney's client. K.S.A. 65-6315.

N. Marriage and Family Therapists are required not to disclose any information acquired through the rendering of marriage and family therapy services. K.S.A. 65-6410.

1. The rule does not apply in the following situations:
 - a. when disclosure is required by other state laws;
 - b. when the failure to disclose will present a clear and present danger to the health of an individual;
 - c. when the patient has waived the privilege because he or she has brought an action against the therapist;
 - d. when the patient is a defendant and the use of the privilege would violate the defendant's right to compulsory process or right to present testimony or witnesses; or
 - e. when the patient has expressly waived the privilege. K.S.A. 65-6410.

O. Alcohol and Other Drug Abuse Counselors commit unprofessional conduct by:

1. failing to obtain written, informed consent from the patient before releasing information to a third party;

2. revealing information, a confidence, or a secret;
3. failing to protect information, a confidence, or a secret; or
4. failing to exercise due diligence in protecting information, a confidence, or a secret, unless another law requires disclosure, keeping the information private will present a clear and present danger to an individual, or the patient waives the privilege because he or she has brought an action against the therapist. K.A.R. 102-6-72(b)(32)-(34).

P. A duty to keep patient information confidential also stems from tort law, and the tort of invasion of privacy. In Kansas, there are four types of invasion of privacy. See *Dominguez v. Davidson*, 266 Kan. 926, 937, 974 P.2d 112 (1999).

1. Appropriation of Name or Likeness

This type of invasion occurs when one appropriates, to his or her own use or benefit, the name or likeness of another. See *Kunz v. Allen*, 102 Kan. 883, 884, 172 P. 532 (1918).

2. Intrusion Upon Seclusion

- a. This type of invasion occurs when one intentionally intrudes, physically or otherwise, upon the seclusion or solitude of another, or upon his or her private affairs or concerns.

- b. The intrusion must be highly offensive to a reasonable person. See *Froelich v. Adair*, 213 Kan. 357, 359, 516 P.2d 993 (1973).

3. Public Disclosure of Private Facts

This type of invasion occurs when one gives publicity to a matter, concerning the private life of a person, if the matter is of a kind that would be highly offensive to a reasonable person and is not a matter of legitimate public concern. See *Munsell v. Ideal Food Stores*, 208 Kan. 909, 922, 494 P.2d 1063 (1972).

IV. Special Rules Relating to Risk Management Activities.

- A. What is it?** The risk management statutes K.S.A. 65-4921 *et seq.*, set forth laws for the investigation, and hopefully reduction of “reportable incidents” occurring both in and out of medical care facilities. A reportable incident is an act by a

health care provider which (1) is or may be below the applicable standard of care and has a reasonable probability of causing injury to a patient, or (2) which may be grounds for disciplinary action by a licensing agency. K.S.A. 65-4921(f).

B. Who is affected? The risk management act sets out two corresponding sets of responsibilities. First, medical care facilities must set up and maintain internal risk management programs to fulfill their mandate to investigate reportable incidents occurring within the facility. K.S.A. 65-4922. Second, health care providers and employees of medical care facilities must report reportable incidents to the appropriate facility or licensing agency. K.S.A. 65-4923.

C. What are the requirements?

1. Risk Management Program Requirements – K.S.A. 65-4922
 - a. A medical care facility must have a risk management program.
 - b. Program must consist of:
 - i. System for investigation and analysis of frequency and causes of reportable incidents
 - ii. Measures to minimize reportable incidents and resulting injuries
 - iii. Reporting system
 - c. The failure to maintain a risk management program can result in denial, suspension or revocation of license. K.S.A. 65-430.
 - d. Each medical care facility must have a written plan for risk management. The plan is approved and reviewed annually by the facility governing body. K.A.R. 28-52-1(a) & (b).
 - e. Documentation of findings, conclusions, recommendations, actions taken and results of actions must be documented and reported per plan procedures. K.A.R. 28-52-1(c).
 - f. Plan format – the plan must include the following sections. K.A.R. 28-52-1(e).
 - i. Section I: description of system implemented for investigation and analysis of RI

- ii. Section II: description of measures used to minimize occurrence of RI and resulting injuries
- iii. Section III: description of implementation of reporting system
- iv. Section IV: organizational elements
 - (i) Name and address
 - (ii) Risk manager
 - (iii) Description of involvement and organizational structure of medical staff as related to the risk management program, including names and titles of medical staff members involved in the investigation and review of reportable incidents
 - (iv) Organizational chart indicating position of facility's review committee
- v. Section V: description of facilities resources allocated to implement plan
- vi. Section VI: documentation that the plan as submitted has been approved by the facility's governing body
- g. Plan is submitted to KDHE at least 60 days before license renewal date. Amendments must also be submitted to KDHE. K.A.R. 28-52-1(f).
- h. KDHE shall notify facility in writing of approval or disapproval. Facility will have 60 days after notice of disapproval to submit revised plan.
- i. Risk management committee, K.A.R. 28-52-3.
 - i. Facility must designate one or more executive committees responsible for standard of care determinations with respect to incident reports. Jurisdiction of each committee must be set forth in the risk management plan.
 - ii. Each committee's activities must be documented in its minutes at least quarterly.

- iii. The documentation in the minutes must show that the committee exercises overall responsibility for determinations delegated to individual clinical reviewers or subordinate committees.
- j. Standard of care determinations. K.A.R. 28-52-4.
 - i. Four categories
 - (i) Standards of care met.
 - (ii) Standards of care not met, but with no reasonable probability of causing injury.
 - (iii) Standards of care not met, with injury occurring or reasonably probable.
 - (iv) Possible grounds for disciplinary action by the appropriate licensing agency.
 - ii. Each incident is assigned an appropriate determination.
 - iii. Separate determinations are made for each provider and each clinical issue.
 - iv. Anything considered a level 3 or 4 shall be considered a “reportable incident” and reported to appropriate licensing agency per K.S.A. 65-4923.
 - v. Each determination shall be dated and signed by an appropriately credentialed clinician authorized to review patient care incidents on behalf of the committee. If primary review was not delegated to individual or subordinate committee, the determination shall be documented in the minutes on a case-specific basis. Determinations made by individual clinicians or subordinate committees shall be approved by the committee on at least a statistical basis.

2. Reporting Requirements – K.S.A. 65-4923

- a. Health care providers and medical care facility employees ***directly involved in the delivery of health care services and who have knowledge*** that a health care provider has committed a reportable incident, shall report their knowledge.
 - i. This is MANDATORY.
 - ii. “Knowledge”: familiarity because of direct involvement or observation of the incident.
 - iii. Example: Nurse involved in a surgery where wrong body part is operated on would be, first, directly involved in delivery of health care services and, second, have knowledge of the reportable incident because of her direct involvement or observation of the surgery.
- b. Reports are made to different entities depending on where the reportable incident occurred.
 - i. Outside a medical care facility. If the incident occurs outside a medical care facility, the report is made to the appropriate state or county professional organization which will refer the matter to a professional practices review committee. That committee will investigate and take appropriate action.
 - ii. Within or involving a medical care facility. If the incident occurs inside a medical care facility, or involves a medical care facility, the report goes to the chief of the medical staff, chief administrative officer or risk manager. The matter is then referred to the appropriate committee for investigation. K.S.A. 65-4923(a)(2) & (3).
- c. Incident reports.
 - i. Each facility must have a written form on which employees and health care providers shall report “clinical care concerns.” K.A.R. 28-52-2(a).
 - ii. The original incident report goes to the risk manager, chief of staff, or administrator. K.A.R. 28-52-2(a).

- iii. Whoever receives the report must acknowledge receipt of the plan (file stamp the report, chronological reporting log, sign or initial report, enter into computer database). K.A.R. 28-52-2(b).
 - d. Findings by risk management committees.
 - i. To licensing agency. If a risk management committee finds that the provider acted (1) below the standard of care and the act had a reasonable probability of causing injury to a patient, or (2) acted in a manner that may be grounds for disciplinary action, the committee must report the finding to the appropriate licensing agency. When the provider at issue is the medical care facility, the report goes to the KDHE.
 - ii. Periodic reports to KDHE. Review committees shall submit summary of reports occurring within or involving medical care facilities at least every 3 months. Report includes number of reportable incidents, whether investigation was conducted, action taken. K.S.A. 65-4923(d).
 - e. Reporting under risk management statutes obviates need to report under K.S.A. 65-28,121 to 65-28,122 (healing arts), see section VIII below, and K.S.A. 65-4216 (mental health technicians).
- 3. Impaired Providers – K.S.A. 65-4924
 - a. The state licensing agency may refer a report received under 65-4923 to an impaired provider committee if the report or complaint relates to a provider's inability to practice with reasonable skill and safety due to physical or mental disabilities.
 - b. Disabilities include:
 - i. Deterioration due to aging
 - ii. Loss of motor skill due to drugs or alcohol
 - c. An impaired provider may request a voluntary restriction on license.

- d. An impaired provider who is participating in or has successfully completed a treating program cannot be excluded from the medical staff solely because of participation in the program. Impairment, however, may still be considered in determining the extent of privileges granted.
4. Document retention: Risk management must be kept for at least *one year* after completing the investigation. K.A.R. 28-52-2(c).

D. Failure to report.

1. Jail and/or fine. The willful and knowing failure to make any report required by K.S.A. 65-4923 or 65-4924 is a class C misdemeanor. The sentence for conviction of a class C misdemeanor is confinement in the county jail of up to one month and/or a fine of up to \$500. K.S.A. 21-4502, 21-4503.
2. License revocation and censure. The license of a person required to report under the risk management act may be revoked, suspended or limited, or the licensee may be publicly or privately censured for willingly and knowingly failing to report under 65-4923 or 65-4924.

E. Privileged communications.

1. General rule – K.S.A. 65-4925: Reports, records and proceedings are confidential and privileged.
 - a. All documents prepared for or by risk management are privileged. This includes reports and records to or by executive or review committees, chief of medical staff, chief administrative officer, board of directors, risk manager, any state licensing agency or impaired provider committee. This includes incident reports, those reports made documenting the reportable incident.
 - b. In addition to documents, the proceedings of risk management committees, officers and their investigations are privileged.
 - c. Reports and records cannot and should not be disclosed outside the risk management/peer review process. They are not subject to ordinary means of discovery, subpoena or other means of legal compulsion. They are also not admissible in both court and administrative proceedings. The exception is in a disciplinary proceeding by a state licensing agency.

- d. No one involved in either risk management or with an impaired provider committee can be compelled to testify in any civil, criminal or administrative action other than a disciplinary proceeding by a state licensing agency. K.S.A. 65-4925(b) & (c).
- e. Persons and committees involved in risk management activities are considered peer review officers or committees under the peer review statute and receive peer review protections. K.S.A. 65-4925(d).
- f. Licensing agencies are required to keep peer review and risk management information confidential and privileged. K.S.A. 65-4925(e).

2. Exceptions?

- a. *Adams v. St. Francis* upsets the apple cart.
 - i. *Adams v. St. Francis*, 264 Kan. 144, 955 P.2d 1169 (1998), marked the beginning of a period of erosion of the peer review and risk management privileges. That case involved the disclosure by the Kansas Board of Nursing of protected peer review and risk management documents provided to the Board by St. Francis. These documents found their way to the plaintiff's counsel who then wanted to depose certain fact witnesses named in the documents. The trial judge refused to allow the depositions. The ruling was appealed, and the Kansas Supreme Court reversed the lower court's ruling.
 - ii. *Adams* misinterpreted. Although clearly limited to its peculiar facts, this opinion was interpreted (or misinterpreted) as allowing the disclosure of peer review and risk management materials, particularly factual information contained in protected documents, including incident reports and committee reports. In some local jurisdictions, providers were told by the courts they had to disclose incident reports and other factual information in their risk management files.
 - iii. The pendulum swings back: what *Adams* really means. In recent years, lawyers and judges have realized that *Adams* really did nothing to change the protection given to peer review and risk management documents. It only

restated a test for the disclosure of any type of privileged material. The court basically set forth a four-part test for the disclosure of privileged factual material:

- (i) The information sought must be factual in nature (no conclusions or deliberations).
- (ii) The information sought must be relevant.
- (iii) The information sought must go to the heart of the matter.
- (iv) The information is not available from alternative sources, and all alternative sources have been exhausted.

b. What can you do?

- i. You should zealously protect your peer review and risk management documents and proceedings.
- ii. Whether an exception to the general rule of privilege applies in a particular case should only arise after a lawsuit is on file.
- iii. Do not disclose the materials to anyone outside the process (excluding licensing agencies and KDHE) unless a court order mandates disclosure.

F. Immunity

- 1. Failure to report. No one can be liable in a civil action for failure to report. K.S.A. 65-4927(a).
- 2. Failure to investigate. No medical care facility or professional organization can be liable for damages for alleged failure to properly investigate or act upon a report under K.S.A. 65-4923. K.S.A. 65-4927(d).
- 3. Good faith in providing information. No person or entity who in good faith reports, provides information or investigates a health care provider under the risk management act will be liable in a civil action for damages.

- a. Exception: There is liability if there is clear and convincing evidence that:
 - i. The report or information was completely false; or
 - ii. The investigation was based on false information and that falsity was actually known to the person making the report, providing the information or conducting the investigation.
4. Members of a medical care facility's medical staff and its governing board are immune from liability for acts performed within the scope of their duties as long as they acted *in good faith, without malice and pursuant to the facility's written bylaws*. K.S.A. 65-442.

V. Special Rules Relating to Peer Review Activities.

A. What is it?

1. Peer review is broader than risk management. It involves a wide-range of activities that promote improvement in the quality of health care. The peer review statutes were implemented to fulfill the public policy of providing Kansas citizens with quality health care. K.S.A. 65-4914.
2. Functions – K.S.A. 65-4915(a)(3). The following functions are considered peer review:
 - a. Quality: Evaluate and improve the quality of health care services rendered by health care providers.
 - b. Professionally Indicated/Standard of Care: Determine that health services rendered were professionally indicated or were performed in compliance with the applicable standard of care.
 - c. Reasonable Cost: Determine that the cost of health care rendered was considered reasonable by the providers of professional health services in this area.
 - d. Qualifications: Evaluate the qualifications, competence and performance of the providers of health care or to act upon matters relating to the discipline of any individual provider of health care.
 - e. Morbidity: reduce morbidity or mortality.

- f. Reduce Cost: establish and enforce guidelines designed to keep health care costs within reasonable bounds.
- g. Research.
- h. Utilization: determine if a hospital's facilities are being properly utilized.
- i. Privileges: supervise, discipline, admit, determine privileges or control members of a hospital's medical staff.
- j. Qualifications Part II: review the professional qualifications or activities of health care providers.
- k. Quality Part II: evaluate the quantity, quality and timeliness of health care services rendered to patients in the facility.
- l. Utilization Part II: evaluate, review or improve methods, procedures or treatments being utilized by the medical care facility or by health care providers in a facility rendering health care.
- m. Risk Management.

B. Confidential communications.

- 1. General rule – K.S.A. 65-4915(b): The primary purpose of the substantive peer review statute is to make peer review documents and proceedings privileged and confidential.
 - a. Reports, statements, memoranda, proceedings, findings and other records submitted to or generated by peer review committees or officers are privileged.
 - b. Documents and information are not subject to discovery, subpoena or other means of legal compulsion. This includes a prohibition on testimony.
- 2. Who claims the privilege?
 - a. Peer review officer or committee receiving or creating the document holds the privilege.

- b. Privilege can be claimed by the legal entity who created the committee or officer.
 - c. Commissioner of insurance.
 - d. Persons with a stake in the peer review?
 - i. Arguably, the provider or person who is the subject of a peer review or risk management investigation has standing to object to the production of related documents and information.
 - ii. Example: In federal court, a party can object to a subpoena issued to a nonparty only if the party has a personal right or privilege regarding the subject matter of the subpoena. *Zhou v. Pittsburgh State Univ.*, 2002 U.S. Dist. LEXIS 15630 (July 25, 2002); *Hertenstein v. Kimberly Home Health Care*, 189 F.R.D. 620, 635 (D. Kan. 1999).
3. Exceptions?
- a. See discussion in risk management section above.
 - b. The privilege does not apply when the provider contests the revocation, denial, restriction or termination of staff privileges or license, registration or certification. Licensing agencies must protect the confidentiality of peer review material, just as with risk management material. K.S.A. 65-4915(c).
 - c. The statute does not prohibit the commissioner of insurance or any licensing or disciplinary boards from requiring that peer review committees and officers report its recommendations and actions or transfer records to it. Such records are still protected from discovery.
 - d. Peer review committees and officers may discuss peer review activities with other peer review committees or officers or a board of directors of a health care provider without waiving the privilege.

C. Immunity

- 1. See immunities noted above in Risk Management section.

2. K.S.A. 65-4909 immunity
 - a. No liability for entities which in *good faith* investigate or communicate information regarding the quality, quantity or cost of patient care by health care providers or furnished at adult care homes for any act, statement or proceeding undertaken or within scope of functions and duties for the entity as long as done *in good faith and without malice*.
 - b. Entities protected:
 - i. State, regional or local association of health care providers
 - ii. State, regional or local association of licensed adult care home administrators
 - iii. Organization (and individual members) delegated review functions by law
 - iv. Individual or entity acting at request of any such organization or entity
3. Immunity is also available under the federal Health Care Quality Improvement Act, 42 U.S.C. 11111 *et seq.*
4. False Light Publicity
 - a. This type of invasion occurs when one gives publicity to a matter, concerning a person that places the person in a false light in public, if the false light would be highly offensive to a reasonable person. *See Dominguez*, 266 Kan. at 937.

VI. Special Rules Regarding Treatment Facilities (Kansas Law) and Drug and Alcohol Abuse Programs (Federal Law).

A. Treatment Facilities

1. K.S.A. 65-5601 – 5605 afford special protections for persons who are patients of a community mental health center, community service provider, psychiatric hospital, or state institution for the mentally retarded (collectively referred to in the statute as “treatment facilities”).

Specifically, the statute prohibits the disclosure of the following information without the written authorization of the patient, the patient's guardian or conservator, or by the personal representative of a deceased patient, except in certain circumstances described below:

- a. The fact that the patient has been receiving treatment;
 - b. Confidential communications made for the purposes of diagnosis or treatment of the patient's mental, alcoholic, drug dependency or emotional condition that are not intended to be disclosed to third persons; and
 - c. Communications made in individual, family, or group therapy.
2. Such information may be disclosed without authorization in the following circumstances:
- a. the treatment personnel or the patient is required by law to report the information to a public official or the information is required to be recorded in a public office;
 - b. the information is necessary for the emergency treatment of a patient and the head of the treatment facility states in writing the reasons for the disclosure;
 - c. the information is relevant to protect a person who has been threatened with substantial physical harm by a patient during the course of treatment, if (1) the patient specifically identified the person; (2) treatment personnel believe there is a substantial likelihood the patient will act on the threat in the reasonable foreseeable future; (3) the head of the treatment facility concludes that notification should be given; and (4) the patient is notified that the information was communicated;
 - d. the patient has been administratively transferred to a state psychiatric hospital pursuant to K.S.A. 75-520 and the disclosure is from the state psychiatric hospital to the administrative staff of the Kansas Department of Corrections;
 - e. the disclosure is to another treatment facility regarding a proposed patient, patient, or former patient, for the purpose of promoting continuity of care between the state psychiatric hospitals and the community health centers;

- f. the disclosure is in proceedings to involuntarily commit a patient to treatment for mental illness, alcoholism, or drug dependency and the treatment personnel has determined the patient is in need of hospitalization;
- g. disclosure pursuant to a court order for examination of the mental, alcoholic, drug dependency, or emotional condition of the patient;
- h. disclosure pursuant to a court order finding that the patient has made the condition an issue of the patient's claim or defense in a legal proceeding;
- i. the disclosure is to the patient or former patient. The head of the treatment facility may refuse to disclose portions of the patient's records if he/she states in writing that the disclosure would be injurious to the welfare of the patient;
- j. the disclosure is to scholarly investigators or to state or national accreditation, certification, or licensing authorities;
- k. the disclosure is to Kansas Advocacy and Protective Services, Inc., concerns individuals who reside in a treatment facility, and is required by federal law and federal rules and regulations to be available pursuant to a federal grant-in-aid program;
- l. the information is relevant to the collection of a bill for professional services rendered by a treatment facility;
- m. the information is sought by a coroner and the information is material to a proceeding conducted by the coroner; or
- n. the information is sought as part of a genealogical study, and includes only the name, date of birth, date of death, name of any next of kin, and place of residence of a deceased former patient.

B. Drug and Alcohol Treatment Programs.

- 1. Although this outline focuses on Kansas law, there are federal regulations concerning a related matter that should be addressed here, the rules concerning the confidentiality of records of patient who participate in federally assisted drug and alcohol programs. Any program that is certified as a Medicare provider is subject to these rules. These

regulations are found at 42 C.F.R. Part 2. These requirements will remain intact following the compliance date for the HIPAA Privacy Rule.

2. Pursuant to these regulations, records of the identity, diagnosis, prognosis, or treatment of a patient in a federally assisted drug and alcohol abuse program must be confidential and may not be disclosed without an authorization, except in certain circumstances discussed below. *Any disclosure must include a statement regarding redisclosure.*
3. Information may be disclosed without an authorization in the following circumstances:
 - a. disclosures to a central registry, detoxification program, or maintenance program that is less than 200 miles away, for the purpose of preventing the multiple enrollment of a patient;
 - b. disclosures to persons in the criminal justice system, when participation in the program is a condition of the disposition of criminal proceedings against the patient, of the patient's parole, or of other release from custody;
 - c. disclosures to medical personnel for the purpose of treating a condition that poses an immediate threat to the health of any individual and which requires immediate medical intervention;
 - d. disclosures to medical personnel of the FDA who have reason to believe that the health of an individual may be threatened by an error in the manufacture, labeling, or sale of a product;
 - e. disclosures to qualified personnel for the purpose of conducting scientific research;
 - f. disclosures for the purpose of conducting management audits, financial audits, or program evaluations;
 - g. disclosures pursuant to a court order issued because:
 - i. disclosure is to protect against an existing threat to life or of serious bodily injury, including circumstances which constitute suspected child abuse and neglect and verbal threats made against third parties;
 - ii. disclosure is in connection with the investigation or prosecution of an extremely serious crime; or

- iii. disclosure is in connection with litigation or an administrative proceeding in which the patient offers testimony or other evidence pertaining to the content of the confidential communications.
- h. disclosures under laws requiring the collection of death or other vital statistics or that permit inquiry into the cause of death;
- i. disclosures that an identified individual is not and never has been a patient; or
- j. disclosure of the fact of a minor patient's application for treatment to a minor patient's parent, guardian, or other person authorized to act on the minor's behalf, if state law requires consent for treatment of a minor patient.

VII. Disclosures of HIV/AIDS Information

Under Kansas law, information concerning a person's HIV/AIDS status may be disclosed without an authorization only in the following circumstances (regardless of whether the disclosure would be permitted by the HIPAA Privacy Rule).

- A. **By Law.** If the information concerning a person's HIV/AIDS status is required by law to be disclosed (*e.g.*, required public health reporting – see Section VIII.C. below).
- B. **To Treatment Personnel.** A physician performing medical or surgical procedures on a patient who the physician knows has tested positive for HIV may disclose such information to other health care providers and emergency services employees, who have been or will be placed in contact with body fluids of such patient.
- C. **To Partners.** A physician who has reason to believe that the spouse or partner of a person who has had laboratory confirmation of HIV infection or who has AIDS may have been exposed to HIV and is unaware of such exposure may inform the spouse or partner of the risk of exposure.
- D. **To Corrections and Law Enforcement Employees.** A physician performing medical or surgical procedures on a patient who the physician knows has HIV may disclose that information to corrections officers, corrections employees, and law enforcement employees who have been or who may be in contact with the patient's bodily fluids. In cases where such officers or employees are exposed to bodily fluids of a person whose HIV status is unknown, a court may order HIV

testing of that person. The results of the test must be disclosed to the court as well as to the person being tested and the person who was exposed. In some cases, the test results must be reported to a health care provider designated by the employee to receive the results.

- E. To Victims.** If an adult or a minor has been charged with or convicted of an offense that may have involved the transmission of bodily fluids, under certain circumstances a judge may order the arrestee/convict/juvenile offender to undergo HIV testing. Test results must be disclosed to the court that ordered the test; and with respect to the arrestee, the arrestee, the arresting law enforcement officer and other persons determined by the court to have a legitimate need to know; and with respect to the convict, the convicted person, the persons designated to receive the results by the victim.

VIII. Disclosures of Health Information Required Kansas Statute or Regulation.

Under the HIPAA Privacy Rule, a covered entity may disclose individually identifiable health information as required by law without obtaining an authorization from the patient. See 42 C.F.R. § 164.512(a). There are numerous Kansas statutes and regulations that require certain health care providers to disclose certain information to state officials. To comply with HIPAA, a health care provider must make these disclosures in writing (or orally and followed up with a written notice), and a copy of such report must be maintained in the individual's medical record.

- A. Vital Statistics.** Reports by hospitals to the Kansas Department of Health and Environment's ("KDHE") Division of Vital Statistics as required by the Kansas Uniform Vital Statistics Act. K.S.A. 65-2401 – 2438 and K.A.R. 28-17-1 – 28-17-21. KDHE is developing a process for reporting information relating to newborn hearing screening (status and results) on the birth certificate. See K.S.A. 65-1,157a.
- B. Infectious and Contagious Diseases.** Hospitals, health care providers, and laboratories are required to report incidents of certain diseases to KDHE. K.S.A. 65-118 – 65-119, 65-6015 – 65-6017 and K.A.R. 28-1-2, 28-1-18. The list of reportable diseases and the reporting form may be found at http://www.kdhe.state.ks.us/disease_reporting/index.html.
- C. HIV and AIDS.** K.S.A. 65-6002 requires reporting to the Kansas Department of Health and Environment concerning HIV testing, HIV status, and AIDS by:
 - 1. a physician who has information indicating that a person is suffering from or has died from AIDS;

2. a physician, administrator of a medical care facility, or such administrator's designee who is in receipt of a report indicating laboratory confirmation of HIV infection resulting from the examination of any specimen provided to a laboratory by such physician, administrator, or designee; or
 3. a laboratory director who has information on laboratory confirmation of HIV infection.
- D. Child Abuse.** Reports by health care providers to the Kansas Department of Social and Rehabilitation Services (or local law enforcement, if the report must be made at a time during which the Department is not open for business) by a person who has reason to suspect that a child has been injured as a result of physical, mental, or emotional abuse or neglect or sexual abuse. K.S.A. 38-1522.
- E. Medical Care for Disabled Infant.** Reports to the local social and rehabilitation services office by health care providers who have reason to suspect that medically indicated treatment is being withheld from a disabled infant with a life threatening condition. K.A.R. 30-45-11 and 30-45-12.
- F. Abuse of Adults Residing in Certain Facilities.** Reports to the Kansas Department of Social and Rehabilitation Services or the KDHE by a health care provider who has reasonable cause to believe that a resident of a medical care facility, adult care home, state psychiatric hospital, or state institution for the mentally retarded, is being or has been abused, neglected, or exploited, or is in a conduct which is the result of such abuse, neglect, or exploitation or is in need of protective services. The HIPAA Privacy Rule requires that if such a disclosure is made by a health care provider, the provider must promptly inform the individual of the disclosure unless it is believed informing the individual would place him/her at risk of serious harm, or the disclosure would be made to a personal representative who is responsible for the abuse, neglect, or other injury and that informing such person would not be in the best interests of the individual. Such notification (or the reasons for not providing notification) shall be documented in the medical record. K.S.A. 39-1401 and 39-1402.
- G. Abuse of Adults Not Residing In Certain Facilities.** Reports by health care providers to the Kansas Department of Social and Rehabilitation Services by a health care provider who has reasonable cause to believe that an adult alleged to be unable to protect his/her own interest and who is harmed or threatened with harm through action or inaction by either another individual or through their own action or inaction is being or has been abused, neglected, or exploited or is in need of protective services. The HIPAA Privacy Rule requires that if such a disclosure is made by a health care provider, the provider must promptly inform the individual of the disclosure unless it is believed informing the individual

would place him/her at risk of serious harm, or the disclosure would be made to a personal representative who is responsible for the abuse, neglect, or other injury and that informing such person would not be in the best interests of the individual. Such notification (or the reasons for not providing notification) shall be documented in the medical record. K.S.A. 39-1430 and 39-1431.

- H. Kansas Advocacy and Protective Services, Inc.** Disclosures made in response to requests to any health care provider from the Kansas Advocacy and Protective Services, Inc., concerning persons with developmental disabilities or mental illness to whom the health care provider has furnished care and treatment, assuming certain statutory requirements are satisfied. K.S.A. 74-5515.
- I. Visually Handicapped.** Reports by every health and social agency, attending or consulting physician or nurse to KDHE regarding sight handicapped and blind persons, unless the person is an adult and objects to the report. K.S.A. 39-739. Although this statute is on the books, there are no implementing regulations, and the KDHE website contains no information concerning this reporting requirement.
- J. Wounds.** Reports by a health care provider to the city's chief of police or the county's sheriff of (1) any bullet wound, gunshot wound, powder burn, or other injury arising from or caused by the discharge of a firearm, or (2) any wound which is likely to or may result in death and is apparently inflicted by a knife, ice pick, or other sharp or pointed instrument. K.S.A. 21-4213.
- K. Cancer Registry.** Reports by hospitals, outpatient surgery centers, pathology laboratory, radiation oncology center, doctor, or dentist to the cancer registry maintained by the KDHE. K.S.A. 65-1,168 – 65-1,174 and K.A.R. 28-70-2.
- L. Burns.** Reports by health care providers to the Kansas fire marshal of second- and third-degree burn wounds involving 20 percent or more of the victim's body and requiring hospitalization. K.A.R. 22-5-6.
- M. Trauma.** Reports by medical care facilities who provide care to persons with trauma injury to the Kansas trauma registry maintained by the KDHE at such time such registry is operational. K.S.A. 75-5666.
- N. Blood Tests for Pregnant Women.** Reports by a laboratory to the Kansas Department of Health and Environment, and to the submitting physician or person attending a pregnant woman, of all positive or reactive blood tests for the detection of syphilis and Hepatitis B. K.S.A. 65-153f. Pursuant to K.S.A. 65-153g, such persons must attach to the birth or stillbirth certificate a statement whether or not a blood test for syphilis has been made during the pregnancy.

- O. Fetal Alcohol Syndrome.** Reports by hospitals of congenital malformations in infants under one year of age and fetal alcohol syndrome. K.A.R 28-1-4.
- P. Genetic Diseases.** Reports by physicians to the KDHE of genetic diseases detected as a result of mandatory newborn infant screening tests. K.S.A. 65-183.
- Q. Infant Eye Disorders.** Reports to the county or joint board of health by any physician or any other person having the care of an infant, but not licensed to practice medicine or surgery, of any swelling or redness in, or discharge from, the eyes of an infant less than six months old. K.S.A. 65-153c.
- R. Insurers Providing PIP Benefits.** Reports to a self-insurer or insurer providing personal injury protection benefits, upon request by the insurer, by a physician, hospital, clinic or other medical institution concerning the treatment of an injured person claiming personal injury protection benefits; upon demand, patient can get a copy of all information provided to the insurer. K.S.A. 40-3114.
- S. Reportable Incidents Under the Kansas Risk Management Statute.** *See* Section IV.
- T. Reports of Reportable Incidents.** Reports by each review and executive committee mentioned in the preceding section to the Kansas Department of Health and Environment summarizing the reports of reportable incidents. K.S.A. 65-4923(d).
- U. Reports to Kansas Board of Healing Arts.** Reports by a medical care facility or person licensed to practice the healing arts to the Kansas Board of Healing Arts of information appearing to show that a person licensed to practice the healing arts has committed an act which may be grounds for disciplinary action under K.S.A. 65-2836, unless reported under K.S.A. 65-4923. In the case of persons licensed to practice the healing arts, the obligation to report is limited to information that is not subject to the physician-patient privilege. K.S.A. 65-28,121 and K.S.A. 65-28,122.
- V. Mental Health Technicians.** Reports by employers of a mental health technician or any health care provider to the Kansas Board of Nursing regarding any information which appears to show that a mental health technician has committed an act that may be grounds for disciplinary action pursuant to K.S.A. 65-4209, or, in the case of the employer only, that the employer has taken disciplinary action against the technician for any such act or that the employer has accepted the resignation of the technician in lieu of disciplinary action. Such reports are not required to be made if the matter is reported pursuant to K.S.A. 65-4923. K.S.A. 65-4216.

- W. Radiation Licensees.** Reports by radiation licensees to the Department of Health and Environment, the referring physician, and the patient or responsible guardian, unless otherwise directed by the physician, regarding a misadministration as defined in K.A.R. 28-35-135(ii)(1). K.A.R. 28-35-230b

IX. Consent for Medical Treatment of Minors

Few issues cause as much confusion for health care providers as the rules relating to consent for medical treatment of minors. The legal constraints against medical or surgical treatment of a minor without parental or guardian consent derive from common law principles of liability for unauthorized treatment. A minor is presumed not to have the capacity to give the informed consent necessary for medical treatment.

A. General Rules.

1. Any parent may consent to the performance of a medical, surgical, or post mortem procedure upon his or her child by a physician licensed to practice medicine or surgery. K.S.A. 38-122.
 - a. Persons who qualify as a parent for purposes of consent:
 - i. The statute does not require that the consenting parent be a joint or sole custodian of the child. *See Yoder v. Yoder*, 11 Kan. App. 2d 330, 332-34, 721 P.2d 294 (1986) (interpreting statute concerning consent to marriage of minor child). However, if a person's parental rights have been terminated by court order, he/she cannot give consent.
 - ii. The statute specifically states that it does not matter whether the parent is married or unmarried.
 - iii. The statute specifically states that a parent who is minor may give consent for treatment for his/her child. Interestingly, that same minor may be unable to give consent to his/her own treatment.
 - iv. A stepparent may not consent to treatment of his/her stepchild without authority granted by the parent.
 - b. Any person under age 18 is a minor unless:
 - i. He/she is 16 or older and has been married. K.S.A. 38-101.

- ii. The Court has conferred rights of majority upon the person pursuant to K.S.A. 38-108 and 38-109.
- 2. Certain persons other than a minor's parent may consent to medical treatment for the minor in certain circumstances.
 - a. Pursuant to K.S.A. 38-133 and 38-1513, a person other than a parent may consent to medical treatment in the following situations:
 - 1) Parent has given written consent for another person to consent to medical treatment of the parent's minor child, and the written document is presented to the health care provider seeking consent. Examples include:
 - (a) Written consent given to friend, relative, or stepparent; or
 - (b) Signed and notarized written consent given to SRS when a child enters foster care. If a health care provider has a question whether a foster parent can give consent in a particular situation, the provider should contact the case manager, the SRS social worker, or the guardian ad litem assigned to the case. The foster parent should be able to provide contact information.
 - 2) By court order presented to the health care provider seeking consent.
 - (a) The court itself may consent to hospital, medical, surgical or dental treatment or procedures; or
 - (b) The court may grant custody or guardianship to another person, who then has the legal ability to consent to medical treatment of a minor.
 - b. Special rules for immunizations. Pursuant to K.S.A. 38-136 and 38-137, consent to the immunization of a minor child may be given by a grandparent, adult sibling or half-sibling, adult aunt or uncle, stepparent, or another adult having care and control of minor when:

- 1) Parent has delegated his or her authority to consent to the immunization in writing to such person; or
- 2) Parent is not reasonably available and authority to consent is not denied.
 - (a) “Reasonably available” means:
 - (i) the location of parent is unknown; or
 - (ii) reasonable efforts to locate the parent made within the last 90 days have failed; or
 - (iii) the parent has been contacted and has not acted on the request to consent and has not expressly denied authority to consent.

Such information must be confirmed in writing by the person seeking to have the child immunized, and such confirmation must be maintained in the minor’s medical record.

- (b) “Authority to consent is not denied” means:
 - (i) The person seeking to have the child immunized does not have actual knowledge that parent has expressly refused to consent to the immunization; and
 - (ii) The parent has not told that person that he or she may not consent to the immunization, or has not withdrawn, in writing, a prior written authorization.

B. Exceptions to the General Rules.

The following exceptions to the general rules concerning consent provide a legal defense to a health care provider in the event it is sued for providing medical services to minors. While the exceptions in effect lower the age of majority and permit a minor to consent to medical treatment, the minor still must be mature enough to give informed consent.

1. An unmarried, pregnant minor may consent to hospital, medical, or surgical care related to pregnancy if no parent or guardian “is available.” K.S.A. 38-123.
2. A minor 17 or older may donate blood voluntarily without parental consent so long as no compensation is received for the donation. K.S.A. 38-123a.
3. A minor 16 or older may consent to hospital, medical, or surgical treatment or procedure if no guardian “is immediately available.” K.S.A. 38-123b.
4. A minor may consent to examination or treatment for venereal disease if the minor is suspected of having a venereal disease or contact with anyone having a venereal disease. K.S.A. 65-2892. A physician may, but is not obligated to, inform the spouse, parent, custodian, guardian or fiancé of person receiving treatment as to the treatment given or needed.
5. A minor may consent to examination and treatment for drug abuse, misuse or addiction by a physician licensed to practice the healing arts in Kansas. K.S.A. 65-2892a.
6. A minor 14 or older may make written application for voluntary admission to a treatment facility for mentally ill persons. The head of the treatment facility must promptly notify child’s parent, legal guardian, or other person known to be interested in the care and welfare of the minor.

If minor was admitted upon his or her own application, the minor may also make written request for discharge from the facility; the head of the treatment facility must make the same notifications as above. K.S.A. 59-2949 and 59-2951.

7. A minor may consent to the performance of an abortion if:
 - a. Minor successfully petitions the district court for waiver of notice requirement to minor’s parents or legal guardian; or
 - b. Notice is not required because one of the persons to whom notice may be given is the father of the fetus, an emergency exists that threatens the health, safety or well-being of the minor, or the persons entitled to notice have signed a written, notarized waiver of notice which is placed in the minor’s medical record. K.S.A. 65-6705.

8. Implied consent to blood, breath, or urine tests relating to operation of motor vehicle.

A minor operating or attempting to operate a vehicle in Kansas has given implied consent to submit to blood, breath, or urine tests to determine the presence of alcohol or drugs. A law enforcement officer may request a minor to submit to blood, breath, or urine tests under certain circumstances listed in K.S.A. 8-1001, and after giving the minor certain notices as required in K.S.A. 8-1001 and 8-1567a.

- a. A health care provider need not obtain consent from the minor, or the minor's parent or legal guardian, to withdraw blood from the minor if the provider receives a written statement from the law enforcement officer directing blood to be withdrawn from the minor.
- b. If the minor refuses to submit to the test, the law enforcement officer must obtain a search warrant under K.S.A. 22-2502, or meet an exception under K.S.A. 22-2501 as a search incident to lawful arrest.

9. "Mature minor" exception.

The Kansas Supreme Court in *Younts v. St. Francis Hospital & School of Nursing*, 205 Kan. 292, 469 P.2d 330 (1970), recognized that in certain circumstances a minor should be permitted to consent to his/her own medical treatment. The court identified the following factors as relevant to this determination: age and maturity; marital status; degree to which minor is dependent on his or her parents or others for support; minor's familial situation; and degree of potential health hazards associated with the particular contraceptive or medical treatment provided.

10. Kansas Good Samaritan Act, K.S.A. 65-2891.

A health care provider may in good faith render emergency care or assistance to a minor without first obtaining consent from the parent or guardian in the following situations:

- a. at the scene of an emergency or accident;
- b. without compensation to a minor requiring such care as a result of having engaged in competitive sports; or

- c. during an emergency which occurs within a hospital or elsewhere, with or without compensation, until such time as the physician employed by the patient or by his or her family or by his or her guardian assumes responsibility for such patient's care.

X. Blood Alcohol Content (“BAC”) Testing.

Another challenging rule for health care providers, particularly hospitals, is determining whether it is proper to respond to a law enforcement officer's request to draw blood.

A. Implied Consent

- 1. K.S.A. 8-1001 is Kansas' "implied consent" statute. Any person who operates or attempts to operate a vehicle in Kansas is deemed to have given consent to submit to one or more tests of the person's blood, breath, urine, or other bodily substance to determine the presence of alcohol or drugs.
- 2. A law enforcement officer shall request a person to submit to a test if there are reasonable grounds to believe that the person:
 - a. was operating or attempting to operate a vehicle while under the influence of alcohol or drugs; or
 - b. was driving a commercial motor vehicle while having alcohol or drugs in his or her system; or
 - c. was under the age of 21 while having alcohol or drugs in his or her system.

and one of the following conditions exists:

- a. the person has been arrested or taken into custody for any offense involving operation of a vehicle while under the influence of alcohol or drugs;
- b. the person has been arrested or taken into custody for violation of K.S.A. 8-1567a (person under 21 driving under the influence); or
- c. the person has been involved in a vehicle accident or collision resulting in property damage or personal injury other than serious injury.

3. A law enforcement officer shall request a person to submit to a test if the person was operating or attempting to operate a vehicle that was involved in an accident or collision resulting in serious injury or death and the person operating could be cited for any traffic offense. The traffic offense violation constitutes probable cause for the testing.

B. Test Procedure

1. If an officer requests a person to submit to a blood test, it may only be performed by:
 - a. a person licensed to practice medicine and surgery, licensed as a physician assistant, or a person acting under the direction of any such licensed person;
 - b. a registered nurse or a licensed practical nurse;
 - c. any qualified medical technician, including, but not limited to, an emergency medical technician-intermediate or mobile intensive care technician, authorized by medical protocol; or
 - d. a phlebotomist.
2. A law enforcement officer may direct a medical professional to draw blood from a person:
 - a. if the person has given consent and the circumstances described in section A.2 and A.3 described above exist;
 - b. if medically unable to consent, if the circumstances described in section A.3 described above exist; or
 - c. if the person refuses to submit to and complete a test, if the person meets the requirements of section A.3 described above.
3. When directed by a law enforcement officer through a written statement, the medical professional must withdraw the sample as soon as practical and must deliver the sample to the law enforcement officer as soon as practical, provided the collection of the sample does not jeopardize the person's life, cause serious injury to the person or seriously impede the person's medical assessment, care, or treatment. The medical professional authorized to withdraw the blood and the medical care facility where the blood is drawn may act on good faith that the requirements have been met for directing the withdrawing of blood once

presented with the written statement. The medical professional shall not require the person to sign any additional consent or waiver form.

4. In such a case, the authorized person and medical facility shall not be liable in any action alleging lack of consent or lack of informed consent, nor any other criminal or civil action when the act is performed in a reasonable manner according to generally acceptable medical practices in the community.
5. If a person must be restrained to collect the sample, a law enforcement officer is responsible for applying any such restraint using acceptable law enforcement restraint practices. The restraint shall be effective in controlling the person in a manner not to jeopardize the person's safety or that of the medical professional or other staff during the drawing of the sample and without interfering with medical treatment.
6. A law enforcement officer may request a urine sample upon meeting the requirements of section A.2 described above and shall request a urine sample upon meeting the requirements of section A.3 described above. If the person is medically unable to provide a urine sample due to the injuries or treatment, the same authorization procedure as used for the collection of blood apply.

C. Refusal to Give Consent

1. The individual still has to consent to testing. Prior to obtaining consent, the officer must give the person oral and written notice that:
 - a. Kansas law requires them to submit to the test;
 - b. the opportunity to consent or refuse the test or consult with an attorney regarding the test is not a constitutional right;
 - c. there are applicable sanctions if the person refuses;
 - d. there are sanctions if the person's BAC is .08 or greater;
 - e. refusal to submit to testing may be used against him/her;
 - f. the test results may be used against him/her; and
 - g. the person has a right to consult with an attorney and obtain additional testing after the test is completed.

2. If the person is under 21 years of age, the officer must give the person the following additional notices:
 - a. that it is unlawful for a person less than 21 to operate or attempt to operate a vehicle in this state with a BAC of .02 or more, and
 - b. that if the person is under 21 and submits to the test and the results show a BAC of .02 or more but less than .08, then his/her driving privileges will be suspended for 30 days on the first occurrence, and for a year on the second or subsequent occurrence.
3. After giving this notice, the officer must request that the person consent to testing.