Selection of terms [Unconv - outdated] CAM

Evolving

18

CME Concept

need Balance

Get rid of Unconventional
Vague,
Recognition of Patients Requests

* Lack of Reliance on New Intervention & Published Literature

Recognition that some interventions will be identified + utilized from practitioners who have not developed appropriate scientific data!
(Recognition) for the need to have practitioners to
mention of. move from

* Statements in Preamble are not fullness
Fairness + Balanced approach not expressed in guideline

* Rely on Professional Judgment as c̄ Conventional Medicine

need
Guidelines for SMA
a lot of subjective judgment - need model guideline
to educate level of panel to understand CAM

- CME - Licensure Renewal for - Requirements
→ AIDS, HIV, Risk Mgt, Violence + Abusive Behavior

DRAFT

~~Functions~~ of Proposed Federal CAM Coordinating Office

Overarching:

- ~~Five broad categories:~~
  1. Centralized coordination of Federal CAM activities across Departments
  2. Federal CAM policy liaison with conventional health care and CAM professionals, organizations, educational institutions, and commercial ventures
  3. Planning and convening conferences, workshops, and necessary advisory groups
  4. Centralized Federal media point of contact
  5. Facilitation of implementation of WHCCAMP recommendations
- Establish a Trans-Departmental CAM Coordinating Committee to coordination CAM activities across all Federal Departments
- Baseline survey of CAM in Federal sector with report to Congress
- Advise Secretary and … on CAM

Education and Training:

- Identify effective CAM education and training strategies and programs through demonstration projects at accredited CAM and conventional institutions and subsequent online publication of models and their evaluation data (~~page 4~~)
- Facilitate identification of funding sources; collaboration between funding sources and educational organizations; and development of selection criteria for competitive award processes for CAM faculty, curricula, and program development at accredited CAM and conventional institutions (~~page 5~~)
- Assemble leadership of chiropractic, traditional Chinese acupuncture, and naturopathic physician professions, educational institutions, and organizations to determine the feasibility of and possible mechanisms for establishing national CAM education and training standards for chiropractic, traditional Chinese acupuncture, and naturopathic physicians (~~page 7~~)
- Determine elements of a core curriculum and best pedagogic methods for incorporating them into existing CAM education and training programs through demonstration projects and conferences with subsequent compilation available online (~~page 9~~)
- Develop and make available online a core curriculum of knowledge about CAM systems, modalities, therapies, approaches, fundamentals, and principles through conferences and workshops so that conventional health professionals can discuss and provide guidance for appropriate use of CAM (~~page 20~~)

Access and Delivery:

- Establish a national policy advisory board no later than 6 months following the receipt of the WHCCAMP report to support and coordinate efforts with a designated Federal office for CAM to develop policy guidelines on issues related to access and delivery of CAM (~~page 9~~)

- Facilitate research, development, and publishing of a set of national standards for the practice of CAM by the national policy advisory board appointed by HHS within 18 months of being established. These standards will establish minimum educational, ethical and practice guidelines for any practitioner wishing to provide health care via CAM approaches and focus on ensuring patients with necessary safeguards.

- Promote development of consensus and practice standards that are specific to a wide variety of CAM practices with guidance from the HHS' national advisory board on CAM policy

- Support and facilitate establishment by CAM practices and professions of a single, voluntary, national organization to register, regulate, and represent its members

- Facilitate HHS' national policy advisory board process to develop national uniform scopes of practice for CAM practices, within 8 months of being established, primarily to address those practices deemed to present the most potential risks to patients. States are encouraged to use these scopes of practice to provide the necessary legal authority and licensure of such practitioners.

- Act as liaison between HHS' advisory board and state medical boards to develop standard operational guidelines for the regulation and oversight of licensed physicians practicing CAM, which are based on national uniform scopes of practices developed by the HHS board

- Coordinate detailed and expanded Federally-funded epidemiologic surveys of CAM patterns of use, with special attention to ethnic and vulnerable populations

- Collaborate with private sector studies and demonstration projects that evaluate the usefulness, effectiveness and cost-benefits of collaborative care models at three delivery levels: global health care systems, such as hospitals, community health centers, and managed care settings; specialized health care systems, such as hospice care; and small clinical settings, such as individual and group practices

- Convene strategic planning conferences based on studies and demonstration projects evaluating the effectiveness and cost benefits of collaborative care models at three delivery levels to address the needs of seriously ill and dying patients, as well as other special populations, to determine best practice guidelines that incorporate conventional palliative care with appropriate and effective CAM approaches

- Report to the Secretary of HHS within 3 years of being established on the use of indigenous healing traditions in the United States to identify common use, best practices, and challenges and potential areas for collaborative learning between such traditions and conventional care, while also providing appropriate protection

of such traditions, as well as research and development of such practices as part of community-based health care

- Evaluate feasibility, costs vs. benefits, and overall impact on allowing Food Stamp Program Participants to use food stamps to purchase specified single or multiple vitamin-mineral products that do not exceed the nutrient recommendations of the Food and Nutrition Board of the Institute of Medicine

Coverage and Reimbursement:

- Convene a public and private HHS task force within to develop a multiyear health services research plan that identifies and addresses CAM research and demonstration questions, methodologies, data, priorities, and coordination which should convene within 3 months of its appointment, and submit its report to the Secretary within 18 months of its appointment

- Support the development of coding for CAM services and products and, specifically, conduct a study analyzing nationally-used coding systems (including current CAM systems) and the issues associated with integrated versus separate CAM coding systems, and make recommendations

- Identify, through the National Institutes of Health and other appropriate agencies, CAM interventions of importance to patients, health care providers, and the general public that need an assessment of the state-of-the-science and conduct conferences to produce consensus statements

- Coordinate a report from appropriate Federal departments to the President and Congress on the status, coverage and reimbursement, and impediments to coverage and reimbursement of CAM services and products for their respective beneficiaries or through their respective sponsorships

- Develop informational programs on safe and effective CAM services and products which are targeted to purchasers, insurers managed care organizations, health care professionals, and providers of health care services

Information Development and Dissemination:

- Establish an inter-departmental task force to identify and eliminate existing gaps in development and dissemination CAM information in the Federal government, and increase resources be provided to centralize CAM information for the public and the media, including a toll-free telephone number that directs callers to the appropriate department, agency, and/or person for specific CAM information

- Form a public-private partnership to review new and existing websites and develop voluntary standards that will promote accuracy, fairness, comprehensiveness, and timeliness of information on CAM internet sites, as well as disclosure of sources of support and any conflicts of interest, so that sites reviewed and found in compliance with these standards could publicize this achievement and display a logo identified with this level of merit

Wellness

- Facilitate CAM becoming part of a national focus to improve the health behaviors of children through appropriate incorporation of CAM into national guidelines on wellness and prevention practices for children and a media campaign that includes public service announcements and involvement of public figures to teach and encourage healthy behaviors among children

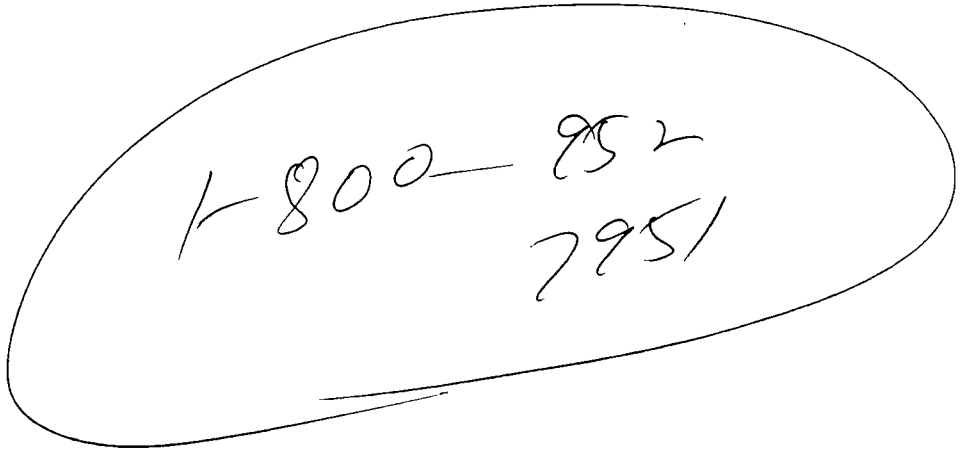
- Develop, in partnership with the business community and school boards, incentives for schools to make available healthier school lunches and snacks and to limit the sale and advertising of high fat snacks, soft drinks, and other products that do not contribute to a healthy lifestyle

- Develop, in consultation with the business community, incentives for employers to include CAM wellness and prevention in worksite wellness programs and health coverage and decrease premiums

- Establish an HHS task force to develop strategies to incorporate CAM wellness and prevention activities in Federal programs such as Head Start; Meals on Wheels; The Special Supplemental Nutritional Program for Women, Infants, and Children; Healthy Mothers/Healthy Babies Program; and the State Children's Health Insurance Program

- Establish a task force to develop strategies to incorporate CAM wellness and prevention in health care delivery programs such as the Department of Veterans Affairs Hospitals, community and migrant health centers, maternal and child health programs, and school health programs

- Establish an HHS task force to develop strategies to incorporate CAM wellness and prevention activities in the nation's hospitals and long term care facilities and programs serving the aging, dying, and those with chronic illness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FEDERATION OF STATE MEDICAL BOARDS
OF THE UNITED STATES, INC.

October 23, 2001

Dear Colleague:

In April 2000, under the leadership of then President Alan E. Shumacher, MD, the Federation's Special Committee for the Study of Unconventional Health Care Practices (Complementary and Alternative Medicine) was charged with developing model guidelines for state medical boards to use in educating and regulating physicians who use complementary and alternative medicine (CAM) in their practices. The Special Committee is comprised of physician and non-physician members representing the Federation and state medical boards.

The Committee met in August and December 2000, and then again in March and August 2001 to thoroughly examine the current status of CAM in the practice setting, determine which states have formal policies/guidelines in place for regulating the practice of CAM, develop definitions crucial to the document's composition, and solicit advice from consultants with varied expertise and professional experience. Additionally, the Committee analyzed the standards used in regulating the use of conventional medicine and evaluated the responsibilities required of both state medical boards and physicians to assure public protection.

A draft of the Special Committee report is being circulated to state medical boards and other interested parties for input in developing a final document. A copy of the draft report is enclosed.

Comments must be in writing and may be returned to Pat McCarty by mail, email at pmccarty@fsmb.org, or fax to 817-868-4167. Comments will be accepted until Friday, December 7, 2001. If you have any questions, please call Lisa Robin at 817-868-4053 or Pat McCarty at 817-868-4067.

Sincerely,

Paul M. Steingard, DO

Paul M. Steingard, DO, Chair
Special Committee for the Study of Unconventional Health Care Practices
(Complementary and Alternative Medicine)

Enclosure as stated
PS/pcm

Model Guidelines for the Use of Unconventional Health Care Practices (Complementary and Alternative Medicine)

Physicians, indeed all health-care professionals, have a duty not only to avoid harm but also a positive duty to do good – that is, to act in the patient's best interest[s]. This duty of beneficence takes precedence over any self-interest.[1]

Introduction

In 1995, the Federation of State Medical Boards' Special Committee on Health Care Fraud was established and charged with developing strategies for recommendation to state medical boards for the regulation and discipline of physicians who engage in unsafe and/or deceptive practices. The Federation's House of Delegates adopted the Committee's recommendations as policy in April 1997. In February 1997, then Federation President James E. West, MD assigned the Committee a new charge – to provide objective information to medical boards for their use in educating licensees, the public and state legislators on issues surrounding health care practices that may be potentially harmful and/or deceptive. In February 1999, the Federation's Board of Directors approved a recommendation by the Committee to modify the title of the Committee to "Special Committee on Questionable and Deceptive Health Care Practices" in order to more appropriately reflect the Committee's work. In April 2000, then Federation President Alan E. Shumacher, MD expanded the Committee's charge to include the development of guidelines for state medical boards to use in educating and regulating physicians who use complementary and alternative medicine (CAM) in their practices. Subsequently, the Committee's name was changed to reflect its new charge. The name of the Committee is the "Special Committee for the Study of Unconventional Health Care Practices (Complementary and Alternative Medicine)."

Because of the increasing interest in and use of CAM practices, state medical boards have a responsibility for assuring that licensees utilize these practices in a manner consistent with safe and responsible medicine. To do this, boards must first understand how CAM is defined.

CAM is a fluid concept that has been defined differently by various organizations and groups. CAM, which may also be termed *unconventional* medical practices, has been described as "medical interventions not taught widely at U.S. medical schools or generally available at U.S. hospitals."[2] *Conventional* medical practices can then

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[1]Schneiderman L. Medical ethics and alternative medicine. *The Scientific Review of Alternative Medicine*. Spring/Summer 1998;2,(1):63-66.

[2]Eisenberg et al. Unconventional medicine in the United States – prevalence, costs, and patterns of use. *New England Journal of Medicine*. 1993;328,(4):246-252.

be defined as medical interventions that are taught extensively at U.S. medical schools, generally provided at U.S. hospitals, or meet the requirements of the generally accepted standard of care. For the purposes of these guidelines, the Committee has chosen to use the terms *conventional* medical practices (as described above and further defined in Section II of this report) and *unconventional* medical practices (which would include CAM).

On behalf of the Federation and its continued commitment to assist state medical boards in protecting the public and improving the quality of health care in the United States, the Special Committee for the Study of Unconventional Health Care Practices (Complementary and Alternative Medicine), chaired by Paul M. Steingard, DO, undertook its initiative in April 2000 to develop model guidelines for state medical boards to use in regulating the use of *unconventional* medical practices.

This initiative focuses on encouraging the medical community to adopt consistent standards, ensuring the public health and safety by facilitating the proper and effective use of *unconventional* treatments, while educating physicians on the adequate safeguards needed to assure these services are provided within the bounds of acceptable professional practice. The Federation believes adoption of guidelines based on this model will protect legitimate medical uses of *unconventional* practices while preventing the proliferation of medical practices that may be potentially harmful.

The intention of the Federation is to provide guidelines that are clinically responsible and ethically appropriate. These guidelines should be consistent with what the state medical board generally considers to be within the boundaries of professional practice and the accepted standard of care.

Section I: Preamble

The *(name of board)* recognizes that the practice of medicine consists of the ethical application of a body of knowledge, principles and methods known as medical science and that these objective standards are the basis of medical licensure for physicians of the state of *(name of state)*. These standards allow a wide degree of latitude in physicians' exercise of their professional judgment and do not preclude the use of any methods that are reasonably likely to benefit patients without undue risk. Furthermore, patients have a right to seek any kind of care for their health problems. The Board also recognizes that a full and frank discussion of the risks and benefits of all medical practices is in the patient's best interest. However, the Board is aware that the use of *unconventional* practices and promotions in the United States has led to the existence of health care treatments that may lack scientific research and clinical validation, or are worthless and likely to harm the public.

There are varying degrees of potential harm that can impact patients who undergo either *conventional* or *unconventional* forms of health care:

- Economic harm, which results in monetary loss but presents no health hazard;

- Indirect harm, which results in a delay of appropriate treatment;
- Direct harm, which results in adverse patient outcome;
- Psychological harm, which results in unreasonable expectations that discourage patients and their families from accepting and dealing effectively with their medical conditions.

Whatever the practice setting, physicians are responsible for practicing good medicine by complying with professional standards and regulatory mandates. In consideration of the above potential harms, the *(name of board)* will evaluate whether or not a physician is practicing appropriate medicine by considering the following practice criteria. Is the physician using a practice that is:

- effective and safe? (having adequate scientific evidence of efficacy and/or safety or greater safety than other established treatment models for the same condition)
- effective, but with some real or potential danger? (having evidence of efficacy, but also of adverse side effects)
- inadequately studied, but safe? (having insufficient evidence of clinical efficacy, but reasonable evidence to suggest relative safety)
- ineffective and dangerous? (proven to be ineffective or unsafe through controlled trials or documented evidence or as measured by a risk/benefit assessment)

Inasmuch as the *(name of board)* is obligated under the laws of the state of *(name of state)* to protect the public's health, safety and welfare and recognizes that the standards used in evaluating health care practices should be consistent, whether such practices are regarded as *conventional* or *unconventional* (a.k.a., complementary, alternative), the Board recognizes that a licensed physician shall not be found guilty of unprofessional conduct for failure to practice medicine in an acceptable manner *solely* on the basis of utilizing *unconventional* practices. Instead, the Board will use the following guidelines to determine whether or not a physician's conduct constitutes a violation of the state's Medical Practice Act with regards to providing *unconventional* practices.

Section II: Definitions

For the purposes of these guidelines, the following terms are defined as indicated:

Conventional Medical Practices

Conventional medical practices refers to those healthcare methods of diagnosis, treatment and interventions that are offered by licensed physicians as generally accepted methods of routine practice, based on current medical education, training, experience and/or peer-reviewed scientific literature.

Unconventional Medical Practices

Unconventional medical practices refers to medical practices not taught widely at U.S. medical schools or generally available at U.S. hospitals, and not included in the above definition of *conventional* medical practices.

Competent and Reliable Scientific Evidence

Tests, analyses, research, studies or other evidence based upon the expertise of professionals in the relevant area that has been conducted and evaluated in an objective manner by persons qualified to do so, using procedures generally accepted in the profession to yield accurate and reliable results. The same standard as often basis

Section III: Guidelines

The *(name of board)* has adopted the following guidelines when evaluating the delivery or co-management of *unconventional* medical practices:

1. Evaluation of Patient

   Parity of evaluation standards should be established for patients whether the physician is using *conventional* or *unconventional* practices.

   Prior to offering any recommendations for *unconventional* practices, the physician shall conduct an appropriate medical history and physical examination of the patient as well as an appropriate review of the patient's medical records. This evaluation shall include, but not be limited to, *conventional* methods of diagnosis and may include other methods of diagnosis as long as the methodology utilized for diagnosis is based upon the same standards of safety and reliability as *conventional* methods, and shall be documented in the patient's medical record. The medical record should also document:

   - what *conventional* medical options have been discussed, offered or tried, and if so, to what effect, or a statement as to whether or not *conventional* options have been refused by the patient or guardian;
   - that proper referral has been offered for appropriate *conventional* treatment;
   - that the risks and benefits of the use of the proposed *unconventional* treatment to the extent known have been appropriately discussed with the patient or guardian;
   - that the physician has determined whether or not the *unconventional* medical treatment could interfere with any other recommended or ongoing *conventional* treatment.

Reduce the practice as negative

2. Treatment Plan

The physician may offer the patient an *unconventional* treatment pursuant to a documented treatment plan tailored for the individual needs of the patient by which treatment progress or success can be evaluated with stated objectives, such as pain relief and/or improved physical and/or psychosocial function. Such a documented treatment plan shall consider pertinent medical history, previous medical records and physical examination, as well as the need for further testing, consultations, referrals, or the use of other treatment modalities.

The *unconventional* treatment offered should:

- have a favorable risk/benefit ratio compared to other treatments for the same condition;
- be based upon competent and reliable scientific evidence;
- be based upon a logical and reasonable expectation that it will result in a favorable patient outcome, including preventive practices;
- be based upon the expectation that a greater benefit will be achieved than that which can be expected by placebo alone.

3. Consultation and/or Referral to Licensed or Other State-Regulated Health Care Practitioners

The physician may refer the patient as necessary for additional evaluation and treatment in order to achieve treatment objectives and may include referral to a licensed or other state-regulated health care practitioner with the requisite training and skills to utilize the *unconventional* practice being recommended. However, the physician is responsible for monitoring the results and should schedule periodic reviews to ensure progress is being achieved.

4. Documentation of Medical Records

The physician should keep accurate and complete records to include:

- the medical history and physical examination;
- diagnostic, therapeutic, and laboratory results;
- results of evaluations, consultations and referrals;
- treatment objectives;
- discussion of risks and benefits;
- appropriate informed consent;
- treatments;
- medications (including date, type, dosage and quantity prescribed);
- instructions and agreements;

- periodic reviews

Records should remain current and be maintained in an accessible manner, and readily available for review.

5. Education

All physicians must be able to demonstrate a basic understanding of the medical scientific knowledge connected with any method they are offering or using in their medical practices as a result of related education and training.

6. Financial Incentives

Physicians may distribute products to patients free of charge or at cost in order to make products readily available. Due to the potential for patient exploitation, physicians should not sell, rent or lease health-related products or engage in exclusive distributorships and/or personal branding. Exceptions can be allowed for the sale of durable medical goods essential to the patient's care, as well as nonhealth-related goods associated with a charitable or service organization. If physicians do provide any goods to their patients, even at cost, they have a duty to inform their patients of any financial interests in these products or goods.

7. Clinical Investigations

As expected of those physicians using *conventional* medical practices, physicians providing *unconventional* practices while engaged in the clinical investigation of new drugs and procedures (a.k.a. medical research, research studies) are obligated to maintain their ethical and professional responsibilities. Investigators shall be expected to conform to the following ethical standards:

- Clinical investigations should be part of a systematic program competently designed, under accepted standards of scientific research, to produce data which are scientifically valid and significant.
- A clinical investigator should demonstrate the same concern and caution for the welfare, safety and comfort of the patient involved as is required of a physician who is furnishing medical care to a patient independent of any clinical investigation.

Furthermore, investigators shall be expected to abide by all federal guidelines and safeguards, such as approval and monitoring of the clinical trial by an Institutional Review Board (IRB), when applicable, to ensure the risks to the patient are as low as possible and are worth any potential benefits.

Section IV: Conclusion

The Federation recognizes that legitimate standards of medical practice are rooted in competent and reliable scientific evidence. These standards are subject to

continual change and improvement as advances are made in scientific investigation and analysis. In addition, standards of medical practice to some degree, and the provision of medical services in individual circumstances in particular, are influenced by psychological, social, political and market forces. It is the responsibility of state medical boards to balance all of these considerations in fulfilling their mission of protecting the public through the regulation of the practice of medicine.

Public protection is carried out, in part, by ensuring physicians in all practices, whether *conventional* or *unconventional*, comply with professional, ethical and practice standards and act as responsible agents for their patients. Accordingly, the Federation encourages state medical boards to adopt these guidelines to assist them in educating and regulating physicians who are (1) engaged in a practice environment offering both *conventional* and *unconventional* forms of treatment; and/or (2) engaged in cooperative therapeutic relationships for their patients with a non-physician licensed or other state-regulated health care practitioner offering *unconventional* practices.

State medical boards need to ensure a balance between the requirements that all medical practices be scientifically based while remaining compassionate and respectful of the dignity and autonomy of patients. This balance should also ensure informed consent and minimize the potential for harm.

The Federation reaffirms its commitment to cooperate with physicians and professional, governmental and other organizations and agencies in supporting the further study of all health care practices that offer promise.

Section V: Bibliography

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Special Committee for the Study of Unconventional Health Care Practices (Complementary and Alternative Medicine): 2001-2002

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The Federation thanks the following consultants for their efforts in providing direction to these guidelines:

- Tammy L. Born, DO – Chair, Michigan Board of Osteopathic Licensing and Regulation; Owner/President, Born Preventive Health Care Clinic

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Texas State Board of Medical Examiners

Standards for Physicians Practicing Integrative and Complementary Medicine

Chapter 200

Standards for Physicians Practicing Integrative and Complementary Medicine

200.1-200.3

200.1. Purpose. The purpose of this chapter is to recognize that physicians should be allowed a reasonable and responsible degree of latitude in the kinds of therapies they offer their patients. The Board also recognizes that patients have a right to seek integrative or complementary therapies.

200.2. Definitions. The following words and terms, when used in this section, shall have the following meanings, unless the context clearly indicates otherwise.

(1) Integrative and Complementary Medicine - Those health care methods of diagnosis, treatment, or interventions that are not acknowledged to be conventional but that may be offered by some licensed physicians in addition to, or as an alternative to, conventional medicine, and that provide a reasonable potential for therapeutic gain in a patient's medical condition and that are not reasonably outweighed by the risk of such methods.

(2) Conventional Medicine - Those health care methods of diagnosis, treatment, or interventions that are offered by most licensed physicians as generally accepted methods of routine practice, based upon medical training, experience and review of the peer reviewed scientific literature.

200.3. Practice Guidelines for the Provision of Integrative and Complementary Medicine. A licensed physician shall not be found guilty of unprofessional conduct or be found to have committed professional failure to practice medicine in an acceptable manner solely on the basis of employing a health care method of integrative or complementary medicine, unless it can be demonstrated that such method has a safety risk for the patient that is unreasonably greater than the conventional treatment for the patient's medical condition. The Texas State Board of Medical Examiners will use the following guidelines to determine whether a physician's conduct violates the Medical Practice Act, <*><*>3.08(4), 3.08(4)(E), and 3.08(18) in regard to providing complementary and integrative medical treatment.

(1) Prior to offering advice about complementary health care therapies, the physician shall undertake an assessment of the patient. This assessment should include but not be limited to, conventional methods of diagnosis and may include non-conventional methods of diagnosis and shall be documented in the patient's chart. Such assessment shall include the following listed in subparagraphs (A)-(E) of this paragraph:

(A) adequate medical records as defined in <*>165.1 of this title (relating to Medical Records);

(B) documentation as to whether conventional medical treatment options have been discussed with the patient and referral input, if necessary;

(C) documentation as to whether conventional medical options have been tried, and if so, to what effect or a statement as to whether conventional options have been refused by the patient;

(D) if a treatment is offered which is not considered to be conventional, documentation of at least a verbal informed consent for each treatment plan must be included (including documentation that the risks and benefits of the use of the treatment were discussed with the patient or guardian);

(E) documentation as to whether the complementary health care therapy could interfere with any other ongoing conventional treatment.

(2) The physician may offer the patient complementary and integrative treatment pursuant to a documented treatment plan tailored for the individual needs of the patient by which treatment progress or success can be evaluated with stated objectives such as pain relief and/or improved physical and/or psychosocial function. Such a documented treatment plan shall consider pertinent medical history, previous medical records and physical examination, as well as the need for further testing, consultations, referrals, or the use of other treatment modalities.

(3) The physician may use the treatment subject to documented periodic review of the patient's care by the physician at reasonable intervals in view of the individual circumstances of the patient in regard to progress toward reaching treatment objectives which takes into consideration the treatment prescribed, ordered or administered, as well as any new information about the etiology of the complaint.

(4) Complete and accurate records of the care provided including the elements addressed in paragraph 1 (A)-(E) of this section should be kept.

(5) If the provisions set out in paragraphs (1)-(4) of this section are met, and if all treatment is properly documented, the board will presume such practices are in conformity with the Medical Practice Act, <*><*>3.08(4), 3.08(4)(E), and 3.08(18).

Effective November 22, 1998.