THE SOUTH DAKOTA PHYSICIAN'S LEGAL GUIDE

FROM THE SOUTH DAKOTA STATE
MEDICAL ASSOCIATION

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South Dakota State Medical Association

SOUTH DAKOTA PHYSICIAN'S LEGAL GUIDE

PREFACE

This publication has been substantially revised since the last edition was published in September of 2000. This version is a blend of various past publications of the South Dakota State Medical Association, including the *Physician's Guide to South Dakota Law* and *The Relationship of New Federal Privacy Rules and South Dakota Law*.

This publication includes a brief summary of certain laws, rules, and regulations affecting the practice of medicine in South Dakota (primarily state law), as well as a verbatim reproduction of certain statutes of this state. This publication is not intended as an exhaustive compendium of all relevant law.

Rather, it is meant to serve as a ready reference for preliminary answers to the topics covered herein. For more specific information or advice, physicians should in all cases consult the appropriate State agency, the South Dakota State Medical Association, or a private attorney.

The laws and regulations summarized are current as of the publication of this booklet. The reader should keep in mind, however, that the law is constantly being changed by Congress, the South Dakota Legislature, the courts, and by administrative rule.

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HIPAA-MANDATED PRIVACY RULES

Effective April 14, 2003, sweeping new federal rules, sometimes known as HIPAA Privacy Rules, became effective. Those rules affect virtually every aspect of patient health information privacy. This section discusses the privacy rules generally, including related security and records retention considerations.

In those cases where the new federal rules are more restrictive than current state law in terms of protecting the privacy of patient health information or granting patients rights vis-à-vis their own health information, the new federal rules preempt or "trump" existing state law, meaning the practitioner will need to comply with the more restrictive federal rule rather than pre-existing state law. In some other cases, existing state law may be more restrictive, or the new federal rules may defer to state law, in which case the practitioner must continue to comply with state law. This section will also, as appropriate and possible, give guidance concerning whether the federal privacy rules or existing state laws govern in cases where disclosures of protected health information are involved[1].

Covered Entities

Virtually all health care providers, including practitioners

1 A complete statute-by-statute or rule-by-rule analysis is beyond the scope of this publication. If the practitioner has a question about a specific situation, he or she should contact their legal counsel.

and clinics, managed care providers, and all health insurance companies are subject to the new rules. The rules are applicable to health care providers and other entities that "transmit health information in electronic form."

A provider that transmits billing or claims information electronically, whether to an insurer, clearing house, governmental entity, or an agent for or on behalf of such entities, is subject to the rules. In addition, a provider that uses simple email to communicate about patients, even in-house, is subject to the rules. When in doubt, a provider should assume that he or she is subject to the rules. Health care providers and others that are subject to the rules are referred to as "covered entities."

Protected Health Information

Generally speaking, individually identifiable health information is subject to protection under the rules and thus is "protected health information." The term "individually identifiable" is generally self-explanatory and means information which clearly is identifiable with a specific person or which could be identifiable with a specific person without much trouble. "Health information" is defined as any information, whether oral, written or in electronic form; created or received by a provider, health plan, public health authority, employer,

life insurer, school, university, or clearinghouse that relates to the past, present, or future mental or physical health of an individual, the provision of health care to that individual (meaning the mere identity of a person as a patient is included), or past, present, or future payment for health care for that individual. These definitions are very broad and cover virtually all health care-related information from the name of the patient to billing and insurance claim records to sophisticated treatment notes.

A practitioner who is a covered entity may not disclose protected health information unless it is required or permitted by the federal privacy rules or unless state law governs and it requires or permits the disclosure.

Minimum Necessary

An overriding concept within the privacy rules is that when disclosing protected health information without the patient's consent, the practitioner may only disclose the minimum amount of information necessary to reasonably comply with the request, unless the disclosure is to another health care provider for treatment purposes, or to the patient, or to the extent necessary to make a disclosure that may otherwise be required by applicable state law. The "minimum necessary" rule applies whether the privacy rules or existing state laws otherwise govern the

disclosure of protected health information.

Disclosures Without the Patient's Consent

Civil Litigation Generally [2]

State law sets out a number of exceptions to the general physician-patient privilege, one of which is civil litigation where the patient's physical or mental condition is at issue. SDCL 19-2-12. The federal privacy rules do not prohibit all non-patient-authorized testimony or production of medical records in connection with civil litigation, but they do change the conditions under which testimony may be given or records produced without the patient's consent.

Generally speaking, in order for the provider to release protected health information without the patient's consent, the privacy rules require either an order of the court or administrative agency or a subpoena which meets the requirements of the rules. In order for a subpoena to be sufficient, it must be accompanied by

(i) an order of the court or administrative tribunal;

(ii) proof that the requestor has given the patient reasonable notice of the subpoena and that the patient hasn't objected or the patient's objections have been addressed and overruled by the court or agency;

(iii) proof that the requestor has asked the court or administrative agency to issue a protective order that complies with the privacy rules; or

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2 Workers' compensation claims and litigation are treated separately under the heading "Workers' Compensation"

(iv) proof that the requestor and the patient have agreed to the terms of a protective order and have asked the court or administrative agency to issue such an order.

Thus, the privacy rules preempt current state law to the extent that disclosures of medical records or other physician-patient communications in a civil or administrative proceeding (other than workers' compensation proceedings) did not otherwise require a court order, and to the extent that state law allowed disclosures in response to a subpoena without giving the patient notice and the right to object.[3]

County Poor Relief Reimbursement Requests

Under South Dakota law, providers may in certain circumstances obtain reimbursement from counties for the cost of medical services provided to indigent persons. SDCL 28-13. In the case of hospitalizations, state law sets out specific criteria for claims and payment of those claims. With respect to claims from other health care providers, however, state law leaves it to the individual counties to adopt their own rules relating to eligibility, claims and payment of those claims. SDCL 28-13-27.2.

To the extent that state law or county rule requires a practitioner to file a claim for reimbursement with a county "poor relief" fund that would then be open to public inspection,

insofar as the practitioner is concerned, those claims would appear to be "payment activities," and therefore the practitioner may make the disclosure.[4]

Criminal Investigations and Litigation

The privacy rules preempt state law in certain circumstances relating to criminal investigations and litigation. The rules create six broad categories of circumstances within which protected health information may be released and the types of information that may be released.

First, a practitioner may disclose protected health information to law enforcement officials as is generally required by state law, such as state laws that require the reporting of gunshot wounds. However, if state law requires that the report be made to the Department of Health or some other specific officer or agency other than law enforcement, such as in the case of venereal disease, the disclosure may only be made to that agency, and not to law enforcement.[5]

A practitioner may also disclose protected health information in compliance and conformity with a court order, warrant, subpoena, or summons issued by a judge or a grand jury. Practitioners may also disclose protected health information in

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3 45 CFR 164.512(e)
4 45 CFR 164.506
5 45 CFR 164.512(f)

response to a subpoena, summons or formal demand of an administrative agency, but only if the information is relevant and material to a legitimate law enforcement inquiry, the request is specific and reasonably limited to the stated purpose of the request and de-identified information could not reasonably be substituted for individually-identifiable health information.[6]

Unfortunately, in the case of administrative requests, the practitioner is put in the awkward position of deciding whether the request meets the criteria set out in the rule. It is our suggestion that when in doubt, the practitioner consult with your legal counsel, and that you consider asking the administrative agency to obtain a court order for production of the information in question.

Second, a practitioner may disclose certain limited information for identification and location purposes. In addition to disclosures made pursuant to a court, grand jury or administrative order or subpoena, in order to assist in identifying or locating a suspect, fugitive, material witness or missing person, the practitioner may disclose the following information only:

(1) Name and address;

(2) date and place of birth;

6 45 CFR 164.512(f)(1)(ii)(C)

(3) Social Security number;

(4) ABO blood type and Rh factor;

(5) type of injury;

(6) date and time of treatment;

(7) date and time of death, if applicable; and

(8) a description of physical characteristics such as height, weight, gender, race, hair and eye color, facial hair, scars and tattoos.

In the absence of a court, grand jury or administrative order or subpoena, the practitioner may not disclose the individual's DNA, DNA analysis, dental records or typing, samples or analysis of body fluids or tissue (except for ABO blood type and Rh factor which may be disclosed).[7]

Third, a practitioner may disclose information about a suspected victim of a crime pursuant to a court, grand jury or administrative order or subpoena, or if the suspected victim consents to the disclosure. The practitioner may disclose such information in the absence of an order, subpoena or consent if the suspected victim is unable to consent because of incapacity or other emergency circumstance, and the requesting law enforcement officer represents to the practitioner that the information is needed to determine if a crime has been committed by someone other than the suspected victim, that the information

7 45 CFR 164.512(f)(2)

won't be used against the suspected victim, and the investigation will be compromised if law enforcement is forced to wait for the suspected victim's consent. In these latter circumstances, the practitioner may disclose the minimum amount of information necessary to meet the request if the practitioner in the exercise of professional judgment deems the release to be in the best interests of the patient. In these circumstances, we suggest that the practitioner make note of the circumstances and representations made by the law enforcement officer in the patient's record.

Fourth, a practitioner may alert law enforcement to the fact that a patient has died if the practitioner suspects that the death was the result of criminal activity.

Fifth, a practitioner may disclose protected health information to a law enforcement official if he or she believes in good faith that such information constitutes evidence of criminal conduct which occurred in the clinic, hospital or other professional setting where the practitioner practices.

Finally, if a practitioner provides emergency health care in a setting other than the clinic or hospital where the practitioner usually practices, such as in a gym or restaurant or on the street, then the practitioner may release protected health information to law enforcement if necessary to alert law

enforcement to the commission and nature of the crime, the location of the crime or victim and the identity, description and location of the perpetrator. However, if the practitioner believes the need for treatment is the result of child abuse or neglect or domestic violence, then the rules for reporting such abuse, neglect or violence apply (see Mandatory Reporting of Suspected Abuse or Neglect, below).

Disclosures to Protect the Health or Safety of Others

Both state law, SDCL 19-2-12, and the federal privacy rules authorize limited disclosures of otherwise confidential or protected information in the case of a serious and imminent threat to the health or safety of a person or persons other than the patient. The federal privacy rules authorize the disclosure of protected health information if the practitioner believes in good faith that the disclosure is necessary to prevent or lessen a "serious and imminent" threat to the health or safety of a specific person or persons, or to the public at large. However, the practitioner may only disclose the minimum amount of information necessary to address the threat and may only disclose to a "person or persons reasonably able to prevent or lessen the threat, including the target of the threat."

The practitioner may also disclose protected health information to a law enforcement official to help identify or

apprehend a person who has admitted participation in a violent crime that has caused serious bodily injury to a victim or if it appears that the patient has escaped from the custody of law enforcement personnel or a correctional facility.

In any event, the practitioner may not disclose information relating to even an imminent and serious threat to law enforcement personnel if the practitioner learns of the threat in the course of treating or counseling the patient for the propensity to commit the criminal conduct which the threat relates to, or learns of it through a request by the patient for such treatment or counseling.[8]

Insurance Claims

Except for certain psychotherapy notes, a practitioner may release protected health information to an insurance company, clearinghouse, or governmental entity paying health care benefits for the purpose of determining eligibility for benefits, the medical necessity of the treatment for which payment is sought or for treatment for the condition or conditions to which the information pertains.[9]

Investigative or Oversight Agencies

Even under the privacy rules, practitioners are still required to submit reports and respond to inquiries from federal,

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8 45 CFR 164.512(j)

state, local or tribal agencies that oversee or regulate the health care system in general and that need access to protected health care information to carry on those activities. Such oversight or regulatory activities include audits, investigations, inspections, licensure or disciplinary actions, and other similar activities.

Absent a court order, subpoena or administrative request that otherwise complies with the rules for disclosures in civil or criminal litigation or investigations, a practitioner may not disclose protected health information to an oversight or regulatory body unless the request is directly related to the patient's receipt of health care, a claim for public benefits related to health care, the receipt of or qualification for public benefits not related to health care, and the patient's physical condition is an integral part of the receipt of or qualification for such benefits.[10]

Reporting of Suspected Abuse or Neglect

SDCL 26-8A-3 and 26-8A-4 require physicians to report suspected child abuse or neglect, including deaths suspected to have resulted from child abuse or neglect. The federal privacy rules specifically authorize such reports to the extent permitted

9 45 CFR 164.506
10 45 CFR 164.512(d)

and required by applicable state law.[11]

SDCL 22-46-6 allows, but does not require, practitioners and their staff to report suspected cases of abuse or neglect of disabled adults. The practitioner may disclose such information if the disabled adult patient consents, if the individual is unable to consent, law enforcement represents to the practitioner that the information will not be used against the patient, and waiting until the patient is able to consent will compromise the investigation of the alleged offense.

If the practitioner makes such a report, he or she must tell the disabled adult patient of the report unless the practitioner believes, in the exercise of professional judgment, that making such a disclosure would place the patient at risk of serious harm. The practitioner is not required to tell the patient's guardian or personal representative if the practitioner, in the exercise of professional judgment, believes that the guardian or personal representative is the person responsible for the abuse or neglect and the disclosure would not be in the best interests of the patient.[12]

Public Health Activities

Numerous state statutes and regulations require practitioners to report statistical data and, in some cases, the

11 45 CFR 164.512(c)

identity of specific individuals to various state agencies. These reports are required by statute or rule and are intended for purposes of preventing or controlling disease, reporting vital events such as births and deaths and the conduct of public health surveillance or interventions. Generally speaking, these types of disclosures are permitted by the federal privacy rules without the need for consent from the patient, and thus the rules do not preempt existing state laws relating to such disclosures.

Examples of existing state statutes or rules which fit into the Public Health Activities category are the following:

Statutory Citation	Subject Matter
SDCL 1-43-11 and following	Cancer Data Collection System
SDCL 1-43-19 and following	Health Care Data System
SDCL 9-32-1	Reports to City Officials to Suppress Disease
SDCL 27B-1-9	Reports of Autism Cases
SDCL 34-20A-10	Collection of Data Concerning Substance Abuse
SDCL 34-22-12 and following	Contagious Disease Reports
SDCL 34-23-2 and following	Venereal Disease Reports
SDCL 34-23-9	Venereal Disease Testing of Pregnant Women
SDCL Ch. 34-24	Report of Ophthalmia Neonatorum

12 45 CFR 164.512(c)(2)(ii)

SDCL 34-24-17 and following	Screening for Metabolic Diseases
SDCL 34-24-26	Reports of Suspected Visual/Auditory Impairment
SDCL Ch. 34-25	Birth and Death Reports

Other Health Care Providers

A practitioner may disclose and discuss protected health information with another practitioner or other health care provider for the purposes of a referral for, or coordination of, treatment of the patient.[13] A practitioner may also disclose protected health information to another practitioner, another health care provider, insurance company, or government health benefit provider if the receiving entity either has or had a health care-related relationship with the patient, the information relates to that relationship and the information is sought for quality assessment, evaluations of provider performance, training, certification or licensing or similar activities, or for health care fraud, abuse control or compliance activities.[14]

Parents or Guardians

Generally speaking, under both the federal privacy rules and state law, a practitioner is authorized to release confidential

13 45 CFR 164.506
14 45 CFR 164.506

or protected health information to the parents of a minor or the guardian of a minor or adult subject to a guardianship. Parents of minor children and guardians are also empowered to consent to the release of confidential or protected health information on behalf of such children or protected persons.

A practitioner may elect not to treat a parent or guardian as such and not release information to them if the practitioner reasonably believes that the patient has been the subject of abuse, neglect or domestic violence by the parent or guardian and that releasing information to the parent or guardian may endanger the patient and is not in the patient's best interests.[15]

Workers' Compensation

The privacy rules specifically state that providers may release information in connection with workers' compensation claims or proceedings without the patient's consent.[16] Accordingly, state law continues to govern the release of information in connection with workers' compensation claims or proceedings, although as with all other protected health information, the "minimum necessary" standard does apply.

15 45 CFR 164.502(g)(5)
16 45 CFR 164.512.(l)

Disclosures With The Patient's Consent

Patient Consent

As in the past, the practitioner may release protected health information pursuant to a written authorization. However, the federal privacy rules require that specific information be included in the authorization form, and any information released must be consistent with that described in the authorization. A form of authorization that is consistent with the HIPAA Privacy Rules is included in the Appendix.

Parents and Guardians.

Generally speaking, under both the federal rules and existing state law, a practitioner is authorized to release confidential or protected health information to the parents of a minor or the guardian of a minor or adult subject to a guardianship. Parents of minor children and guardians are also empowered to consent to the release of confidential or protected health information on behalf of such children or protected persons.

Except in certain circumstances, South Dakota law requires 48 hours prior written notice to the parent or guardian of an unemancipated minor or to the guardian of an incompetent adult of

the patient's request for an abortion.[17] A parent or guardian need not be notified if the treating physician certifies that a medical emergency exists or if the patient asks that a parent or guardian not be informed, in which case a court order is necessary. In these circumstances, the federal privacy rules defer to state law as to the issues of notice to a parent or guardian and the minor patient's right to demand that a parent or guardian not be notified.[18]

A practitioner may elect not to treat a parent or guardian as such, and not release information to them, if the practitioner reasonably believes that the patient has been the subject of abuse, neglect or domestic violence by the parent or guardian and that releasing information to the parent or guardian may endanger the patient and is not in the patient's best interests.[19]

Psychotherapy Notes

Any other state or federal rule to the contrary notwithstanding, psychotherapy notes may only be released pursuant to a valid, written authorization unless the disclosure is to the originator of those notes for treatment purposes, for training purposes, to defend the practitioner in a legal

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17 SDCL 34-23A-7. The authors express no opinion concerning whether these provisions of state law are constitutional.

18 45 CFR 164.502(g); *see also*, OCR, U.S. Department of Health and Human Services, *Standards for Privacy of Individually Identifiable Health Information* at 31 (Dec. 3, 2002).

19 45 CFR 164.502(g)(5)

proceeding brought by the patient or for oversight activities relating to the originator of those notes.[20]

"Psychotherapy notes" are notes recorded by a mental health professional in any form (handwritten, typed, dictated) which document or analyze contents of conversations during individual or group counseling sessions. The term does not include medication prescription and monitoring documentation, treatment records, test results and the like.

Patient's Right of Access, to Amend and to an Accounting

Under the HIPAA-mandated privacy rules, a patient has a right of access to his or her medical records as long as they are maintained, except for psychotherapy notes, information compiled in anticipation of litigation, information protected by certain other federal laws[21], and in certain other circumstances. A provider may refuse to provide the patient access to records, and the patient has no right to seek a review of that denial, if the records are of a kind described above, if they relate to an inmate in a correctional institution (in some circumstances), if they relate to research, or if the records were received by the practitioner from a third party under a confidentiality agreement.[22]

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20 45 CFR 164.508(1)(2)
21 45 CFR 164.524(a)
22 45 CFR 165.524(a)(2)

The practitioner may also refuse to release records if the practitioner believes, in the exercise of professional judgment, that access would be reasonably likely to endanger the life or physical safety of the patient or some other person, if the record makes reference to another patient and the practitioner believes that such access is reasonably likely to cause substantial harm to the other patient, or if the request is made by a patient's parent or guardian and the practitioner believes that such access is likely to result in substantial harm to the patient or another person. In these circumstances, the patient, parent or guardian has a right to seek a review of the denial of access by another health care professional who is designated as the reviewing official by the practitioner's office or clinic.

The federal privacy rules also give the patient the right to request an amendment to their medical records. The practitioner may deny the request if he or she did not create the record, it is not part of the practitioner's records, it is not a record open to inspection by the patient or if the record is "accurate and complete."[23]

The patient also has the right to request an accounting of all disclosures made by the practitioner within the six years preceding the request, except for disclosures for treatment

23 45 CFR 164.526

activities, for payment activities, to the patient, pursuant to a written authorization, or for various other purposes.[24]

Records Retention Policies

South Dakota law provides that patient records may only be transferred to another practitioner, the patient, the patient's parent or personal representative, a licensed health care facility, or a corporation organized for the purpose of operating a health care clinic. If there is no one willing and able to accept the transfer of active patient records, the practitioner or his estate may retain or destroy them.

However, the practitioner or his estate must make a reasonable attempt to give thirty days prior written notice of the intent to destroy active records. State law also provides that the practitioner may destroy inactive patient records or if the practitioner is no longer aware of the patient's whereabouts.

Whether transferred by a retiring physician or the estate of a deceased physician, patient records are "protected health information," and therefore they may only be transferred consistent with the new federal rules. Accordingly, unless patient records are being transferred to another physician involved in the patient's care, they may not be transferred without the patient's authorization.

24 45 CFR 164.528

When attempting to notify a patient of the physician's intent to destroy records, the physician must make reasonable efforts to protect the privacy of the patient's protected health information, including the fact that the person was a patient. Accordingly, we recommend that the practitioner comply with the state law notice requirement by first sending a generic letter asking the patient to contact the practitioner about an "important matter," but without being more specific. If the patient responds, the practitioner should then request written authorization to destroy the records. If there is no response, a more specific notice indicating that the records (other than those required by the new rules to be retained) will be destroyed may be sent.

The new rules require practitioners to maintain certain records for a period of at least six years from the date of their creation. Those records include the documentation necessary to provide the patient an accounting of certain disclosures of protected health information[25] and certain other documentation. We recommend that practitioners follow the general rule that all medical records and related documentation be retained at least seven years from the date of their creation.

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25 45 CFR 164.528; *see also,* 45 CFR 164.530

Security Procedures For Protected Health Information

The privacy rules also require covered entities to develop and implement policies and procedures to protect the privacy of protected health information. Covered entities are required to designate a "privacy official" with primary responsibility for the development and implementation of such policies. Covered entities must also designate a contact person or office that is responsible for receiving complaints about alleged violations. Covered entities are not required to hire new personnel to perform these functions.

Covered entities must also put in place "appropriate administrative, technical and physical safeguards" to protect the privacy of protected health information. What is "appropriate" depends in part upon the circumstances, including the size of the clinic or office. At a minimum, the covered entity must have in place a written policy concerning the privacy of health information and the steps taken to protect that privacy, including appropriate sanctions for those who violate the privacy rules or the covered entity's policies.

Covered entities must provide for training for office personnel concerning what information is to be kept private and the safeguards implemented by the covered entity to keep such information private. Training must be provided within a

reasonable time after a new employee is hired, and must be updated as necessary as there are changes in the privacy rules, the covered entity's policies, or the circumstances under which existing policies are to be enforced (such as in the case of a move to a new clinic or office building).

There are a number of publications available which more fully address the privacy rules in general and the security requirements in particular. Some of those publications include sample or model policies and procedures. Among those publications is "HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT MODEL PRIVACY AND SECURITY POLICIES AND PROCEDURES" published by the South Dakota State Medical Association in cooperation with the Illinois State Medical Society and ISMIE Mutual Insurance Company, and available on the web at www.sdsma.org.

The Telephone and the Privacy Rules

The HIPAA-mandated privacy rules concerning disclosures with or without the patient's consent, of course, also apply to disclosures made over the telephone. The fact that an inquiry is made over the telephone adds the additional complicating factor of the need to verify the identity of the person requesting the information. For more information, the reader is referred to "HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT MODEL PRIVACY AND SECURITY POLICIES AND PROCEDURES" published by the

South Dakota State Medical Association in cooperation with the Illinois State Medical Society and ISMIE Mutual Insurance Company, and available on the web at www.sdsma.org.

SUMMARY OF LAWS (SELECTED) AFFECTING MEDICAL PRACTICE

ABORTION (See also, **MINORS, TREATMENT OF VENEREAL DISEASE**)

Since the 1973 decision of the United States Supreme Court in Roe vs. Wade, 410 U.S. 113, recognizing a woman's right to have an abortion in certain cases, abortions have been limited by state statute (SDCL 34-23A). The trimesters of pregnancy are recognized by statute, and abortions in those trimesters are regulated in the following manner:

(1) During the first 12 weeks of pregnancy, the decision of whether to seek or perform an abortion is left to the mother and the medical judgment of the attending physician;

(2) An abortion performed following the twelfth week of pregnancy[26] through the twenty-fourth week of pregnancy must be performed in a licensed hospital (or one operated by the United States) unless hospital facilities are not available, in which case it may be performed in the physician's clinic subject to the requirements of paragraph (4);

(3) An abortion may be performed after the twenty-fourth week of pregnancy only in a duly licensed hospital and only if there is appropriate and reasonable medical judgment that the performance of the abortion is necessary to preserve the life or health of the mother; and

(4) Abortions performed under paragraph (2) or (3) may be

26 Pursuant to the terms of a Consent Decree entered in 2005 by the U.S. District Court in Planned Parenthood v. Rounds, the twelfth week of pregnancy is now defined as ending 14 weeks and six days after the first day of the pregnant woman's last menstrual cycle.

performed only in a facility which has a blood bank or a sufficient supply of blood immediately available, together with Rh testing facilities.

The Legislature has imposed certain notice and consent requirements for adults, minors, and legally incompetent females. No abortion (except those performed in emergencies) may be performed upon any person without written notice and consent that meets the following criteria:

(1) At least 24 hours before the abortion is to be performed,the physician who is to perform the abortion, the referring physician, or an agent of either, must provide the following information to the patient seeking the abortion in person or by telephone:

(a) That medical assistance benefits may be available for prenatal care, child birth, and neonatal care;

(b) That the father of the unborn child is obligated to provide financial support for the child following birth, and that this obligation exists even if he offered to pay for the abortion;

(c) The name, address and telephone number of a nearby pregnancy help center;

(d) That the patient seeking the abortion has the right to review certain information published and made available by the South Dakota Department of Health. If the patient asks to see the information, it must be hand-delivered to her at least 24 hours before the abortion or mailed to her at least 72 hours before the abortion.

2) The patient must be informed of the following, in writing and orally by the physician or the physician's agent at least two hours before the abortion is performed:

(a) The name of the physician performing the abortion;

(b) That the abortion will "terminate the life of a whole, separate, unique, living human being;"

(c) That the patient "has an existing relationship with that unborn human being and that the relationship enjoys protection under the United States Constitution and the laws of South Dakota;"

(d) That by undergoing the procedure, the patient's "existing relationship" and "existing constitutional rights with regard to that relationship" will be terminated;

(e) A description of all known medical risks of the procedure and statistically significant risk factors to which the patient would be subjected, including depression and related psychological distress; increased risk of suicide ideation and suicide; an accurate statement of the rate of deaths due to abortions, including all deaths in which the procedure was a substantial contributing factor; all other known medical risks to the physical health of the patient, including infection, hemorrhage, danger to subsequent pregnancies and infertility; the probable gestational age at the time the abortion is to be performed, and a scientifically accurate description of the development of the unborn child at that age; and the statistically significant medical risks of carrying the child to term compared to undergoing an induced abortion.

Prior to performing an abortion, the physician must obtain written certification from the patient that she has received all of the notifications described above and must provide written answers to any questions she may ask. The physician must also certify in writing that all of the required information has been provided to

the patient, and to the best of the physician's knowledge, the patient has read and understands the information. There are specific requirements concerning the means of providing notice and obtaining the patient's certification, and the reader is referred to the statute for those rules. The statute also specifies the contents of the material to be published by the State Department of Health. SDCL 34-23A-10.1 to 10.4.

In the event of a medical emergency necessitating an immediate abortion (SDCL 34-23A-1(5)), the physician must inform the patient of the reasons for his judgment that an emergency exists and an abortion is necessary, and if possible, must do so before performing the abortion. The physician must also note the reasons for the physician's judgment in the patient's medical record. In such circumstances, the prior notice and written consent described above are not necessary.

Minors and Incompetents - Notice

If the patient is an unemancipated minor or is subject to a guardianship due to a finding of incompetency, then there are additional rules concerning notice. Specifically, 48 hours prior written notice must be given to one parent or the patient's legal guardian or conservator. The statute is very specific concerning the procedure to be followed in giving the notice. SDCL 34-23A-7 (2005 version).

The notice otherwise required by SDCL 34-23A-7 need not be given if any of the following circumstances exist:

1. If a medical emergency, SDCL 34-23A-1(5), exists and there is insufficient time to provide the required notice;

2. If the person who is otherwise entitled to the notice certifies in writing that he or she has been notified and the person's signature is acknowledged by a notary public; or

3. If the patient elects not to allow the notification of her parent or legal guardian, in which case the patient must petition the court for permission to proceed with the abortion without notification. The court then determines whether the patient is mature enough to make the decision without notifying her parent or legal guardian or whether proceeding without notice is in the best interests of the patient. In this scenario, absent a medical emergency, the physician cannot proceed without the court's approval. Orders denying permission for an abortion without notice are subject to an expedited appeal process. Orders granting permission for an abortion without notice may not be appealed.

If an abortion is performed without prior notice to a parent or guardian because of a medical emergency, the physician must notify a parent or guardian of the abortion within 24 hours after the procedure. The patient may petition the court to prohibit the physician from providing such notice. Absent a court order

prohibiting the physician from notifying the patient's parent or guardian, the physician must proceed to provide notice as required by the statute. SDCL 32-23A-7(1).

The HIPAA-mandated privacy rules defer to state law on the question of notice to parents and guardians.

Physicians, nurses or hospitals are not required to perform, assist or provide facilities for abortions if they choose not to do so. By statute, they incur no liability because of a refusal.

Reporting Requirements

When an abortion procedure results in a live birth, a birth certificate must be issued certifying the birth even though the fetus may thereafter die within a short time. When death occurs, a death certificate must be issued.

The 1998 and 2004 Legislatures imposed new reporting requirements relating to abortion procedures. Specifically, by January 15th of each year, physicians must file a report on a form provided by the State Department of Health setting out for the previous year the number of abortions performed, the method used, reason for the abortion, how the procedure was paid for and other information. SDCL 34-23A-34.

By February 28 of each year, physicians must also file a report on a form provided by the Department of Health listing for the previous year, among other things, the number of patients who

were provided with the informed consent required by South Dakota law relating to abortions, how they were informed, the number who asked for information from the Department of Health, how many proceeded with the procedure and how many abortions were performed without 24 hours notice due to medical emergencies. Physicians must also by February 28 file a state-supplied form with information from the prior year concerning, among other things, the number of unemancipated minor and legally-incompetent patients seeking abortions, whether notice was given to the parent or guardian and the number performed without notice but with judicial consent.

Because these reports fall into the category of public health activities, the physician may file such reports without fear of violating the HIPAA-mandated federal privacy rules.

Fetal Transplantation - Disposal of Aborted Fetuses

Fetal transplantation after an effective abortion is prohibited unless the tissue or organ was removed in the course of removal from an ectopic or molar pregnancy. There are special requirements for the disposal of aborted fetuses. SDCL 34-25-32.3, et. seq.

Partial Birth Abortions

Under current law, "partial birth abortions" are outlawed in South Dakota except when necessary to save the life of the mother.

"Partial birth abortion" is defined as "any abortion in which the person who performs the abortion causes a living fetus to be partially vaginally delivered before killing the infant and completing the delivery." SDCL 34-23A-32. The performance of a partial birth abortion is a Class 6 felony with a maximum sentence of two years in the state penitentiary and a $2,000 fine. In addition, the father of the aborted fetus and parents of a minor mother of the fetus may sue the physician performing the abortion for damages.

In *Stenberg v. Carhart*, 530 US 914 (2000), the United States Supreme Court affirmed a decision of the Eighth Circuit Court of Appeals declaring unconstitutional a Nebraska ban on so-called "partial birth abortions." The Eighth Circuit Court of Appeals also hears appeals from United States District Courts sitting in South Dakota.

Any discussion of the effect of the decision of the Supreme Court on the South Dakota ban is beyond the scope of this publication. Physicians with questions concerning the legal status of South Dakota's ban on partial birth abortions should confer with their own legal counsel.

Criminal and Civil Penalties

There are various civil and criminal penalties for failing to abide by South Dakota law relating to abortions. The following is

a listing of some of those penalties:

1. Prior to the 2002 decision in *Planned Parenthood v. Rounds*, 216 FSupp2d 983 (DSD 2002), the performance of an abortion "other than as authorized by chapter 34-23A" was a Class 6 felony, punishable by two years in the state penitentiary and a $2,000 fine. The district court in the Rounds case declared the felony penalty set out in SDCL 22-17-5 to be unconstitutional, and the defendants did not appeal that ruling. Accordingly, this particular criminal penalty no longer exists.

2. The performance of a "partial birth abortion" is also a Class 6 felony.

3. It is a Class 2 misdemeanor, punishable by 30 days in jail and a $200 fine, to knowingly or recklessly disregard the notice and informed consent rules above-described.

4. It is also a Class 2 misdemeanor to knowingly or recklessly fail to submit the reports above-described. In addition, the failure to file required reports within 30 days may result in an additional penalty of $500 for each 30 days that the report is late.

5. The law also provides for civil causes of action for performing unlawful abortions or failing to abide with the notice and consent requirements of the statutes. The Legislature has also in some cases authorized awards of punitive damages and attorney

fees.

This is not intended as an exhaustive listing of the various civil and criminal penalties that may apply. Physicians with questions are urged to contact their own counsel before performing the procedure in question.

Changes in the Law Relating to Abortions

While the details of the constitutionality of abortions and the parameters of permissible restrictions thereon are still being refined by the U.S. Supreme Court and Circuit Courts of Appeal, the general rules concerning abortions during the trimesters of pregnancy, as described above, continue to be the law. As of the publication of this Guide, there is ongoing litigation concerning the informed consent requirements imposed by the 2005 South Dakota Legislature. Accordingly, physicians with questions concerning the lawfulness of restrictions and conditions placed upon abortions by the state and federal government are encouraged to confer with their own legal counsel.

ACUPUNCTURE

No South Dakota statute or court decision suggests whether acupuncture is a form of the practice of medicine. However, an attorney general's opinion concludes that "the severing or penetrating of the tissues of human beings for the diagnosis or treatment of human ills are acts which have therefore been reserved

to physicians and surgeons licensed under SDCL 36-4." Opinion No. 75-109. Therefore, according to the Attorney General of South Dakota, the practice of acupuncture is part of the practice of medicine. Opinions of the Attorney General are persuasive authority, but not binding on the courts. It should be noted, however, that Medicaid will not pay for acupuncture, even if performed by a physician.

ADVANCE DIRECTIVES

South Dakota law allows patients to give advance directives for health care via either a durable power of attorney for health care or a living will. At a patient's request, and after informed consent, a physician may also give a specific advance directive concerning cardiopulmonary resuscitation.

Generally speaking, a durable power of attorney is a means by which the patient can appoint a specific person or persons to make health care decisions in the event the patient is incapable of doing so. A living will, on the other hand, sets out in writing the patient's preferences concerning artificial nutrition and hydration and other life-sustaining treatment. An advance directive relating to cardiopulmonary resuscitation is in the form of a physician's order and is specific to cardiopulmonary resuscitation, including use of a defibrillator, CPR, or a ventilator.

In order to be valid and enforceable as a power of attorney for health care purposes, the document granting the power must include the words "this power of attorney shall not be affected by disability of the principal" or "this power of attorney shall become effective upon the disability of the principal," or other similar language showing the principal's intent that the power of attorney shall continue to be enforceable despite the principal's disability. It must be signed by the principal/patient and acknowledged by a notary public.

Such a power of attorney may, but is not required to, be recorded in the office of the Register of Deeds. The power of attorney remains effective during the lifetime of the principal unless revoked in writing and the revocation is recorded in the office of the Register of Deeds where the original was recorded. If recorded, a certified copy of the power of attorney is effective as an original. If the power of attorney is not recorded, the practitioner should insist on seeing the original before relying on it.

If the patient is incapacitated to such an extent that he or she cannot make a reasoned decision concerning health care issues, the attorney-in-fact named in the power of attorney may make those decisions on behalf of the patient. If the attending physician in good faith believes that the patient is able to make such

decisions, then the physician may rely on the decisions made by the patient and disregard those made by the attorney-in-fact.

Any decision made by an attorney-in-fact must be in accordance with accepted medical practice, must take into account the advice of the attending physician and must, to the extent possible, take into account the wishes of the patient if the patient had the ability to make the decision.

In no event may an attorney-in-fact authorize the withholding of comfort care or nutrition or hydration. However, artificial hydration or nutrition may be withheld or withdrawn if

(1) not needed for comfort care and the attending physician reasonably believes the patient will die within approximately one week;

(2) it cannot be physically assimilated by the patient;

(3) it is more burdensome than beneficial to provide it, except that the burden of providing it is not to be compared to the patient's quality of life;

(4) there is clear and convincing evidence that the patient refused artificial hydration while still able to make decisions for himself or herself;

(5) the power of attorney specifically directs that it not be given or specifically gives that decision-making authority to the attorney-in-fact; or

(6) there is clear and convincing evidence that while still able to make decisions, the patient expressed a desire not to receive artificial hydration or nutrition.

Even if the circumstances otherwise would allow for the withdrawal of artificial nutrition or hydration, it cannot be withdrawn if

needed for comfort or the relief of pain.

If the patient is pregnant, life-sustaining treatment or artificial hydration or nutrition must be provided unless providing such treatment, hydration, or nutrition will not allow the continuing development and live birth of the unborn child, will be physically harmful to the woman or will prolong severe pain which cannot be controlled by medication. In order to withhold such treatment, the attending physician and one other physician who has examined the patient must certify in the patient's chart to a reasonable degree of medical probability that one of the above-described grounds for withholding or withdrawing treatment exists.

An alternative to a durable power of attorney for health care is a living will. In order to be valid, a living will declaration must be in writing and signed by the patient or at the patient's direction and witnessed by two adults or acknowledged by a notary public.

An otherwise valid living will only governs the withholding or withdrawal of life-sustaining treatment, which is defined as any medical procedure or intervention that will serve only to postpone the moment of death or maintain the patient in a condition of permanent unconsciousness. The term includes artificial nutrition and hydration, but does not include the provision of appropriate care to maintain comfort, hygiene and human dignity, the oral

administration of food and water, or the administration of medication or any medical procedure deemed necessary to alleviate pain.

The practitioner must abide by the terms of the living will if the attending physician and one other physician determine that the patient is in a terminal condition and is no longer able to make decisions concerning the administration of life-sustaining treatment. The term "terminal condition" is defined to mean an incurable and irreversible condition that, without life-sustaining treatment, will cause death within a short time or a coma or other state of permanent unconsciousness in which the patient is unable to communicate in any fashion, demonstrates no purposeful movement and is unable to purposefully interact with environmental stimulation.

Once the determination is made that the patient has a terminal condition, the physician should record that determination and the terms of the living will in the patient's chart. If the patient orally or in writing revokes the living will, even if the patient does not appear mentally competent to do so, it is deemed revoked and the physician must so note in the patient's chart.

The same rules concerning life-sustaining treatment and artificial nutrition and hydration apply to the treatment of a pregnant woman with a living will as to a pregnant woman with a

durable power of attorney for health care.

If the practitioner for any reason does not wish to participate in the withholding or withdrawal of life-sustaining treatment or artificial nutrition or hydration, the practitioner must make a reasonable effort to transfer the patient to a practitioner willing to comply with the patient's wishes. If the patient has directed that life-sustaining treatment or artificial nutrition or hydration be provided, the practitioner must do so as long as it is technically feasible. If the practitioner objects to continuing such treatment, he or she must continue to provide it until the patient's care is transferred to another practitioner willing to carry out the patient's wishes.

An "EMS cardiopulmonary resuscitation directive" is in the form of a medical order signed by or behalf of the patient and by the patient's physician, physician's assistant or nurse practitioner. The order directs emergency medical service personnel, health care providers and health care facilities not to use cardiopulmonary resuscitation. If the existence of the directive is "readily apparent" to the health care provider, and the provider complies with it, that provider is not subject to civil or criminal liability or discipline for unprofessional conduct.

The statute does not define or give examples of "readily

apparent," but the Department of Public Safety has promulgated rules allowing for the use of both "standard" and "non-standard" forms of written directives and standard bracelets issued by the Department. In the absence of an apparently valid written directive or a standard bracelet, EMS personnel are by rule directed to presume that the patient consents to resuscitation efforts.

In the absence of a valid advanced directive or of the attorney-in-fact designated by the incapacitated patient, health care decisions may be made by the following who are available to make the decision, in the order stated:

(1) spouse, if not legally separated;

(2) an adult child;

(3) a parent;

(4) an adult sibling;

(5) a grandparent or adult grandchild; or

(6) an adult aunt or uncle or adult niece or nephew.

ADVERTISING

The U.S. Supreme Court effectively settled the question of whether professionals may advertise, notwithstanding rules to the contrary by their licensing bodies, in Bates vs. State Bar of Arizona, 433 U.S. 350 (1977). So long as the advertising is not false, deceptive or misleading, it is permissible, and neither the

state nor a professional association can prohibit the members of a profession from advertising. In South Dakota, state statutes make false and misleading advertising a deceptive trade practice and illegal. Advertising which is false or misleading can subject a person to conviction of a Class 2 misdemeanor, civil liability in certain circumstances, or an injunction prosecuted by the Attorney General of the state.

The HIPAA-mandated privacy rules allow health care providers to disclose protected health information to business associates who "assist" the provider with its advertising activities. This does not mean that a provider can use individually-identifiable health information in its general advertising. It does mean, however, that the provider can generally use protected health information to identify potential consumers of health care services and to target specific advertising to certain potential consumers.

ANATOMICAL GIFTS

South Dakota has adopted the Uniform Anatomical Gift Act (SDCL 34-26-20 to 34-26-41, inclusive), and under that Act, any person "of sound mind and fourteen years of age or more may give all or any part of his body" to:

(1) Any hospital, surgeon or physician for the purpose of medical or dental education, research, advancement of medical or dental science, therapy or transplantation;

(2) Any accredited medical or dental school, college or

university for the purpose of education, research, advancement of medical or dental science, or therapy;

(3) Any bank or storage facility, for the purpose of medical or dental education, research, advancement of medical or dental science, therapy or transplantation;

(4) Any specified individual for therapy or transplantation needed by him.

If the donor is younger than eighteen, a parent or guardian must give consent for the donation. The HIPAA-mandated privacy rules relate only to the privacy of healthcare-related information, and not to consent to treatment, so the privacy rules do not affect state law concerning who may or must consent to the donation of an organ.

Any of the following persons, in order of priority stated, when persons in prior classes are not available at the time of death, and when there is no actual notice of contrary indications by the decedent or actual notice of opposition by a member of the same or a prior class, may give all or any part of a decedent's body for any approved purpose:

(1) The spouse;

(2) An adult son or daughter;

(3) Either parent;

(4) An adult brother or sister;

(5) A grandparent;

(6) A guardian of the person of the decedent at the time of

his death;

(7) Any other person authorized or under obligation to dispose of the body.

The gift of all or part of the body may be made by will, by a donor card or by some other document. The document must be signed by the donor or by another person acting at his direction. A gift document may be imprinted on or affixed to the donor’s driver’s license. If a state or local law enforcement officer has possession of the deceased’s driver’s license, that officer may, upon request, inform the decedent’s attending physician or nurse, next of kin, the coroner, any other person having lawful custody of the decedent’s body, or any procurement agency for anatomical gifts of the notation or lack thereof on the decedent’s driver’s license concerning organ donation. The federal privacy rules do not prohibit such a disclosure.

Only the potential organ donor may revoke a previous decision to become an organ donor. If the will, card or other document expressing the intention to become an organ donor has been delivered to a specific donee, the potential organ donor may revoke the gift by delivering a signed statement to the donee, by making an oral statement in the presence of two persons and communicated to the donee, by statement during a terminal illness or injury made to an attending physician and communicated to the donee, or by a

signed card or other document found on the person or in the person’s effects.

The physician who certifies death may not participate in the procedures for removing or transplanting a part given by a donor. The provisions of the Uniform Anatomical Gift Act are subject to the laws of South Dakota on autopsies. A licensed funeral director or any other person certified under SDCL 34-26-29.1 may, at the direction of a physician, enucleate eyes to facilitate a gift under this chapter after proper certification of death by a physician.

The sale of transplantable organs is prohibited. A sale in knowing violation of this provision, except in an emergency, is a Class 6 felony (2 years and a $2,000.00 fine).

All hospitals are required to establish a written protocol for the identification of potential organ donors. That protocol must include the following:

(1) It must assure that families of potential organ donors are made aware of the option of organ and tissue donation and their option to decline;

(2) It must encourage discretion and sensitivity with respect to the circumstances, views and beliefs of such families;

(3) It must require that an organ procurement agency designated by the United States Secretary of Health and Human Services be notified of potential organ donors; and

(4) It must require that an eye and tissue donation organization designated by the hospital be notified of potential eye and tissue donors.

BIRTHS, REGISTRATION OF

The birth of every child born in this state must be registered with the local registrar within seven days after the date of each live birth. When a birth occurs in an institution, the physician in attendance at the birth or his designated representative must, within five days, obtain the necessary data and provide it to the person designated by the institution to file such certificates.

If the child is born outside an institution, the certificate must be prepared by the physician in attendance at or immediately after the birth, or if no physician was in attendance, by any other person in attendance at or immediately after the birth. If there was no physician or other third party in attendance, then it is the duty of the father or mother, or if they are absent or unable, the person in charge of the premises where the birth occurred. If the child is born in a moving conveyance, the place where the child is first removed from the conveyance is the place of birth.

If the child is born out of wedlock, the name of the father may not be placed on the certificate without the permission of the mother and the putative father or by court order. The certificate must contain the unwed mother's surname unless an affidavit of paternity signed by both parents is filed with the certificate. If the father of the child is someone other than the mother's husband, then the husband's surname must be used unless the mother, husband,

and father all sign an affidavit naming the true father.

As to live births resulting from abortion procedures, see **ABORTIONS.**

BLOOD TRANSFUSIONS

Insofar as the transmission of viral hepatitis, HIV and certain other infectious diseases through blood transfusion is concerned, state statute (SDCL 57A-2-315.1) provides that there are no implied warranties of merchantability or fitness applicable to the sale of human blood, blood plasma or other human tissue or organs if the diseases cannot be detected by standard tests. This statute presumably protects the provider of blood, blood plasma or tissue or organs from liability where the donee contracts viral hepatitis or one of the other listed diseases. However, the statute does not apply to other blood transmitted diseases or anomalies.

For the discussion of blood transfusions to minors without parental consent and blood donation by minors, see **MINORS, TREATMENT OF.**

CHELATION THERAPY

In response to a determination by the Board of Medical and Osteopathic Examiners declaring chelation therapy effective only for the treatment of hypercalcemia, digitalis toxicity and heavy

metal poisoning, the 1993 Legislature passed legislation permitting other uses for chelation therapy. The legislation does not specify those uses for which chelation therapy is approved, although the proponents of the legislation were specifically advocating chelation therapy for the treatment of atherosclerosis. The bill passed by the Legislature prohibits the Board from basing a finding of unprofessional or dishonorable conduct solely upon the basis that a licensee practices chelation therapy.

CHILD ABUSE

Physicians, as well as others (e.g., other health care personnel, social workers, law enforcement officers, teachers, and counselors), are required to report cases where they have reasonable cause to believe that the abuse or neglect of any child under the age of 18 years has occurred. The definition of "abuse and neglect" is broad and includes not only starvation, intentional physical injury or sexual abuse, but also lack of proper supervision or medical care, emotional harm or mental injury that has affected the child's intellectual or psychological capacity, prenatal exposure to the abusive use of alcohol or drugs, and knowing exposure of the child to an environment that is being used for the manufacture of methamphetamines. Further, any person who has reasonable cause to suspect that a child has died as a result of child abuse, sexual abuse or neglect must report it to the

medical examiner or coroner.

In other circumstances, the report should be made orally and immediately by telephone or otherwise to the state's attorney, the Department of Social Services, the county sheriff or the city police. Persons who in good faith report child abuse are immune from any liability, civil or criminal, by reason of such a report. The physician-patient privilege may not be claimed in any judicial proceeding involving child abuse or child neglect or resulting from the giving of any report concerning child abuse. Any person required by law to report child abuse who knowingly and intentionally fails to do so is guilty of a Class 1 misdemeanor.

If the child suspected to have been abused is examined in a hospital or similar institution, the person suspecting child abuse must immediately notify the person in charge of the institution or his designee, who then is required to make the report. All hospitals and similar institutions are required to have a written policy on report of child abuse and neglect.

The HIPAA-mandated privacy rules specifically authorize child abuse or neglect reports to the extent permitted and required by applicable state law.[27]

COMMITMENT OF MENTALLY ILL

The procedures to be followed for the involuntary commitment

of adults and minors for treatment of mental illnesses or chemical dependency set forth in state law are complex and have become more fraught with potential pitfalls because of the overlay of the HIPAA-mandated privacy rules. Accordingly, the following is intended only as an overview of the law as it currently stands, and the physician is directed to the statute and the physician's personal lawyer for more information.

Adults

Any person 18 years of age or older may voluntarily commit themselves to the South Dakota Human Services Center. Any person voluntarily admitted must sign an informed consent in a form required by the statute. If the person is not 18 years of age, or otherwise is not able to give an informed consent, a court-appointed guardian or next of kin may give the consent with specific court approval. In any event, however, the patient must also voluntarily sign the admission form.

If necessary, any person 18 years of age or older may petition the chairperson of the County Board of Mental Illness for an involuntary commitment. A person may be involuntarily committed only if the patient is in need of, and likely would benefit from, treatment for a severe mental illness which causes the patient to

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27 45 CFR 164.512(c)

be a danger of the patient or others. The petition must be directed to the board of the county in which the patient is found.

The petition must be verified by a sworn affidavit and contain the following:

(1) A statement by the petitioner that he believes, on the basis of personal knowledge, that the patient is, as a result of severe mental illness, a danger to self or others;

(2) The specific nature of the danger;

(3) A summary of the information upon which the statement of danger is based;

(4) The facts which caused the patient to come to the petitioner's attention;

(5) The name, address and signature of the petitioner and a statement of his interest in the case (such as "attending or treating physician"); and

(6) The name, address, age, marital status, and occupation of the patient, and the name and address of the patient's nearest relative (or parent or guardian if the patient is a minor).

After a petition is filed, the patient may be apprehended and temporarily detained. It should be noted that a police officer may at any time apprehend a person if the officer has probable cause to believe that the person requires emergency intervention. A petition must be filed immediately, and in no event later than 24 hours after such an apprehension.

Immediately after the patient is taken into custody, he must be notified both orally and in writing of his right to immediately

contact the person of his choosing, to immediately contact and be represented by counsel, that he will within 24 hours be examined by a qualified mental health professional designated by the chairperson of the county board and that he is entitled to a hearing within five days of the date of his apprehension. The person may, at any time, voluntarily admit himself to an inpatient psychiatric facility or other treatment program. Should the person express a desire so to do, the chairperson of the County Board of Mental Illness shall determine whether or not an admission is appropriate.

Within 24 hours after apprehension of a person who allegedly requires emergency intervention, the chairperson of the County Mental Health Board must designate a qualified mental health professional to conduct an examination, including a mental status examination, of the patient. Prior to the examination, the mental health professional must identify himself to the patient and explain the nature and purpose of the examination, including the fact that it is being performed to assist in the determination of whether custody should continue. The mental health professional must also advise the patient that the examination may be used as evidence in an involuntary commitment hearing.

Upon completion of the examination, the mental health professional must immediately report his findings to the

chairperson of the county board. The expense of the examination is to be paid by the appropriate county.

If the examination does not support a finding that the patient is a danger to self or others, the patient must be released. If the examination supports a finding that the person should be detained, however, then the chairperson of the county board may order that the person continue to be detained for a period of not longer than five days pending a hearing.

Within five days of detention, the patient must be given a hearing at which he or she may be represented by counsel. The cost of counsel may be reimbursed by the appropriate county. Prior to the hearing, the qualified mental health professional that conducted the examination must submit a copy of his report, along with truthful answers to the following written questions:

(1) HISTORY

(a) Informant: (1) Name
(2) Address
(3) Relationship

(b) Patient: (1) Full name
(2) Born, place, date
(3) Sex, race, education
(4) Occupation
(5) Social Security No.
(6) How long in South Dakota

(c) Wife/Husband: (1) Name
(2) Address

(d) Father: (1) Full name

(If a minor) (2) Address

(e) Mother: (1) Full name
(If a minor) (2) Address

(f) Next of kin: (1) Full name
(2) Address
(3) Relationship

(g) Legally responsible relative or guardian:
(1) Full name
(2) Address
(3) Relationship

(h) Military service

(i) Previous treatment for mental illness: Give dates and places of treatment, dates of previous hospitalization, etc.

(2) EXAMINATION

Findings:

(a) Physical condition, including any special test results;
(b) Present mental condition;
(c) Is this patient considered to be a danger to self? If so, explain:
(d) Is this patient considered to be a danger to others? If so, explain:
(e) Diagnostic impression;
(f) Is the person taking any medication or drugs?
(g) In your opinion, could this person benefit from treatment? If so, please list the least restrictive alternatives:
(h) Signature of qualified mental health professional.

If the patient in detention is receiving mental health treatment during the detention, the independent mental health professional appointed by the chairperson of the county board must take all reasonable precautions to insure that at the time of the

hearing the person is not so under the influence of, or so affected by drugs, medication or other treatment or interventions as to be hampered in preparing for or participating in the hearing. The Board of Mental Illness must, at the time of the hearing, be presented a record of all drugs, medication and other treatments or interventions the person has received since being taken into custody.

At the hearing, the qualified mental health professional that conducted the examination must testify concerning the following:

1. The availability and appropriateness of treatment alternatives, including those other than inpatient treatment, and specifically including those available at the local mental health center serving the area where the patient resides or was apprehended; and

2. The nature of alternative treatment programs that are or should be made available, the nature of the alternative treatment programs that were investigated, and why investigated alternatives were not chosen.

The HIPAA-mandated privacy rules specifically authorize testimony or other disclosures in response to an order of a court or administrative agency, provided that the information provided is limited to that expressly authorized or requested by the order

of the court or as part of an administrative proceeding.[28] A County Mental Health Board or similar entity created by statute and operating within the scope of the law creating it was likely intended to be included within the meaning of the phrase "administrative proceeding," and thus the new rules likely authorize such disclosures, but only in response to a specific order.

In those situations where the patient (adult or minor) is a serious and imminent threat to the patient or others and involuntary commitment to a mental health treatment facility is necessary, the HIPAA-mandated privacy rules allow the practitioner to provide relevant information or sign a petition for involuntary commitment.[29] However, any release of information in these circumstances may only be made to a person or entity reasonably able to lessen the threat or to the person that is the subject of the threat. Under this standard, the practitioner can reveal such information to the Board of Mental Illness, to law enforcement (subject to the exception set forth below), and perhaps to a close family member, but probably not to others.

In any event, the privacy rules do not allow the

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28 45 CFR 164.512(e)

29 45 CFR 164.512(j)

practitioner to disclose to law enforcement personnel information relating to even an imminent and serious threat if the practitioner learns of the threat in the course of treating or counseling the patient for the propensity to commit the criminal conduct which the threat relates to, or learns of it through a request by the patient for such treatment or counseling.[30]

An even more difficult issue arises when family members, law enforcement officials, or others ask the practitioner to provide information or sign an initial affidavit or petition seeking an involuntary commitment. At this stage, there is no proceeding within which the County Board or Chairman thereof can issue an Order, but in some circumstances the signature of a practitioner is required as a part of the Petition. Is this the type of situation where the practitioner can release protected health information without an order? What if the practitioner learns of the threat while treating the patient for the condition which gives rise to the propensity to be a threat? Until such time as these questions are resolved by amendments to the privacy rules or South Dakota law or by the courts, it is suggested that practitioners consult with their local counsel concerning the facts and circumstances with which they are faced.

If at the hearing the person is not found to be a danger to

30 45 CFR 164.512(j)(2)

self or others, he or she must be released. If the person is found to be a danger to self or others, then the Board of Mental Illness must determine what treatment is most appropriate. If appropriate alternatives to in-patient treatment are available, commitment to an in-patient program is not allowed. Commitment should then be to the least restrictive form of appropriate treatment.

If the patient is committed to the Human Services Center or some other facility, the patient is entitled to periodic reviews.

The terms "qualified mental health professional" and "independent mental health professional" mean any physician who is licensed to practice medicine or osteopathy in South Dakota or any one of the following who has received a competency-based endorsement from the Department of Human Services:

(1) A psychologist who is licensed to practice psychology in South Dakota;

(2) A psychiatric nurse with a master's degree from an accredited education program and two years of supervised clinical experience in a mental health setting;

(3) A certified social worker with a master's degree from an accredited training program and two years of supervised clinical experience in a mental health setting;

(4) Any person who has a master's degree in psychology from an accredited program, two years of supervised clinical mental health experience, and who is working in a public or private non-profit organization or institution under the supervision of a licensed psychologist; or

(5) A counselor who is certified as a licensed professional counselor - mental health.

Each qualified mental health professional must meet all licensing and certification requirements promulgated by the State of South Dakota for persons engaged in private practice of the same profession in South Dakota. In order to be independent, a qualified mental health professional must be a person other than the person who filed the petition described above.

Minors

An unemancipated or unmarried minor may be admitted to an inpatient psychiatric facility upon application of a guardian or legal custodian (including a parent) upon the recommendation of a qualified mental health professional. Admission is proper only if the following criteria are met:

(1) The minor has a severe mental illness, defined as substantial organic or psychiatric disorder of thought, mood, perception, orientation or memory which significantly impairs judgment, behavior or ability to cope with the basic demands of life. Mental retardation, epilepsy, other developmental disability, alcohol or substance abuse, brief periods of intoxication, or criminal or delinquent behavior do not in and of themselves constitute severe mental illness;

(2) The minor needs and is likely to benefit from inpatient psychiatric treatment;

(3) The inpatient psychiatric treatment facility has determined that:

(a) Reasonable efforts have been made to provide treatment through means less restrictive than inpatient treatment; and

(b) Less-restrictive alternatives have failed to meet the needs of the minor; or

(c) Less-restrictive alternatives are unlikely to meet the needs of the minor; and

(4) The parent has given an informed written consent to inpatient treatment. (The minor must give oral consent).

If the foregoing criteria are met, the administrator of the facility may forthwith admit the minor for an immediate clinical evaluation. Upon completion of the evaluation, the administrator or director of the facility may continue the admission for a period of up to 45 days, but only upon written findings by the evaluator that the criteria for admission have been met. Additional evaluations must be performed at least every 45 days.

A parent who requested admission may also demand immediate discharge. If there is an objection to the discharge, then the burden is on the objecting party to seek emergency intervention or an involuntary commitment.

The minor to be admitted, or an adult acting on his behalf, may object to the admission. If such an objection is made, the minor may remain in the facility, but the chairperson of the Board of Mental Illness for the county where the facility is located must order an independent evaluation, including a mental status examination. The evaluation must be completed within 24 hours of the objection.

The chairperson of the county board may at any time order the discharge of the minor to the custody of his or her parent if the chairperson determines that the admission is inappropriate. If the parent refuses to take custody, the state’s attorney is notified, and temporary custody proceedings (presumably including foster care) will be initiated.

After an objection, and assuming no discharge by the county chairperson, the county board must within five working days hold a hearing. The board may overrule the objection and continue the admission or require an immediate discharge.

Within 10 days after admission, a written comprehensive individualized treatment plan must be developed and implemented. The plan must be developed by appropriate qualified mental health professionals, including a psychiatrist, and must be explained to the minor and the parent. The minor must also receive educational programming consistent with applicable federal and state law. The treatment plan must be reviewed at least every 30 days.

A minor may be involuntarily committed utilizing the same basic procedures, criteria and rights provided for adults. The following differences exist:

(1) When determining whether a minor is a “danger to self,” a decision regarding the ability of a minor to attend to basic human needs shall be based upon the age of the minor and appropriate expectation of the abilities of a minor of such age to attend to basic human needs;

(2) Delinquent behavior alone does not constitute “severe mental illness;”

(3) A detained minor must be kept separate from detained adults;

(4) The chairperson of the county board must appoint legal counsel for the minor.

In those circumstances where the patient is a minor or a person (adult or minor) already subject to a guardianship, the privacy rules generally authorize a parent (in the case of a minor) or guardian to consent on behalf of the patient to the release by the practitioner of information relating to the patient’s mental health.[31]

In the case of any minor in inpatient care, an aftercare plan must be formulated before discharge.

During treatment, no intrusive or experimental procedures, including convulsive or shock therapy or electric shock may be utilized, absent court order. The oral and written informed consent of the parent must be obtained. If the minor is over age 16, his or her consent must also be obtained.

Psychotropic medications may only be administered if they are the least restrictive alternative and the parent has given oral and written informed consent. If the minor is over age 16, the minor’s

31 45 CFR 164.508(g)

consent must also be obtained. Absent consent, treatment with psychotropic medications may only take place pursuant to court order.

The Legislature has also mandated the creation of a state interagency coordinating network council and local interagency teams made up of representatives of the Department of Human Services, Department of Social Services, Department of Health, Department of Corrections, the court system and others. The council and local teams are to coordinate the provision of services, gather data and act as a resource for mentally ill persons, their parents or guardians, health care professionals and others.

CONTROLLED SUBSTANCES

Drugs and other substances are controlled by state statute. A schedule of various chemical substances is provided for the purpose of control. The schedules are as follows:

> Schedule I. These substances have a high potential for abuse, have no accepted medical use in the United States, and lack accepted safety for use under medical supervision.
>
> Schedule II. These substances have a high potential for abuse, have a currently accepted medical use in the United States, or currently accepted medical use with severe restrictions, and under abuse may lead to severe psychic or physical dependence.
>
> Schedule III. These substances have a potential for abuse less than the substances listed in Schedules I and II, have a well documented and approved medical use in the United States,

> and with abuse may lead to moderate or low physical dependence or high psychological dependence.
>
> Schedule IV. These substances have a low potential for abuse relative to the substances listed in Schedule III, have a currently accepted medical use in the United States, and use may result in limited physical dependence or psychological dependence, or both, relative to substances listed in Schedule III.

Specific substances are listed under each schedule. The 2004 Legislature added ephedrine to the list of Schedule III drugs.

Prescriptions

No person, other than a practitioner (e.g., M.D., physician's assistant, osteopath, podiatrist, optometrist, dentist or D.V.M.) who is not a pharmacist, may dispense a controlled drug or substance included in Schedule II to an ultimate user without the written prescription of a practitioner other than a pharmacist. No prescription for a Schedule II drug or substance may be refilled.

However, a pharmacist may dispense a Schedule II drug upon receipt of an oral prescription from a practitioner other than a pharmacist if the practitioner states that immediate administration of the controlled substance is necessary for proper treatment of the patient; that no appropriate alternative treatment is available, including administration of a drug which is not a controlled substance under Schedule II; and that it is not reasonably possible for the prescribing practitioner to provide a written prescription to be presented to the person dispensing the

substance prior to the dispensing, and the pharmacist reduces the prescription and information required by this provision to writing and retains it with his records. The practitioner must within seven days provide to the pharmacist a written prescription for the emergency quantity prescribed, which prescription must include the statement "Authorization for Emergency Dispensing."

Except when dispensed directly by a practitioner, other than a pharmacist, to an ultimate user, no controlled drug or substance included in Schedules III or IV may be dispensed without a written or oral prescription. The prescription may not be filled or refilled more than six months after the date thereof or be refilled more than five times after the date of the prescription, unless reviewed by a practitioner.

Prescriptions for Schedule III and IV controlled substances may be transmitted to the pharmacist by facsimile equipment, and the facsimile will suffice as an original. Prescriptions for Schedule II controlled substances may also be transmitted by facsimile equipment, but the original, written prescription must be presented to the pharmacist before the drug may be dispensed.

No controlled drug or substance included in Schedules II, III, or IV may be distributed or dispensed other than for medical purpose.

Practitioners may not prescribe controlled substances for

their own use. Practitioners may not directly administer or direct a controlled substance, including a controlled sample, for their own use.

Records

Practitioners must be registered with the State Health Department, Division of Health Systems Development and Regulation, to dispense substances in Schedules II through IV if they are authorized to dispense under the law of South Dakota. Registrants dispensing controlled drugs and substances must maintain complete and accurate records of all stocks of such drugs and substances on hand. Records and inventory shall contain such information as shall be provided by rules and regulations promulgated by the department. All required records must be kept for a period of at least two years. The provision relating to records does not apply to practitioners who lawfully prescribe or administer, but do not otherwise dispense, controlled drugs and substances.

Destruction of Drugs

Medical practitioners or clinics often must destroy out-dated, damaged, returned or unneeded office drugs or samples. A medical practitioner may destroy such undesired items, except for controlled substances and hazardous materials, in any safe and prudent manner.

The actual destruction may be done in any proper and prudent

manner such as dissolution through the sewer system, incineration, or compaction and direct burial at a landfill. Great care must be taken to insure that all drugs, including samples, are rendered unfit for consumption. Very special care must be given to injectable items to insure that all needles are properly disposed of.

Determination of Expiration Dates

It is the responsibility of the practitioner to see that out-dated products and near out-dated products are removed from stock. The United States Pharmacopeia directs that unless specified by an actual date, it is assumed that the product will be out-dated on the last day of the month shown on the package. Good practice dictates that careful consideration be given by the practitioner to expiration dates of the product before dispensing. If the directions for use and the quantity dispensed would mean that the patient would be taking the medication beyond the expiration date, the product must be removed from stock.

Because of differences in packaging and handling, samples carry shorter expiration dates than conventionally packaged drugs. Any drug retained in stock beyond its expiration date is considered by law to be adulterated and misbranded.

Hazardous Materials

Certain drugs, primarily chemotherapy agents and materials

used in handling the drugs, may be considered to be hazardous materials by state and federal regulation. These materials should not be disposed of through conventional methods. Arrangements should be made with other facilities that dispose of hazardous materials to insure proper disposal.

Controlled Substances (Scheduled Drugs)

Practitioners are not authorized to destroy any controlled substances, including controlled samples, without authorization from the Drug Enforcement Agency (DEA). Controlled substances may be destroyed by an agent from the DEA, authorized Health Department personnel, or an inspector from the South Dakota Board of Pharmacy. This procedure applies to all controlled substances in Schedules II, III, IV, and V.

All controlled substance drugs, before destruction, must be listed on DEA form 41 which is available from the DEA, authorized Health Department personnel, the Board of Pharmacy, or Board of Pharmacy Inspector. Schedule II drugs must be counted and listed. Schedule III, IV, or V may be estimated. It is the responsibility of the practitioner and not the agent or inspector to count and list the items on the form.

The destruction must be witnessed and signed for by the practitioner and the DEA agent, authorized Health Department personnel, or the inspector from the Board of Pharmacy. A copy of

the DEA form is retained at the site, and others are forwarded to the DEA. The form should be retained by the practitioners for a minimum of two years.

In the past, DEA offices would, following certain procedures, accept controlled substances and destroy them at the DEA office. This practice is no longer followed. Instead, DEA encourages the use of licensed “reverse distributions” (see below). Questions about destruction of controlled substances can be addressed to:

Des Moines DEA Office: 515-284-4700

SD Department of Health: 605-773-4520

SD Board of Pharmacy: 605-362-2737

Reverse Distributors

Because of the increasing complexity of regulations regarding destruction of controlled substances and disposal of hazardous materials, a number of companies have been formed to handle the return and disposal of out-dated drugs. Many of these companies have obtained DEA permits to handle controlled substances. These companies may offer a lawful and effective method of disposing of unneeded drug products.

CORPORATE PRACTICE OF MEDICINE

Generally speaking, a corporation may not practice medicine. However, a corporation is not engaged in the practice of medicine by employing a physician at a salary so long as the corporation

through agreement does not direct the manner in which the physician practices medicine and that employment does not result in a profit to the corporation from the practice of medicine itself (i.e., from "marking up" the cost of services provided). Such agreements are limited to a term of three years. SDCL § 36-4-8.1.

In addition, a corporation or limited liability company certified by the Board of Medical and Osteopathic Examiners pursuant to SDCL Ch. 47-11 may "own, operate and maintain an establishment" for the "study, diagnosis and treatment of human ailments." In order to qualify for certification, all of the officers, directors, shareholders or members of the corporation or limited liability company must be licensed to practice medicine.

DEATHS, REPORTING OF

The physician, physician's assistant or nurse practitioner last in attendance to any person whose death occurs in the state must within 24 hours make a medical certificate concerning the death. Where death occurs without the attendance of a physician, the funeral director or other person in charge of the body must notify the county coroner who has responsibility for making the medical certificate. The body of a person whose death occurs in this state, or of a fetus of 20 weeks gestation or more, may not be finally disposed of unless a permit for burial, removal or other disposition has been issued by the registrar of the registration

district having jurisdiction.

A fetal death report for each fetus which exceeds 500 grams of weight and which is not an abortion and reportable as such must be filed with the Secretary of Health. If a fetal death occurs without the attendance of a physician, the coroner has responsibility for making the report.

In the case of deaths which appear to have resulted from other than natural causes, the county coroner must cause blood samples to be drawn and notify appropriate law enforcement personnel.

DRUG PACKAGING REQUIREMENTS

The Federal Poison Prevention Packaging Act (15 U.S.C. §1471, et. seq.), requires physicians dispensing oral prescription drugs to package drugs in child-proof containers. Certain exemptions apply, such as drugs with specialized packaging, e.g., oral contraceptives. Also, a patient can request conventional packaging. If accidental poisoning occurs, a physician may be liable for failure to provide child-proof packaging of drugs dispensed in the physician's office.

DURABLE POWER OF ATTORNEY FOR HEALTH CARE (See **ADVANCE DIRECTIVES**)

GOOD SAMARITAN PROTECTION

A physician, duly licensed, who in good faith renders emergency care at the scene of an emergency is protected from liability for any civil damages resulting from his acts or

omissions rendering emergency care. (SDCL 20-9-3) Also, for the purposes of the emergency, the physician is not considered to be practicing medicine. This protection relates only to the scene of the emergency and not to other locations such as emergency rooms.

See also, **MINORS, TREATMENT OF.**

HIV TESTING

In certain criminal or juvenile delinquency cases involving a possible exchange of blood, semen or other bodily fluids, the victim, the state's attorney or a law enforcement officer may request the entry of a court order issuing a search warrant to draw blood from the defendant or juvenile to be tested for blood-borne pathogens, including hepatitis B and HIV. Upon the issuance of such a search warrant, the State Department of Health is required to conduct the testing and report the results to a licensed physician designated by the victim or law enforcement officer with whom the blood, semen or other bodily fluids were or may have been exchanged. The victim or law enforcement officer may also request that they be tested as well. The results of such testing are to be kept confidential, except that the Department of Health is required to report the results of the test of the defendant or juvenile to the victim or law enforcement officer.

IMMUNIZATION

Prior to admission, any pupil entering school or an early

childhood program must present to the appropriate school authorities a certification from a licensed physician that the child has received or is in the process of receiving adequate immunization against poliomyelitis, diphtheria, pertussis, rubeola, rubella, mumps, tetanus, and varicella according to recommendations provided by the Department of Health which may modify or delete any of the required immunizations. As an alternative to the requirement for a physician's certification, the pupil may present:

(1) Certification from a licensed physician stating that the physical condition of the child is such that a test or immunization would endanger his life or health; or

(2) A written statement signed by one parent or guardian that the child is an adherent to a religious doctrine whose teachings are opposed to such immunization; or

(3) A written statement signed by one parent or guardian requesting that the local health department give the immunization because the parents or guardians lack the means to pay for such immunizations.

Although none are presently in existence, the Department of Health is authorized by statute to provide by rule for compliance and documentation of these requirements.

A school board or school superintendent, with the concurrence of county health officers, may exclude from school attendance any student who is a risk or nuisance to the health of other students due to the presence of infectious disease or communicable parasite. When the student is no longer infected, as determined by the county

health officer, he may be readmitted.

Sharing of Immunization Records

South Dakota law provides that a patient's immunization record may be shared among health care providers, health care facilities, federal or state health agencies, child welfare agencies, schools or family day care facilities without the consent of the patient or the person acting on the patient's behalf unless the patient's signed refusal to release immunization information is part of the patient's medical record. If the patient is a minor, the refusal to release immunization information may be signed by the patient's parent or guardian on behalf of the minor patient. A person who receives immunization data and knowingly or intentionally discloses or fails to protect the confidentiality of the information is guilty of a class 1 misdemeanor. SDCL 34-22-12.5.

There is an open issue concerning whether the information-sharing requirements of SDCL 24-22-12.5 are in some circumstances preempted by the HIPAA-mandated privacy rules. In order to avoid possible violations of those rules, it is recommended that the practitioner obtain written authorization from the patient to share immunization records with child welfare agencies, schools or family daycare facilities or any health care provider or facility which is not currently providing care or treatment to

the patient.

Day Care Centers

The South Dakota Department of Health has promulgated rules concerning immunization requirements for admission to day care. Prior to admission, a physician, physician's assistant, certified nurse practitioner, or community health nurse must certify in writing that the child has attained the following age-specific immunization levels:

(1) Two months: one dose hepatitis B (HepB); one dose diphtheria, pertussis, and tetanus (DTaP); one dose Haemophilus influenza type B (Hib); one dose inactivated poliovirus (IPV); and one dose pneumococcal conjugate (PCV);

(2) Four months: two doses Hep B; two doses DTaP; two doses Hib; two doses IPV; and two doses PCV;

(3) Six months: three doses DTaP; three doses Hib and three doses PCV;

(4) 12 to 15 months: four doses Hib; one dose measles, mumps and rubella (MMR); four doses PCV;

(5) 15 to 18 months: three doses Hep B; four doses DTaP; three doses IPV; and one doses Varicella;

(6) Four to six years: five doses DTaP; four doses IPV; and two doses MMR.

Children may be exempted from these requirements for the same reasons as set forth above in connection with school-entry immunization requirements. A.R.S.D. 67:42:10:14.

LICENSURE

The State Board of Medical and Osteopathic Examiners has jurisdiction over the licensure and discipline of doctors of medicine and doctors of osteopathy. The Board can issue four types of licenses or permits:

(1) A license to practice medicine or osteopathic medicine, surgery and obstetrics in all of their branches without limitations (SDCL 36-4-18);

(2) A temporary permit (SDCL 36-4-20);

(3) A locum tenens certificate (SDCL 36-4-20.3); and

(4) A resident certificate (SDCL 36-4-20.6).

By consent of a majority of the Board, a license to practice is granted to each applicant successfully passing the examination required by the Medical Practice Act and fulfilling all other requirements of the Act.

A temporary permit may be granted by the Board following an examination prepared and administered by the Board when an urgent need exists in any State-owned and operated medical institution for the services of a practitioner of medicine, surgery and obstetrics and their branches, as a State employee, which cannot be adequately and effectively served by a regularly licensed practitioner. The

temporary permit is effective for one year and entitles the holder to engage in the practice of medicine, surgery and obstetrics and all of their branches as a State employee under the supervision of a licensed physician in a State-owned and operated medical institution and not elsewhere.

A locum tenens certificate allows the holder to practice medicine in the state for a limited period of time not exceeding 60 days, subject to the requirements and conditions of the certificate. It may be issued to an applicant who is a current holder of a valid license to practice medicine or osteopathy in another state, who has graduated and received a diploma from an approved medical or osteopathic college and who has completed at least one year of an approved internship or residence program or its equivalent. The petition for locum tenens certificate must be signed by the applicant and a licensed physician practicing in this state.

A resident certificate may be issued to a person who has satisfied all of the requirements for licensure except the completion of an internship or residency. To qualify, the person must have successfully completed at least the first year of a residency program.

A resident certificate is valid for a period not exceeding one year and only if the holder successfully continues in an approved

residency program. The certificate allows the holder to practice medicine in all functions involved in his or her residency program, to provide emergency room medical coverage on an irregular basis and to provide short term medical care to patients in the absence of their regularly licensed physician by agreement with that physician.

To receive an unrestricted license to practice medicine, a person must be at least 18 years of age, of good moral character, and a citizen of the United States (or a person who has declared his or her intention to become a citizen or who is a resident of the state of South Dakota). Additionally, the applicant must pass an examination on those subjects determined by the Board to be necessary to establish medical competence. The applicant must also present evidence of graduation and receipt of a diploma from a reputable, approved medical or osteopathic college. If the diploma is from a medical or osteopathic college outside of the United States, the Board may require such further proof of competence as it deems necessary. The applicant must also present evidence satisfactory to the Board that he or she has successfully completed a program as an intern or resident, or such equivalent service as may be approved by the Board, in a hospital approved by the Board for such time as the Board may by regulation provide.

The Board in its discretion may issue a license without

examination to an applicant holding a license or certificate issued by any other state, the National Board of Medical Examiners, the National Board of Osteopathic Physicians and Surgeons, or any province of Canada, if the legal requirements of such examining board at the time of its issuing such license or certificate are in no degree less than those of this state at the time when the license is presented for registration. The Board may, however, still require the applicant to take either an oral or written examination, and the applicant must personally appear before the board, a member thereof or board staff.

Cancellation, revocation, or suspension of a physician's license to practice medicine may be ordered by the Board after hearings in conformance with the Administrative Procedure Act upon satisfactory proof of professional incompetence, unprofessional or dishonorable conduct or proof of a violation of the Medical Practice Act. "Professional incompetence" is defined as a "deviation from the statewide standard of competence, which is that minimum degree of skill and knowledge necessary for the performance of characteristic tasks of a physician or surgeon in at least a reasonably effective way." Some 24 acts are considered unprofessional or dishonorable conduct and are set forth at SDCL 36-4-30.

Among the acts which may be considered unprofessional or

dishonorable conduct which are of somewhat more recent vintage, some of which impose affirmative duties on the physician, are:

1) The "failure to fulfill a valid obligation to a federal or state student loan or scholarship program for medical school education designed to provide medical services to underserved geographical areas;"

2) A practitioner with a "substantial" financial interest in certain unaffiliated health care facilities must disclose that interest before referring a patient to that facility. The covered facilities include imaging centers, surgical centers, pharmacies, suppliers of medical equipment, home health agencies, rehabilitation centers, and similar facilities. "Substantial" financial interest is defined as ownership of 25% or more of the facility, debt owed by the facility or (as lessor) of a lease with the facility.

3) The physician must post in a conspicuous place in the waiting room or reception area a sign with large black type on a white background containing the following invitation: "Should any patient wish to discuss fees or charges, you are encouraged to ask about them." All fees and charges must be disclosed upon request from a patient.

The Board may not base a finding of unprofessional conduct solely on the fact that a physician practices chelation therapy.

The Board, together with its officers and employees, are authorized at any time during business hours to inspect any place where medicine or osteopathy are practiced for purpose of enforcing the Medical Practice Act, together with accompanying rules and regulations. This inspection may include records and inventories relating to drugs and controlled substances.

<u>See also</u> The Medical Practice Act in Appendix.

LIMITATION OF ACTIONS

A medical malpractice action may be commenced against either individual physicians or professional corporations only within two years after the alleged malpractice occurred. A different rule applies to injuries to minors allegedly caused by medical malpractice. A minor must commence an action within two years of the alleged malpractice or before her 19th birthday, whichever period is longer.

Because a minor need not bring a malpractice action until after she becomes an adult, all records pertaining to the treatment of minors should be kept beyond their 19th birthday. This rule should apply even if the physician-patient relationship terminated prior to that time.

Although the statute of limitations generally bars malpractice actions commenced more than two years after the occurrence of the alleged malpractice (or, in the case of a minor, before age 19), the South Dakota Supreme Court has created a judicial exception to that rule. Where the action of the practitioner amounts to a continuing wrong against the patient (the "continuing treatment rule"), so that it can be said that no final act or occurrence exists sufficient to commence the running of any statute of limitations, an action will not be barred by the statute of limitations until two years after such a final act or occurrence

takes place.

LIVING WILLS (See **Advance Directives**)

MEDICAL MALPRACTICE

The total amount of general damages (e.g., pain and suffering, loss of enjoyment of life) which a plaintiff may recover in a medical malpractice action is limited to five hundred thousand dollars. This limit also applies to a physician's corporate, limited liability partnership or limited liability company employer. (See also **Medical Corporations, Limited Liability Companies and Limited Liability Partnerships**). SDCL 21-3-11. The constitutionality of this statute has been upheld by the South Dakota Supreme Court. *Knowles v. United States*, 1996 SD 10, 544 NW2d 183. Courts in other states have reached divided opinions, some upholding similar statutes and others striking them down. There is no specific statutory limit on the amount of special damages (such as ongoing medical expenses) which the judge or jury may award.

South Dakota law also provides for voluntary binding arbitration between hospitals or physicians and patients relating to services provided to the patient. To be implemented, the procedure requires the execution of arbitration agreements by physicians and their patients. Should a patient thereafter have a claim against the physician alleged to be malpractice, the claim

must be submitted to the less complex and costly procedure of arbitration. The records and files of proceedings before the health care services arbitration panel are not, until the entry of a judgment, open to public inspection or examination.

The same statute of limitation for the commencement of actions for medical malpractice applies to the filing of arbitration claims. Arbitration awards are generally binding upon the parties and may only be set aside by a court on certain limited grounds, including that the award was procured by corruption or other undue means, that there was evident partiality of an arbitrator or corruption in any of the arbitrators, that the arbitrators exceeded their powers, that the arbitrators refused to postpone a hearing on sufficient cause or refused to hear material evidence, that there was no valid arbitration agreement or that a hearing officer was guilty of conduct which would substantially prejudice the rights of a party.

State statute provides for the organization of mutual malpractice insurers where at least 250 applications for coverage have been received by the proposed insurer for the issuance of medical malpractice coverage. All insurers writing medical malpractice insurance in the state must file reports with the Division of Insurance setting forth data on the disposition of all medical malpractice claims handled by the insurer in the state.

In a malpractice action where the plaintiff seeks to recover special damages by reason of his injuries or death, evidence is admissible to prove that these special damages were paid for or were payable by insurance not subject to subrogation and not purchased privately, or were paid or payable by state or federal government programs not subject to subrogation.

The proceedings of review committees relating to the quality, type or necessity of care rendered by a physician are not subject to discovery or disclosure and are not admissible as evidence in any court or arbitration forum involving alleged medical malpractice.

To lessen the harassment value of discovery concerning punitive damage claims in medical malpractice and other actions, the Legislature has provided that discovery may not commence until after the court has found that there is reasonable basis to believe that willful, wanton or malicious conduct has occurred. SDCL 21-1-4.1.

In any bodily injury claim, including medical malpractice claims, large awards for future damages may in some circumstances be payable in periodic payments over a term of years. The present statute requires periodic payments if future damages exceed the sum of $200,000.00 and the other notice and related provisions of the law have been met. SDCL Chapter 21-3A.

Generally speaking, physicians are held to certain standards of care in their treatment of patients, and when their treatment of a patient falls below this standard of care, they may be held responsible in damages for medical malpractice. This standard of care for a physician requires that he or she possess and use that degree of care and skill ordinarily possessed and exercised under similar circumstances by physicians in good standing engaged in the same line of practice in the same or similar locality. Further, the physician must be diligent in an effort to accomplish the purpose for which he or she is employed.

A physician is not necessarily negligent because he or she errs in judgment or because treatment proves unsuccessful. Negligence occurs if the error in judgment or lack of success is due to a failure to perform any of the duties associated with the care and skill ordinarily exercised under similar circumstances by similarly situated physicians.

A physician has the duty to disclose to the patient the nature of a proposed procedure, the material benefits of the procedure, the material risks associated with the procedure, the likelihood those risks will occur, and the consequences of remaining untreated. If an alternative procedure is reasonably appropriate, the physician has a duty to disclose the material risks and benefits associated with the alternative procedure as well. It is

generally held that the failure of a physician to obtain an informed consent from his or her patient constitutes a departure from the usual standard of care applicable to physicians, thus constituting malpractice.

MEDICAL CORPORATIONS, LIMITED LIABILITY COMPANIES AND LIMITED LIABILITY PARTNERSHIPS

Traditionally under the law, the so-called "learned professions", including medicine, could not be practiced by corporations. Generally speaking, this remains the applicable rule of law, and a lay corporation may neither dictate the manner that a physician diagnoses and treats his patients, nor establish or own the fees for the physician's services. However, if the corporation is organized in conformity with South Dakota's Medical Corporations Act, SDCL Ch. 47-11, then it is permissible.

Under South Dakota's Medical Corporation Act, one or more persons licensed under the Medical Practice Act may associate to form a corporation pursuant to the provisions of law pertaining to private corporations. However, medical or surgical treatment, consultation or advice may only be given by employees of the corporation who are licensed physicians. The name of the corporation must end with a designation showing that it is a corporation. The approved designations are "chartered," "limited," "Ltd.," "professional association," or "P.C."

All officers, directors and shareholders of a medical corporation must be licensed physicians. No unlicensed person may have any part of the ownership or control of the corporation, nor may any such person vote any shares of the corporation.

Before a medical corporation may commence business, it must obtain a certificate of registration from the Board of Medical and Osteopathic Examiners which must be posted upon the premises. The certificate of registration is not assignable, and it must be annually renewed with the Board.

The Medical Corporation Act does not alter any law applicable to the relationship between a physician furnishing medical service and a person receiving that service, including the liability arising out of that service. Except as otherwise provided in the Medical Corporation Act, the provisions of law governing private corporations are applicable to medical corporations.

The same general rules apply to limited liability companies (L.L.C.) and limited liability partnerships (L.L.P.). In some situations, there are federal income tax benefits available when practicing within an L.L.C. or L.L.P. In addition, both an L.L.C. and an L.L.P. are designed to limit the liability of the individual members or partners. The differences among corporations, L.L.C.'s, and L.L.P.'s as they relate to taxation and limited liability are beyond the scope of this publication. The reader is encouraged to

contact his or her personal attorney for further information and advice.

In the case of an L.L.C., the company name must include the words “professional limited liability company” or “limited liability company” or the abbreviations “Prof. L.L.C.,” “P.L.L.C.,” or “L.L.C.” In the case of a L.L.P., the partnership name must contain the words “Professional Limited Liability Partnership” or “Limited Liability Partnership” or the abbreviations “P.L.L.P.” or “L.L.P.”

MEDICAL AND OSTEOPATHIC EXAMINERS, BOARD OF

The Board of Medical and Osteopathic Examiners is the licensing and regulatory body for medical doctors, osteopathic physicians and physician’s assistants. The board has joint control and regulation with the State Board of Nursing of nurse practitioners and midwives. Additionally, respiratory care practitioners, physical therapists, physical therapy assistants, occupational therapists, medical assistants, nutritionists, dieticians, athletic trainers and emergency medical technicians (including paramedics) are licensed or registered by the board. Information concerning regulation or licensure for any of these professions or occupations may be obtained from the office of the Board of Medical Examiners.

MINORS, TREATMENT OF

An unemancipated minor is by law incapable of giving his or her consent for medical treatment. While implied consent usually arises under a course of dealing between the physician and the parent of a minor patient, it is advisable to obtain parental consent for all but the most routine aspects of the treatment of minors.

One exception may exist in those instances where the physician reasonably believes in the exercise of professional judgment that the minor patient has been the subject of abuse, neglect or domestic violence by the parent or guardian and that releasing information to the parent or guardian may endanger the patient and is not in the patient's best interests. In those circumstances, the privacy rules allow the physician to withhold certain information from the parent or guardian. The privacy rules do not address consent, but these circumstances may lead the physician to believe it is better to report the suspected abuse or neglect to the appropriate authorities and seek consent to treatment through the courts, rather than seek consent from the parent or guardian.

No statute or court decision applicable in this state places the prescription of birth control devices or oral contraceptives to minors in a different category, although it has been argued by some

that certain U.S. Supreme Court decisions dealing primarily with abortion indicate that minors may be treated for birth control by physicians without parental knowledge or consent. While this argument may have some logical merit, there is no definitive support in the decided cases, and legal counsel for the State Medical Association has issued an opinion recommending that the more advisable practice is to refrain from prescribing birth control devices or oral contraceptives without parental consent or knowledge.

An apparent exception exists, however, in favor of those physicians providing family planning services under federal Title X. In the opinion of the AMA Office of General Counsel, Title X and the regulations promulgated pursuant to it preempt state law in the area of parental notification for contraceptive services. Thus, for those physicians not providing contraceptive services pursuant to Title X, the prudent course of action continues to require parental notification associated with contraceptive services for minors.

Few areas of law and medicine are more controversial than the topics of contraceptives and abortions for minors. It is one thing to advocate a minor's right to these services. It is quite another thing to discuss the potential malpractice liability of a physician for treating a minor without parental consent, because no court has

determined a physician to be free from liability for so doing. The U.S. Supreme Court has upheld laws requiring parental consent for abortions where the parent is not given an absolute veto and a court is given the opportunity to evaluate the minor's wishes.

South Dakota has adopted new notice and consent requirements involving minors. See discussion under the heading **ABORTION** for a more complete discussion of those requirements.

A minor at least 17 years of age may donate blood without obtaining parental permission unless the parent of the potential minor donor specifically informs the facility taking the blood that the donation is prohibited.

Religious Conflicts

Occasionally the treatment of a minor is complicated by the religious convictions of the parent. Most commonly this occurs where a blood transfusion is necessary to preserve the life or health of a minor. Courts have almost universally ordered blood transfusions necessary to save a minor's life where the parent refuses consent on religious grounds.

Under South Dakota law, a law enforcement officer or a court services worker may take a minor into temporary or protective custody where he reasonably believes that protective custody is warranted because there exists an imminent danger to the child's life or safety, there is not time to apply for a court order and

the parents refuse an oral request for consent to the child's removal from their custody. SDCL 26-7A-12. Also, a court may issue temporary or emergency orders for medical, surgical, or dental treatment of a child under its jurisdiction. SDCL 26-7A-42. A physician presented with parental refusal to consent to a course of treatment necessary to save a life should consider contacting the state's attorney, the Department of Social Services or the court services office of his or her county as soon as there is reason to believe that such a situation is developing.

Emergency Treatment

Where a parent or guardian is not immediately available to consent to treatment, and if, in the opinion of the treating physician exercising competent medical judgment, the attempt to secure the consent would result in delay of treatment which would threaten a minor's life or health, the treating physician may proceed with the necessary treatment. No physician, hospital or other person assisting in the treatment of a minor in these circumstances may be held liable for providing medical or surgical treatment without consent, provided only that competent medical judgment is exercised by the treating physician in determining that the minor's life or health would be threatened by delaying treatment. This provision of law does not apply to elective abortion, sterilization or contraceptives. SDCL 20-9-4.2.

See also **ABORTION, VENEREAL DISEASE**

NEWBORN REQUIREMENTS

The physician having charge of a case of childbirth must inform the parents or guardians of the newborn infant of the possibility of ophthalmia neonatorum and give advice for the prevention of its development through the use of such preventative measures as are prescribed for such purpose by the Department of Health. Upon the birth of the infant, the physician is required to use measures for the prevention of ophthalmia neonatorum unless specifically directed not to do so by the parents or guardian of the infant. Cases of ophthalmia neonatorum must be reported to the local health officer within eight hours. The failure to abide by state law relating to ophthalmia neonatorum is a Class 1 misdemeanor.

All infants born in the state must be screened for phenylketonuria, hypothyroidism and other metabolic diseases unless the parents or guardian object in writing to the physician in attendance, the person responsible for ordering the test, or both, on the grounds that such tests and treatment conflict with their religious tenets and practices. Tests for detecting metabolic disorders of newborn infants prescribed by the Department of Health include the testing for excessive phenylalanine in the serum of the newborn and for hypothyroidism in the newborn.

Upon the birth of a child to an unmarried woman, and prior to discharge, any hospital, physician or other health care provider who assists in the birth must afford to the mother and alleged father "an opportunity" to sign an affidavit of paternity. The hospital, physician or other health care provider must also supply to the mother and alleged father certain written information involving paternity and parentage provided by the Department of Social Services. An affidavit of paternity, if signed, must be forwarded to the Department of Health within seven days of the birth.

PHYSICIAN ASSISTANTS

The licensing of physician assistants is required by South Dakota statute. The chapter regulating physician's assistants is reproduced in its entirety elsewhere in this publication. SDCL Chapter 36-4A. The law specifies that the physician's assistant must be supervised by a physician; it prescribes the educational program necessary for a person to become a physician's assistant, and it sets forth the specific tasks which a physician's assistant may perform.

The State Board of Medical and Osteopathic Examiners has the responsibility for placing physician's assistants. An employer physician may apply to the Board of Medical and Osteopathic Examiners for authority to supervise more than one physician's

assistant, up to a maximum of four FTEs, and may also seek authority to modify the otherwise applicable rules of supervision set out in SDCL § 36-4A-29. The board may grant authority or modifications it considers appropriate based upon its finding of adequate supervision, training and proficiency.

PRESCRIPTIONS AND GENERIC PRESCRIPTIONS

A pharmacist may under certain circumstances substitute a generic equivalent of a drug product prescribed by its brand name. The physician may prohibit the substitution of a generic equivalent by <u>handwriting</u> on the prescription order the words "brand necessary" or words of similar meaning. The language of prohibition may not be preprinted or stamped on the prescription form, but a reminder to the physician of the necessary procedure may be printed on the form. If the prescription order is oral, the physician or his authorized agent must specifically instruct the pharmacist that substitution is prohibited. The pharmacist must note the prohibition on the file copy of the prescription drug order.

If not prohibited by the physician and otherwise authorized by law, a pharmacist may make generic substitutions, but only if she advises the patient of the substitution and the patient's right to reject the substitution. A pharmacist may not substitute a product unless it has been manufactured by a manufacturer who:

1) Marks capsules and tablets with identification code or monograms;

2) Labels products with their expiration date;

3) Provides reasonable services to accept returned goods that have reached their expiration date;

4) Maintains reasonable resources for product information;

5) Maintains recall capabilities for unsafe or defective drugs; and

6) Makes available therapeutic equivalency ratings.

PRIVILEGES

A patient has a privilege to refuse to disclose and to prevent any other person from disclosing confidential communications made for the purpose of diagnosis or treatment of his or her physical, mental or emotional condition, including alcohol or drug addiction, among the patient, his or her physician or psychotherapist, and persons who are participating in the diagnosis or treatment under the direction of a physician or psychotherapist, including members of the patient's family. The privilege may be claimed by the patient, his or her guardian or conservator, or the personal representative of a deceased patient. The physician or psychotherapist may claim the privilege, but only on behalf of the patient. If the patient waives the privilege, the physician or psychotherapist may not claim it.

Certain exceptions to the privilege are recognized under state

law. There is no privilege:

(1) For communications relevant to the physical, mental or emotional condition of a patient, if under the circumstances, the physician reasonably believes actions by the patient are likely to result in imminent death or substantial bodily harm to another,

(2) For communications relevant to an issue in proceedings to hospitalize a patient for mental illness if the psychotherapist in the course of diagnosis or treatment has determined that the patient is in need of hospitalization;

(3) Where the court orders an examination of the physical, mental or emotional condition of a patient with respect to the particular purpose for which the examination is ordered;

(4) In any proceeding (including workers' compensation cases)in which a patient relies upon his physical, mental or emotional condition as an element of his claim or defense, including discovery with respect thereto, but only insofar as the otherwise privileged information is relevant to the claim or defense;

(5) In criminal prosecutions;

(6) Respecting reports made concerning an injury from a firearm; and

(7) In circumstances where the physician is required to give reports to governmental entities (<u>see</u> Reportable Diseases and Information).

Physicians serving on peer review committees, including medical staff committees of a licensed hospital, are immune from suit for any act or proceeding undertaken or performed within the scope of the functions of any such committee if the committee member acts without malice, has made a reasonable effort to obtain

the facts of the matter, and acts in reasonable belief that the action taken by him is warranted by the facts known to the member.

Furthermore, the proceedings, records, reports, statements, minutes or any other data of any such committee are not subject to discovery pursuant to litigation and are not admissible as evidence in any court or arbitration forum. However, the prohibition relating to the discovery of evidence does not apply to deny a physician access to or use of information upon which a decision regarding staff privileges is based, nor does it apply to deny any person access to materials in the defense of an action against that person.

The HIPAA-mandated privacy rules affect the physician/patient privilege in the sense that the definition of "protected health information" in the rules is broader than the state law definition of "confidential communications." "Confidential" communications are defined under state law as communications between physician and patient which are not intended to be disclosed to third parties except other health care providers, and in some cases, the patient's family. SDCL 19-13-6.

"Protected health information," on the other hand, includes virtually any healthcare-related information that is specific to an individual, including treatment and billing or payment

history. The difference is that the parties do not have to intend for the communication to be "confidential" in order for it to constitute "protected health information."

Accordingly, a casual question or comment from the patient in a social setting may not be "confidential," but it and the physician's response would be "protected health information."[32] Disclosures to the patient's family or others that may be permitted when applying the state law definition of "confidential" may in some circumstances not be permitted under the new federal rules. Billing and insurance records which clearly were not "confidential" under state law are in most instances "protected health information" under the privacy rules.

The practitioner is advised to be mindful of the difference and to generally assume that any healthcare-related information must be kept confidential and can only be released subject to the HIPAA-mandated privacy rules.

RECORD RETENTION AND DISCLOSURE

Generally speaking, the records in a physician's office can be divided into two categories: business records and patient records. No state statute or rule prescribes a specific minimum time during which either type of record should be kept.

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32 There is an exception in the privacy rules for "incidental disclosures" which may include a conversation such as is described here.

In the case of business records, the principal concerns for the retention of records have reference to the tax laws, and a rule of thumb is that records must be retained for seven years after the filing of the tax return to which they relate. However, certain records relating to the depreciation of a capital asset should be kept until the asset is fully depreciated. Each individual physician or clinic should obtain the further guidance of his or her attorney, accountant or tax advisor on this subject.

As to the retention of patient records, many practical considerations involving the individual physician or clinic are relevant in establishing a record retention policy. The applicable statute of limitations would provide a minimum time within which records should be retained. The subject of limitation of actions is covered elsewhere in this work.

Medical records, reports and x-rays are the property of the patient, and copies must be produced for the patient or his designee upon signed written request. The provider may require the patient to pre-pay the actual, reasonable cost of reproduction and mailing. Although the provision of copies (especially where litigation is involved) may to some seem a nuisance, it is important to recall that the records are the property of the patient, that the physician is only entitled to charge for the reasonable cost of reproduction and mailing, and

that the patients themselves most often bear that cost.

The new federal privacy rules are virtually identical to state law in that they allow the practitioner to impose a reasonable, cost-based fee for copying and mailing records or for preparing summaries of those records. However, this fee may not exceed the actual cost of copying or mailing records or of preparing a summary. The federal privacy rules go one step further, however, and prohibit the practitioner from charging any sort of fee for researching or retrieving records. To the extent practitioners charge something more than a purely cost-based fee as allowed by the privacy rules, that practice is prohibited and the practitioner is subject to a civil penalty imposed by the Secretary of the U.S. Department of Health and Human Services of up to $100 per violation.

Patient records may only be transferred to another physician, the patient, the patient's parent (if the patient is a minor), the patient's personal representative or designee, a health care clinic or other licensed health care facility. A patient's records may also be transferred to any person designated in writing by the patient or the patient's personal representative, guardian or parent. If patient records cannot be transferred to a qualified person or entity, they must be retained or destroyed.

No active patient record may be transferred or destroyed

unless at least 30 days advance written notice is sent to the patient at his or her last known address. The notice must include a statement of the proposed disposition of the records and a deadline by which they must be claimed. A physician may, however, destroy medical records which have become inactive or when the whereabouts of the patient is no longer known to the physician. SDCL 36-4-37 and 36-4-38. When determining whether a file has been inactive for a sufficient period of time to justify destruction, the physician should make reference to the discussion above concerning statutes of limitation and related issues.

Although the federal privacy rules do not specifically address records retention, they do have an indirect effect because the records are "protected health information." For a discussion of the effects of the federal privacy rules on records retention, see the **HIPAA-Mandated Privacy Rules** section of this publication under the heading "**Records Retention Policies.**"

Under current South Dakota law, a minor may commence an action for malpractice alleged to have occurred during his minority at any time prior to his 19th birthday. Accordingly, medical records relating to minors should be kept until their 19th birthday, or two years after their last consultation or treatment, whichever is longer.

REPORTABLE DISEASES AND INFORMATION

This topic includes reports of diseases or information which must be rendered by a physician because of his status as a physician. Other statutes requiring reports are not included in this topic, such as where the report is an expected part of a position or office held (e.g., county or municipal jail physicians, court appointed physicians in juvenile matters, court appointed physicians in commitment proceedings).

Abortion

See ***ABORTION.***

Auditory or Visual Impairment

Any physician having cause to suspect severe auditory impairment or severe visual impairment in any child must provide the name and address of any such child and his parents to the State Department of Health on forms provided by the Department unless the physician has cause to believe that such condition has already been reported. SDCL 34-24-26.

Child Abuse

Any physician having reasonable cause to suspect child abuse must immediately report it orally to the state's attorney, the Department of Social Services, the county sheriff, or the city police. If the child is hospitalized, the report is to be made to the person in charge of the institution or his designee. SDCL 26-8A-3. In addition to these reports, any person having reasonable cause to suspect the death of a child due to child abuse must give that information to the medical examiner or coroner. SDCL 26-8A-4. The failure to make these reports is a Class 1 misdemeanor, punishable by up to one year in the county jail and a $1,000.00 fine.

Communicable Disease

The South Dakota Department of Health provides for the collection and processing of mandatory reports of identifiable and suspected cases of communicable disease, communicable disease carriers and laboratory tests for communicable carriers from all physicians, hospitals, laboratories and institutions. SDCL 34-22-12. Included in the appendix to this guide are the regulations of the Department of Health, as well as a copy of the Department's easy reference guide and form report card.

Fetal Death

The physician in attendance at or after delivery must within seven days file a report of fetal death with the Health Department for each fetal death where the fetus exceeds 500 grams of weight and which is not otherwise reportable as an abortion. SDCL 34-25-32.1 and 32.2.

Gunshot Wounds

Any person treating any bullet wound, gunshot wound, powder burn, or any other injury arising from or caused by the discharge of a firearm must, as soon as possible, report the treatment by any available means to the sheriff of the county in which the wound is treated. SDCL 23-13-10. Such reports are specifically authorized by the federal privacy rules. Persons reporting gunshot wounds are immune from civil or criminal liability by reason of the report.

The failure to make such a report is a Class 1 misdemeanor, punishable by a $1,000.00 fine, one year in the county jail, or both.

Metabolic Disorders

Results of tests for metabolic disorders required by the Department of Health, including phenylketonuria and hypothyroidism, must be sent to the Health Department by physicians, public health nurses, and hospitals on forms prescribed by the Department. SDCL 34-24-23.

Ophthalmia Neonatorum

Any physician observing in a newborn infant any symptoms of ophthalmia neonatorum must report this condition within eight hours thereafter in writing or by telephone followed by a written report to the local health officer of the city, town or other political subdivision in which the infant is located. SDCL 34-24-9.

Physician’s Assistants

The physician, as well as the physician’s assistant, must notify the board within 72 hours of the termination of any working contract and the reasons for the termination. SDCL 36-4A-32.

Syphilis

In reporting every birth and still birth, physicians must state on the birth certificate or fetal death certificate whether a blood test for syphilis has been made during the pregnancy upon the

blood of the mother and, if made, the date when such test was made, and if not made, the reason why such test was not made. The certificate shall not state the result of the test. SDCL 34-23-12.

Tuberculosis

Any hospital or private bacteriologic laboratory receiving a specimen or culture to grow or isolate mycobacterium tuberculosis must report to the State Department of Health the name of the patient from whom the specimen was collected and the name of the physician in charge of the patient. The report must be made within seven days after results of the culture have been determined, and in no event later than eight weeks from receipt of the specimen. The federal government and its agencies are exempted from this reporting requirement. SDCL 34-22-22.

Any health officer or physician having information that a person by his conduct or mode of living may endanger the health or well being of his family or other persons because of tuberculosis must report this to the State Health Department. The report must state the name and address of the person and a summary of the pertinent information available to and known by the health officer or physician. SDCL 34-22-25.

Venereal Disease

Physicians must report all cases of venereal disease diagnosed or treated by them to the State Health Department. SDCL 34-23-2.

SIGNATURE STAMPS AND FACSIMILE SIGNATURES

There is no general rule of law that prohibits the use of signature stamps or signatures on documents sent via facsimile machine. However, there are certain potential pitfalls associated with the use of each.

A signature stamp can be a useful way to save time for a practitioner, but its use carries with it some risk. If the person in possession of the stamp misuses it and a third party is harmed or damaged as a result, the physician authorizing the use of the stamp could be held liable. If a stamp is to be used, it is up to the supervising physician to ensure that the person in possession of the stamp is trustworthy and is using it appropriately.

The facsimile transmission of documents is of course commonplace, and in some instances is taking the place of sending originals. There is nothing inherently unlawful or otherwise wrong with the use of facsimiles, but the practitioner must be aware that some recipients of such documents may not be willing to proceed with the order or respond to the request contained in the document unless and until he or she receives the original. Just as there is generally nothing unlawful about sending a document or signature via facsimile, there is generally no requirement that the recipient accept anything other than an original.

STERILIZATION

State statutes providing for the sterilization of mentally ill and mentally retarded persons were repealed in 1974, and no procedure for involuntary sterilization is provided by state statute. No statute deals with voluntary sterilization. The prevailing view is that this is a procedure requiring only the consent of the adult patient seeking sterilization, without regard for consent from the spouse or other interested persons.

VENEREAL DISEASE

The chapter on venereal diseases (SDCL 34-23) deals extensively with the identification and treatment of venereal diseases. The overall purpose of the chapter is to ensure that persons contracting venereal disease are treated and that the cause is traced to its source by the Health Department, ultimately requiring treatment of the source. Physicians must report all cases of venereal disease diagnosed or treated by them to the State Health Department. Physicians are required to obtain blood samples from all pregnant women and transport them to the State Health Laboratory for standard serological tests for syphilis. Such reports and tests are allowed under the federal privacy rules.

Physicians are specifically permitted to treat minors for venereal disease, including prophylactic treatment for exposure to venereal disease, without parental consent.

See also **REPORTABLE DISEASES AND INFORMATION** and **MINORS, TREATMENT OF.**

INTERPROFESSIONAL GUIDELINES FOR PHYSICIANS AND ATTORNEYS IN SOUTH DAKOTA

Drafted and approved by the South
Dakota State Medical Association and
the State Bar of South Dakota
(Revised November, 2005)

PREFACE

The purpose of the Interprofessional Guidelines is to provide attorneys and physicians with a guide for harmonious interprofessional relations, promote better understanding between the professions and aid in the resolution of interprofessional disputes. The best interests of the public and the two professions require that each profession develop an enlightened and tolerant understanding of the other.

These interprofessional guidelines are a successor to the Interprofessional Code for Physicians & Attorneys of South Dakota which was published by the South Dakota State Medical Association and the State Bar of South Dakota in 1984. The principles contained in the new guidelines have evolved from previous guidelines and the desire to amplify guidelines for the relationship between the two professions. These interprofessional guidelines were revised in 2005 in response to the implementation of the HIPAA-mandated medical privacy rules. An effort has been made to address common areas of misunderstanding in these guidelines. The guidelines were drafted by the Commission on Medical Practice of the South Dakota State Medical Association and the Professional Liaison Committee of the State Bar of South

Dakota. They have been approved by the South Dakota State Medical Association and the State Bar of South Dakota.

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INTERPROFESSIONAL GUIDELINES FOR PHYSICIANS AND ATTORNEYS IN SOUTH DAKOTA

INTRODUCTION – Overview of the Litigation Process

There are generally two types of legal cases. Criminal cases involve a charge prosecuted by a governmental body that some individual broke a criminal law and should be punished. Civil cases involve private disputes between individuals where damages or some other remedy is requested. Administrative claims such as worker's compensation or social security claims are resolved through a form of civil proceeding conducted by an administrative body. These different types of cases involve different burdens of proof, different rules of procedure, and different roles for the physician witness.

The physician is most often asked to become involved in a civil lawsuit – often involving personal injuries of some kind.

In civil cases, the "plaintiff" is the party who brings the lawsuit and the "defendant" is the party who is being sued. Before a lawsuit is commenced, the injured party may be referred to as the "claimant." A civil action is started when a "summons," usually accompanied by a pleading called a "complaint," is "served" upon the defendant. If the complaint is not served with the summons, it must be provided upon demand to the defendant, after which the summons and complaint must be promptly filed with the court. The defendant must then timely

file a pleading called an “answer.” Depending upon the complexity of the lawsuit, other pleadings and parties may be added. The purpose of this pleadings stage is simply to determine the legal claims, defenses and other legal issues involved. The pleadings serve as a framework for later proceedings.

The parties may then conduct discovery, where each side seeks to discover the facts and evidence relevant to the legal issues involved and which tend to support or contradict a given party’s position. Various discovery devices are allowed under the Rules of Civil Procedure. These include “interrogatories” (written questions requesting information provided under oath); “requests for production of documents or things” (written requests for documentary or tangible evidence in the possession or control of the other party); “requests for medical examination” (an examination by a physician or health care specialist of a party’s own choosing of some physical or mental condition which has been placed “in controversy” by the opposing party); and “depositions” (sworn testimony taken before a shorthand reporter wherein the attorneys can personally ask questions of a party or witness).

- A complete statement of all opinions to be expressed and the basis and reasons therefor.

- The data or other information considered by the witness in forming the opinions.
- Any exhibits to be used as a summary of or in support for the opinions.
- The qualifications of the witness, including a list of all publications authored within the preceding ten years.
- The compensation to be paid for preparation, examination and testimony.
- A listing of any other cases in which the witness has testified as an expert at trial or by deposition within the preceding four years.

The disclosure can be written by the lawyers and can incorporate any expert witness reports, records or depositions given by that expert. Treating physicians are often disclosed as possible expert witnesses based solely on their role as a treating physician and the notes or records they have generated, even though they have never been contacted by the lawyer. Opinions or other potential testimony of an expert witness that are not adequately disclosed to the other side and to the court can result in their not being allowed at trial.

After an expert witness is disclosed, he or she may be asked to submit to a deposition so that the opposing attorney can gain further knowledge as to that expert's opinions and possible testimony. This also assists the opposing attorney in assessing the need for obtaining experts of his or her own choosing to address the same issue.

If the case proceeds to trial, those physicians who have been disclosed as expert witnesses may be called to testify. The party who calls the witness asks the first series of questions on "direct examination," the opposing attorney can then "cross-examine," and there may be further "redirect examination" by the attorney who called the witness. Adequate pretrial consultations should prepare the physician-expert concerning this trial testimony.

In jury trials, the judge determines the admissibility of evidence and instructs the jury on the applicable law. The jury in its capacity as "trier of fact" determines the facts based on the credibility of the witnesses and the weight of the evidence and determines the outcome based on the law as provided by the court. In non-jury trials and administrative proceedings, the judge or administrative law judge fulfills the functions of both judge and jury. If legal errors were made by the court in ruling on motions, admitting evidence, or instructing the jury, a party may ask the trial court to correct that error or may appeal to an appellate court.

Most civil cases are settled. Settlement can occur at any time including before the case is filed, during the pretrial phase or discovery phase, during trial or even jury deliberations, or after trial and during appeal.

1. GENERAL PRINCIPLES

1.1 – Where a patient has a physical or mental condition which is the subject of a legal dispute, a treating physician has a duty to provide medical information pertinent to the patient's claim in reports, depositions, conferences and trial testimony.

It is recognized that the primary duty of a physician is to treat a patient's illness or injuries. However, an additional responsibility of a treating physician is to provide necessary medical information and opinions by virtue of his or her acceptance of that patient for treatment. Like any other citizen, a physician can be required to tell what he or she knows if such information will aid the judicial process.

The transmittal of this medical information may include a written report which either sets forth the diagnosis, treatment and prognosis, or which responds to specific questions posed by an attorney concerning important medico-legal issues in the case. Later, the physician's deposition may be taken to "discover" further information. Incidental to these contacts, one or more conferences between the physician and the attorney disclosing or retaining the physician may be requested. Finally, if the case does not settle, the

physician may be called as a witness to testify in court.

The physician and attorney should cooperate in this information-gathering process to facilitate settlement, promote the administration of justice, and control the costs of litigation. This cooperation should include the recognition by all parties of the requirements for the release of protected health information imposed by the HIPAA-mandated privacy rules.

1.2 – Physicians and attorneys should openly communicate with one another and, wherever possible, agree in advance concerning the terms of their relationship so as to avoid conflicts and disputes between the professions.

Open communication is the touchstone of dispute avoidance and dispute resolution. While physician's services are essential to the administration of justice, the physician and attorney should seek out and discuss ways of minimizing the burden of medico-legal services on physicians as well as minimizing the cost to patient-clients.

Unless an attorney and physician have a history or prior business dealings, it is desirable to agree in

advance concerning the nature, scope, and costs of the physician's medico-legal services. (These subjects are discussed in greater detail in other sections of this Code.) The physician may already have set policies, or an agreement may be worked out at the time of the initial contact. Preferably this agreement should be reduced to writing.

If an agreement cannot be reached, the matters should be discussed immediately. At all times, the patient-client's best interests should be the overriding concern. The professionals should agree on as much as possible and submit any residual dispute to the court or an interprofessional dispute resolution committee.

Toward this end, direct communication between the physician and attorney is preferable to communication between secretaries, receptionists or clerical staff.

1.3 – The role of the physician is not that of an advocate or trier of fact and, at all times, the physician's opinions should remain fair, unbiased, and objective.

The role of the physician in a lawsuit is that of a witness only. The physician should never become an advocate or trier of fact. The physician should not

seek to openly support or oppose the position of either party. No matter how much he or she inwardly favors or opposes the cause of one party to a lawsuit it is the physician's clear duty to present information in a fair, unbiased, and objective fashion. Notwithstanding the natural tendency of the treating physician to advocate his or her patient's case, open advocacy, as distinguished from firm, objective support, will likely diminish the physician's effectiveness as a witness.

When called to testify, the physician's duty is to answer the questions truthfully and to the best of his or her knowledge. Under no circumstances is a physician justified in suppressing medical evidence. The physician should never be influenced by extraneous matters such as the source of his or her compensation, friendships, personalities, or inappropriate pressures from patients, attorneys, insurers, or professional organizations.

1.4 – Although an attorney is an advocate, an attorney is never justified in abusing or intimidating a medical witness in any manner, in an attempt to discourage the physician's further involvement in the litigation or to alter or suppress the physician's testimony.

An attorney is an advocate and has a duty to zealously represent his client's best interests in litigation. However, that duty as advocate never justifies abuse, intimidation, badgering, or personal attacks on a medical witness. Improper attempts to discourage the physician's further involvement in the litigation or to alter or suppress the physician's testimony should be strongly denounced. Such attempts are never justified or necessary. Adequate means are available to test credibility by cross-examination, impeachment, and rebuttal. A physician need not tolerate abusive or improper conduct and should promptly bring it to the attention of the opposing counsel, the court or tribunal in which the action is pending, or an appropriate grievance committee.

1.5 – Attorneys should refrain from giving advice on medical management or interfering in the physician-patient relationship. Similarly, physicians should refrain from giving advice on legal matters or interfering in the attorney-client relationship.

Both physicians and attorneys must recognize that they hold a position of trust and confidence with their patient-client. Each professional must recognize the limitations of his or her role and expertise and defer

to the other professional in matters uniquely within that individual's expertise.

Hence, a lawyer should not encourage "physician shopping," should not counsel a client concerning treatment options, and should not otherwise improperly influence the patient in medically related matters in an attempt to accentuate damages.

At the same time, the physician should refrain from counseling the patient concerning such legal matters as the value of patient's claim, the nature or terms of the fee agreement with the attorney, or trial techniques and strategy decisions. These are exclusively the province of the lawyer.

2. CONFIDENTIALITY OF MEDICAL INFORMATION

2.1 – Medical information obtained by a physician for diagnosis or treatment of a patient is privileged by statute, and deemed confidential by federal administrative rule medical ethics and common law. Great care must be exercised to prevent unauthorized or inappropriate disclosures of such medical information.

To assure frank and complete disclosure of sensitive information concerning a person's health to a

physician to assist in diagnosis and treatment, the law in South Dakota recognizes that such information is privileged and confidential and should not generally be disclosed without the patient's consent. *See* SDCL § 19-13-7. Administrative rules promulgated by the U.S. Department of Health and Human Services further restrict when and how individually-identifiable "protected health information" may be disclosed.

The unauthorized disclosure of such medical confidences may expose the physician or health care provider to a common law claim for damages; it may constitute a violation of the physician-patient privilege; it may be a breach of the physician's ethics; it may be grounds for license suspension or revocation; and it may also give rise to the imposition of civil penalties by the U.S. Department of Health and Human Services.

When a person makes a claim for damages for personal injury or otherwise places his or her mental or physical condition in dispute, any claim of privilege may be waived and the patient may be required to permit disclosure of relevant medical information. Similarly, a medical negligence claim asserted against a physician or health care provider constitutes an

implied waiver as to information concerning medical care and treatment held by that health care provider or his or her consultants. In any event, the requirements of the HIPAA-mandated privacy rules must be met before protected health information is disclosed. In certain circumstances, if the disclosure of sensitive medical, psychiatric or psychological information would undermine the relationship with the patient or adversely affect his or her treatment, disclosure may be opposed until appropriately reviewed by a court.

If a question arises concerning the propriety of a requested disclosure of medical information, the physician should consult the patient or the patient’s attorney, or seek advice from the physician’s personal attorney.

3. MEDICAL RECORDS

3.1 – Complete and accurate medical records should be maintained for each patient.

Medical records are not only necessary for proper patient care but also assume important medico-legal implications. They are invaluable to the physician in defending medical liability claims. They are also of

great assistance in evaluating and presenting a patient's personal injury claim. If they are sufficiently complete and legible, they may avoid the necessity, time, expense, and effort of formal reports. Because of their medico-legal importance, accuracy is crucial and such records must not be altered, supplemented, or destroyed because of pending or anticipated litigation.

3.2 – A treating physician should surrender legible and complete copies of any medical records requested to assist a patient in litigation and to advance the administration of justice.

Under South Dakota law, all licensees of the healing arts must provide copies of all medical records, reports and x-rays pertinent to the health of the patient, if available, to a patient or the patient's designee upon written request signed by the patient. The written request form must comply with the requirements of the HIPAA-mandated privacy rules. The licensee may not charge more than actual reproduction and mailing expense. A licensee withholding records or overcharging for their reproduction can be prosecuted under state law for a class 2 misdemeanor, *see* SDCL §

36-2-16, and can be liable for civil penalties under federal administrative rules.

A physician therefore has a duty to provide pertinent information concerning a patient's health to assist the parties and the finder of fact in the evaluation and presentation of that patient's personal injury claim. (*See § 1.1*). The HIPAA-mandated federal privacy rules allow physicians to deny the patient access to some or all of his or her medical records in certain limited circumstances. *See* 45 CFR 164.524. If a decision is made to deny access, the physician should promptly notify the requesting attorney, and the parties should consult and cooperate concerning how best to submit any disputed decision to deny access to a court or administrative tribunal of competent jurisdiction.

Oftentimes, all parties to a lawsuit will request such medical records. When this occurs, an attempt should be made to coordinate requests for medical records to avoid needless duplication of effort and unnecessary inconvenience to the health care provider.

Whenever possible, if a medical records deposition is taken and the only purpose is to obtain patient medical records, the subpoena should be addressed to

the custodian of records or the physician’s agent and not the physician.

Generally, the original medical records or x-rays should not be provided. These remain the personal property of the health care provider who generated them. However, all copies provided should be complete and legible. If records are not legible, a literal translation of those records may be requested.

If original records from a health care provider are required for trial purposes, this should be fully explained to the custodian of the records. Promptly following the completion of the trial, copies should be substituted in the court file for the original records and the originals should be returned to the custodian.

3.3 – A medical release authorization form, complying with all federal and state statutes and regulations, should be provided to the physician or health care provider before such medical records are released.

Under South Dakota law, a medical records release must be in writing and signed by the patient. A licensee of the healing arts is permitted to accept a legible copy of the original counterpart of the

release. Records may be released to the patient or the patient's designee. *See* SDCL § 36-2-16.

Federal law requires that the consent form contain specific information as set out in the HIPAA-mandated privacy rules. *See* 45 CFR 164.508(c). In addition, other federal privacy acts concerning the release of drug and alcohol treatment program records also have very specific requirements concerning the contents of an authorization form (42 C.F.R. 2.31). Other federal, state, and local statutes, laws, and regulations may also limit the disclosure and dissemination of certain medically related information.

A standard approved authorization form, complying with all existing applicable laws and privacy interests, has been developed in a joint effort by the South Dakota State Medical Association and the State Bar of South Dakota, and is included here as an Appendix. If questions arise concerning the propriety of releasing certain information, the health care provider should contact his or her attorney. The requirement by some institutions and health care providers that a special internally developed form be used is disapproved. Such special forms add undue expense and are also a waste of time and effort to the

institution or health care provider, as well as to the patient and attorney. The perceived advantages of internal forms are outweighed by the advantages of the standard approved authorization form.

Further, an internal requirement by a health care provider that the form be signed within a certain period of time prior to the request is disapproved, and the signed form should be deemed valid unless, by its expressed terms, it has expired.

There is no requirement that the signature be notarized. The release should identify the individual or entity to which the authorization is given, but one release may cover multiple health care providers. There should be a description of the information requested.

3.4 – A reasonable charge may be requested for copies of medical records. Unless records are subpoenaed, payment of such costs may be required before the records are surrendered.

A health care provider is entitled to charge a reasonable fee for providing copies of medical records. It must be reasonably related to the actual cost of copying and mailing such records. Similarly, a physician or health care provider should never charge

an exorbitant fee for medical records simply because litigation is involved and he or she wishes to discourage litigation-related requests. (*See §§ 3.1 and 9.3*)

If an attorney requests that a physician's hand-written chart be transcribed, an additional reasonable charge may be requested for that service.

This code recommends that reproduction charges should not exceed $5.00 for the first ten pages and $0.25 per page thereafter.

Records should be released without regard to any outstanding unpaid balance due on the patient's bill for medical treatment. (*See § 9.7*)

4. MEDICO-LEGAL OPINIONS, REPORTS AND ENDORSEMENTS

In many instances, expert medical reports may be legally required by procedural rules or court order. Even when not required, reports from treating or examining physicians may foster settlement or avoid more formal, expensive, and time-consuming depositions.

Physicians should be mindful that all expert opinions must be disclosed to the opposing side by way of either a report or an endorsement of the expert witness in discovery or pretrial documents. If an opinion is not disclosed, it may be precluded.

Therefore, clear communication of the expert's opinion is of utmost importance.

4.1 – A request for a formal medico-legal opinion should be in writing. It should fully inform the physician concerning the purpose for which the report is sought. It should identify the parties to the claim and the party requesting the report. It should specify the information and documentation provided to the physician on which the expert opinion should be based. The request should preferably provide a brief summary of the case. Finally, the request should specify the medico-legal issues to be addressed and the legal terminology, if any, required.

> The request for a formal medico-legal opinion is intended to alleviate any future misunderstandings concerning the nature, scope, and purpose of the physician's review and further involvement. In more complex cases, and in those instances involving nontreating physicians, this request may be preceded by a conference where the expert's qualifications will be reviewed, the medico-legal issues discussed, the information needed by the physician to complete the review will be discussed, and financial arrangements will be agreed upon.

4.2 – The attorney has the duty to determine the physician's legal competency to render opinions on a given issue. The physician should recognize the difference between a legal expert and an expert among his or her peers in a given specialty.

The attorney should be familiar with the legal rules of evidence governing competency of expert witnesses. It is the attorney's duty to make adequate inquiry into the physician's education, background, training and experience to determine if the physician is legally qualified to address a given medico-legal issue. An attorney should accept the limitations of the physician's expertise and avoid attempts to obtain opinions from a physician that are clearly beyond that physician's expertise.

At the same time, the physician should be aware that under the South Dakota and Federal Rules of Evidence, an expert witness is one who by knowledge, skill, experience, training or education, has sufficient knowledge and expertise to assist the trier of fact to understand the evidence or determine a fact in issue. However, to qualify as an expert for the purpose of testifying at trial, such an individual need not be a super-specialist or a university professor,

nor must that person be recognized as an expert in a given subspecialty by the physician’s peer group.

4.3 – A copy of all medical records and other documentation pertinent to the medico-legal issues to be addressed should be furnished to a reviewing physician before a formal opinion is rendered.

Treating and examining physicians may legitimately rely upon the history, examination findings, radiological studies, and other test results which they acquire in their treatment or examination of a claimant.

However, nontreating physicians who are requested to evaluate a medico-legal issue should be provided with all relevant documentation and medical records such that the opinions rendered are fully informed opinions. The practice of providing only partial medical records which are favorable to a client’s position is firmly condemned. If a physician requests further information which is reasonably available to the attorney, it should be provided. However, the expert should not be burdened with unnecessary, extraneous materials. Fair and unbiased summaries of depositions, records, or other facts may be provided to

assist the physician in economically reviewing the case involved.

The physician and retaining attorney should discuss the advantages and disadvantages of providing other experts' reports to the reviewing physician before he or she arrives at an opinion. Such disclosure of other experts' opinions may appear to affect the expert's independence and objectivity in his or her initial review.

Both physician and attorney should bear in mind that all documentation and information provided to the medical expert, as well as all research, notes, reports and other papers generated by the medical staff in his or her review of the claim, may be discoverable by the opposing side.

4.4 – If the treating physician has an opinion, he or she is obligated to state it. It is unclear to what extent a treating physician may be required to form an opinion.

The extent to which treating physicians may be required to formulate expert opinions is unclear. However, a physician can be compelled to state his or her observations concerning a patient and may be required to testify as to medical information acquired

in the course of treating a patient. If the physician has an opinion concerning a medico-legal issue, he or she may be compelled to express it.

4.5 – Expert witnesses should be advised of factual disputes concerning the underlying facts on which the expert opinion is to be based. Even where the expert is asked to assume a "hypothetical" set of facts, the expert witness should still be provided with all relevant facts and records.

Physicians asked to review medico-legal issues should understand that they are not the ultimate finders of fact. Therefore, there may be factual issues which are beyond the competence of an expert witness to resolve, as where there are discrepancies in various medical records or disagreements over certain conversations, etc. The physician may therefore be requested to assume the truthfulness of a "hypothetical" set of facts when formulating his or her opinion.

"Hypothetical" facts do involve real cases. The reviewing physician should still be provided with all relevant medical records and facts and is entitled to know the nature of the underlying dispute.

In responding to hypothetical questions, the expert witness should set forth the significant factual assumptions underlying his or her opinions, and may qualify an opinion by stating that it could change if different factual assumptions were made.

4.6 – It is preferable that the physician's opinions be set forth in writing in the physician's own language. If an attorney makes an expert witness disclosure in addition to, or in lieu of an expert report issued by the physician, such a disclosure should only be done after its contents have been carefully reviewed and approved by the physician.

Physicians often prefer that their medico-legal opinions be set forth in writing to avoid future misunderstanding concerning the nature, extent and scope of the expert's review and opinions. The expert report also assures that the opinions are accurately communicated in the physician's own language.

However, in some instances, typically involving nontreating physicians, an attorney may desire that no expert report be issued. This is because reports may limit the scope of that expert's future testimony; the physician's language may not adequately set forth necessary legal terminology; reports provide potential

grounds for cross-examination; and early reports may hamper future modifications or supplementations of the expert's opinions as new or different information becomes available. To provide for such flexibility, the attorney may prefer that an expert witness disclosure in court documents be in the attorney's own language.

To avoid miscommunication, expert witness reports should be encouraged. However, when an affidavit or a discovery or pretrial disclosure of expert testimony is drafted by the attorney in the attorney's own language, legal terminology should be fully explained, and it should not be tendered to the court or opposing counsel until its contents are fully approved by the physician to whom the opinions are attributed.

4.7 – Medico-legal reports should be promptly provided.

Physicians should recognize that there are often legal time restrictions and court-imposed deadlines concerning the submission of expert reports or the disclosure of expert opinions. Therefore, attorneys should retain the expert and request reports sufficiently in advance of such deadlines so as to avoid inconvenience and hardship to the reviewing physician. At the same time, undue delay in providing

expert reports may hamper settlement negotiations, cause otherwise unnecessary continuances of trial dates, create burdensome scheduling difficulties for later depositions, or otherwise prejudice the party's ability to use the expert witness at trial.

4.8 – A medico-legal report should be accurate, objective, and fully and fairly address the issues presented. The author should be mindful of the legal terminology necessary to satisfy evidentiary rules concerning competency and burden of proof.

The physician should be aware of the significance and use of his or her reports. They play a vital role in the settlement process and in the necessary pretrial disclosure of expert witness opinions. The physician should therefore carefully review the attorney's request for the report and fully and objectively answer any special questions posed. Where legal terminology is required, the physician should attempt to set forth his or her opinions consistent with that necessary legal terminology.

4.9 – Unless otherwise requested, a report from a treating or examining physician should generally include the following information:

(a) History of present illness

(b) Examination findings

(c) Pertinent radiological and other diagnostic test results

(d) Diagnosis

(e) Etiology and/or causation

(f) Treatment rendered

(g) Course and prognosis, including anticipated permanency and residual disability

(h) Future treatment options and needs

(i) Past and future medically related expenses.

4.10 – A reasonable charge may be made for the time spent in preparing a medico-legal report and payment may be requested in advance of the doctor's release of the report.

Physicians have the right to be reasonably compensated for preparation of medico-legal reports. The amount, terms and conditions of such payment should be handled at the outset, preferably in a written retainer agreement or a letter setting forth the physician's policies. (*See § 9.2*)

4.11 – The furnishing of a medico-legal report should never be conditioned upon payment of a patient's bill for the underlying treatment. (*See § 9.7*)

4.12 – A physician who may be the subject of a medical liability claim should not provide a written report to the

patient's attorney without first contacting his or her professional liability insurer or attorney.

When a physician is contacted by a patient's attorney and advised that he or she is being investigated as a possible defendant in a medical liability claim, the physician should not provide that attorney with new summary reports concerning the care and treatment of that patient. If information is requested and the appropriate consent form provided, the patient's medical records should be provided and the physician should contact his or her professional liability carrier or attorney for further advice and instructions.

Similarly, attorneys investigating a potential medical liability claim against a physician or health care provider should clearly state their purpose when requesting medically-related information.

5. CHOICE OF LANGUAGE AND THE COMMUNICATION OF MEDICAL OPINIONS AND TESTIMONY

5.1 – Physicians and attorneys should attempt to understand the differences between medical causation and legal causation to avoid confusion in medico-legal opinions.

Physicians and attorneys differ in how they define causation. This often leads to misunderstanding when the physician is asked an expert opinion on the issue of legal causation.

Medical etiology is the science of determining the causes of disease requiring medical treatment. As such, it is concerned with all possible causes. Through differential diagnosis, these causes can be narrowed such that treatment is rendered based on a final diagnosis. Therefore, the physician focuses primarily on those causes which are still operative and can be controlled, altered, or removed by treatment such that the outcome is affected. Legal causation focuses on these earlier precipitating or aggravating causes brought about by allegedly tortious conduct. Legal causation is a political and social decision as to where society feels a loss should fall. It is a factual determination, based on legal standards, as to whether a sufficient causal relationship exists between the alleged wrongdoing and the injury complained of.

Legal causation therefore has little to do with medical etiology and focuses on the role of a single past traumatic event rather than all possible causes and conditions contributing to a medical condition.

A legal cause is often defined as a cause without which the claimed injury would not have occurred. A legal cause is also sometimes defined as conduct which is a "substantial factor" in bringing about the claimed injuries. It need not be the sole cause nor the last or nearest cause.

So long as it is a cause, it does not matter that it joined with other causes to bring about the claimed injury.

In cases where an underlying medical condition was allegedly aggravated or worsened by a defendant's conduct, the defendant should only be responsible for that portion of the total harm caused by his or her conduct. This often requires a physician's opinion attempting to apportion the plaintiff's total harm as between multiple causes, *i.e.*, the underlying condition and the aggravation of that condition by defendant's conduct. If apportionment is impossible, the law will hold the defendant legally responsible for all of the harm.

5.2 – A physician should understand the legal standards of proof and evidentiary rules concerning expert opinions, and

attempt to express medico-legal opinions by using necessary legal terminology.

Each profession has a highly technical language largely unknown to the other. This technical terminology is needed in each profession to attain accuracy and certainty of meaning. However, while this terminology facilitates understanding within a profession, it often blocks understanding between professions. Physicians reporting or testifying on medico-legal issues should attempt to understand some of the legal standards of proof and technical terminology. The physician should understand that law is largely a profession based on words and language. Therefore, while many legal terms are foreign to the physician, they are of critical importance in stating a relevant and competent legal opinion.

Foremost among these necessary legal terms is "reasonable medical probability." To be competent, a physician's medical opinion should generally be based upon "reasonable medical probability." This term simply means that which is more probable than not, more likely than not, or over 50 percent probable.

This is consistent with the legal standard of proof that findings must be based upon probabilities and not possibilities. Opinions based upon surmise, speculation, or conjecture are irrelevant and inadmissible in law. However, an opinion need not be based upon scientific or medical certainty, which is a far more stringent standard than the law requires.

Therefore, physicians should attempt to express their opinions using such terms as "reasonable medical probability," or "probably" or "likely." Terms such as "possibly," "might," "may," "could," "guess," "maybe," and the like may, under some circumstances render the opinion inadmissible.

Similarly, before testifying regarding a medical liability claim, the physician should be thoroughly versed on such terms and issues as "standards of care," "negligence," "respectable minority," "judgment calls," etc.

It is the responsibility of the attorney requesting a medico-legal opinion to educate the physician concerning the legal standards of proof and the significance of technical legal terminology. This can and should be done in the various meetings with the

physician and any letters requesting a formal medico-legal opinion.

5.3 – Physicians should use clear, plain and understandable language when testifying and should attempt to avoid overuse of complex medical terminology.

A physician may have an excellent command of the facts and medicine and may be adequately versed in the legal terminology. However, the physician must communicate his or her facts and opinions consistent with the level of sophistication of the fact-finding body hearing the case. Medical testimony may be so technically worded that its meaning is entirely lost to the jury or is so completely misunderstood that the jury arrives at a verdict that would have been different had it known the true import of the testimony.

The medical witness should remember that his or her role is essentially that of a teacher. The testimony is not intended to impress or edify, but to explain. If the testimony does not help explain and does not clarify the issues of a particular case, it has failed in the sense that it was not useful to the determination of the case.

To make expert medical testimony clear, a medical witness should preferably express his or her findings and opinion in medical terms first. Those terms should then be translated as accurately as possible into language intelligible to the court, attorneys, and jury.

The attorney should assist the medical witness in choosing appropriate terminology and then monitor the testimony. If undue use of complex medical terminology is used by the physician, it is appropriate and even recommended that the attorney interrupt the testimony and obtain necessary clarification.

In complex medical cases, it may be appropriate to compile a glossary of terms and definitions which, with permission of opposing counsel, and the court, may be provided to the jury.

6. CONFERENCES AND CONSULTATIONS BETWEEN THE PHYSICIAN AND ATTORNEY

Communication with the treating physician or medico-legal expert is all-important to assure that necessary, competent and persuasive expert opinions are developed. This in turn facilitates settlement and the orderly presentation of evidence

at trial. Therefore, contingent upon the existence of an appropriate consent form, conferences and open communication between the attorney and physician are encouraged so as to minimize misunderstandings over scheduling and fees and diminish the frequency and impact of surprises to both physicians and lawyer.

6.1 - It is often advisable to meet with a treating physician or potential expert at the outset before the expert has reviewed the medical issue or rendered a report.

An attorney and physician should often confer at the very outset before opinions are formally rendered. The attorney should explore the physician's background, training and experience to determine that physician's competence to render opinions on the medical issues involved. The background facts and medico-legal issues should be explored. The nature, scope and availability of medical records and other documentation on which the expert opinion will be based should be discussed. Any special legal concepts or language needs which should be included in a report should be addressed. Finally, financial arrangements, deadlines, scheduling and availability should be fully reviewed at the initial consultation. Such conferences

can often be held over the telephone, which saves the time, expense, and inconvenience of a more formal office consultation. Fees may be charged for such telephone conferences.

6.2 - An attorney who expects to call a physician to testify as an expert witness in a deposition or at trial should confer in advance with that physician.

An attorney should always meet with a physician before a trial, hearing or deposition to place the physician at ease. Most physicians have a fear of looking "foolish" in a testimonial setting and, by proper preparation of the physician, any such fears should be alleviated while, at the same time, a more effective presentation of evidence should be fostered. It is the responsibility of the attorney to schedule that conference at a mutually convenient time sufficiently in advance of the time for testimony. Some or all of the following topics should be discussed at a pre-deposition or pretrial consultation:

(a) The purpose for which that physician is being called as an expert witness, if that purpose has not previously been disclosed;

(b) The significant medical issue which may arise during testimony;

(c) Any potentially problematic evidentiary rules or issues;

(d) The strengths and weaknesses of the medical evidence concerning these medical issues;

(e) The medical theories and evidence which will probably be advanced by the opposing side and its experts;

(f) Important legal terminology as it relates to the medical issues;

(g) Supporting and contrary medical literature;

(h) Any reports, records or literature generated by the physician or others which should be studied to prepare for testimony;

(i) Updating and reviewing the physician's qualifications and *curriculum vita* and assuring his or her competency to address certain medico-legal issues;

(j) The substance of the questions the attorney will probably ask of the physician, including key specific questions and hypotheticals;

(k) The scope and content of the anticipated cross examination by the opposing side, including prior depositions, publications, reports, conflicting medical histories; fee arrangements, etc.;

(l) Scheduling and trial or deposition procedures; and

(m) Financial arrangements.

6.3 - A treating physician should not discuss the case privately with a patient's adversaries without a clear and expressed authorization to do so or without knowledge by the patient's attorney of the time and place with an opportunity to object or to be present at that meeting. Similarly, a non-

treating expert medical witness should not engage in private consultations with a representative of the opposing party without permission of the party or attorney who originally retained him or her.

Physicians should attempt to understand the adversarial system of justice and recognize the principle of adverse interest as between the patient and his or her adversary. It is axiomatic that a physician's integrity, honesty, objectivity, and judgment are among his or her most precious assets and can never be "purchased" by a litigant. However, that physician also has a duty of confidentiality concerning the patient's medical information. (*See §2.1*)

A treating physician should therefore generally resist private communications with an opposing party's representative unless a clear, expressed and written authorization for such contact is provided. This will assure that the relationship of trust and confidence between a physician and patient is not undermined and will assure the propriety of any disclosures made.

If contacted by an opposing party or counsel, the physician should be provided with a prior express authorization for that contact. If such authorization

is not provided, the physician should advise his or her patient's counsel or the attorney initially retaining him or her concerning the contact so as to enable that attorney to object to any such private contact or attend, observe, and participate in any such consultation with the opposing party.

7. ***SCHEDULING AND SUBPOENAS***

7.1 - The attorney should schedule a physician's testimony in depositions or at trial far enough in advance and in such a manner so as to minimize inconvenience to the physician and disruption of the physician's practice.

Scheduling of a doctor's deposition or in-court testimony should be done as far in advance as possible.

Once an appointment is given for a deposition, either the physician or the lawyer should memorialize the appointment with a letter outlining the major details of the arrangement. At a minimum, the letter should:

- Clearly establish who is responsible for payment of the physician's charges;\
- Clearly establish a fair fee and describe the manner in which it is computed and whether there are additional charges for photocopying, use of the premises and the like;

- Ask the lawyer to make sure that he has all recent medical records prior to the deposition;
- Establish whether the deposition will be videotaped so that adequate facilities can be scheduled;
- Clearly establish a date and time for the deposition; and
- Specify that the letter states the agreement between the parties unless either advises the other to contrary.

It is often a good practice to advise all potential medical witnesses of a trial date at the time the trial is first set. Vacation schedules and other potentially conflicting obligations can then be determined and resolved in advance. Specific arrangements concerning the date, time and place of trial testimony preferably should be made more than sixty (60) days prior to the scheduled appearance.

Similarly, depositions should be scheduled at a mutually convenient time and place. Attorneys should readily agree to depositions "after hours" at the physician's office it that is the least disruptive to the physician's practice. However, if the physician's office is not large enough to accommodate the attorneys in a multiple party case, the physician should readily agree to the deposition being held at the attorney's office, hospital, or other convenient location.

To avoid delays and unnecessary waiting at trial, the attorney should try to schedule a medical witness at the first witness in the morning or afternoon sessions. Lay witnesses may also be used as buffers to medical witnesses. It is sometimes possible to call a physician "out of order" to accommodate his or her schedule.

However, being called "out of order" may disrupt a trial, inconvenience other witnesses and interrupt the logical flow of evidence. Therefore, while the physician is entitled to some estimate of the amount of time needed for testimony, he or she should be mindful that the attorney has little control over the court's docket, the needs of other witnesses, or the opposing attorney's conduct or questioning. These may necessarily result in some delay in testimony or other inconvenience to the physician.

7.2 - Physicians should understand the significance of the subpoena and honor its enforcement. Likewise, an attorney should never abuse the power of the subpoena.

A *subpoena* is an order of court, that may be issued by an attorney, compelling a witness to appear at the time and place stated in the subpoena. A

subpoena duces tecum ("subpoena to produce") requires a witness to appear and produce certain things or documents. Subpoenas may be issued for deposition or trial testimony. The failure to comply with a subpoena may constitute contempt of court and subject the noncomplying witness to fine or imprisonment unless there exists "good cause" for the failure to comply - such as a true medical emergency. A physician who does not comply with a subpoena takes the risk of later having to convince the court that the emergency was of sufficient gravity to constitute "good cause." The HIPAA-mandated privacy rules restrict the use of subpoenas to a certain extent, and the physician should consult with his or her own attorney if there is a question concerning whether a subpoena should be honored. *See* 45 CFR 164.512(e).

Not only professional courtesy, but the reputation of the physician and the safety of his or her patients, demands that an attorney not abuse the subpoena power. A patient's life or health must not be jeopardized so that a physician can make a timely appearance in court. On the other hand, every reasonable effort should be made by the medical witness to appear as scheduled, whether or not a subpoena has been issued.

While every attempt should be made to accommodate the physician, it must be understood by the physician that he or she does not always have the right to choose the time and place to give medical testimony. Like any other witness, a physician summoned to court by subpoena must appear at the time and place so designated. However, it must constantly be stressed that a lawyer should never abuse the use of a subpoena and should always recognize the potentially disruptive effect it could have on a physician's practice and his or her patients.

If a physician feels that a subpoena has been improperly used, or a *subpoena duces tecum's* request to produce documents is overly burdensome, oppressive, or invasive of his or her privacy, the physician should contact his or her lawyer to determine what protective measures, if any, might be available.

Even though testimony is scheduled in advance, sound reasons still exist for subpoenaing a physician. The doctor should understand that the issuance of a subpoena does not signify a lack of trust in the physician's agreement to appear nor is it intended as a heavy-handed tactic to compel a recalcitrant or hostile witness. Rather, a subpoena is often necessary to

protect the interests of the client seeking the testimony of the physician and to allow the attorneys and the court to better accommodate the physician's scheduling needs. Courts are often reluctant to grant continuances in the event of a medical emergency, take witnesses out of order, or otherwise accommodate busy physicians unless they have been previously subpoenaed.

Frequently, a judge will permit the physician who has been subpoenaed to remain "on call," which means that the doctor need not be personally present at all times, so long as he or she can be reached by telephone and respond promptly when needed.

When the testimony of the medical witness has been completed, counsel should immediately move the court to excuse the physician from further appearances under the subpoena.

7.3 - The use of a subpoena to compel a physician's presence does not in any way affect the physician's entitlement to an expert witness fee.

If the subject of testimony arises out of an individual's role or status as a physician, he or she is entitled to an expert witness fee. (*See § 9.6*) The use of subpoena to compel a physician's presence at a

deposition, hearing, or trial does not in any way affect the physician's entitlement to such an expert witness fee.

Before a subpoena is issued and served on the physician, the better practice is for the attorney to contact the physician and attempt to agree upon a reasonable expert witness fee for complying with the subpoena. At the very least, a short note by the attorney should be served with the subpoena explaining that the check for the statutory mileage and witness fee accompanying the subpoena should not be considered the physician's sole remuneration for appearing under subpoena and a further expert witness fee is justified.

If no prior agreement is reached, the physician may bill the attorney for a reasonable expert witness fee for attending pursuant to the subpoena. (*See §9)* If a disagreement arises over the entitlement to such a fee, or the amount requested, that dispute may be submitted to the Court or to an interprofessional dispute resolution committee. (*See §10)*

7.4 - Service of a subpoena should be handled in the least disruptive manner. A physician should never seek to evade service of a subpoena so as to avoid having to give testimony.

At the time the physician’s testimony is scheduled, the attorney should discuss with the physician the need for service of a subpoena and the manner in which the subpoena should be served. Personal service on the physician can be disruptive to the physician’s office and embarrassing to the physician. A private process service should be instructed by the attorney concerning tactful and discreet service of a subpoena.

Many physicians prefer that the subpoena be sent through the mail with a “Waiver and Acceptance of Service.” This can also save the client service of process costs. If this is not returned within a reasonable time before trial, personal service can still be accomplished.

A physician should never seek to evade service of a subpoena so as to avoid having to testify. This is beneath the dignity of the physician, substantially increases litigation costs, obstructs the administration of justice, and can result in eventual embarrassment to the physician when service is finally accomplished.

8. DEPOSITIONS

8.1 - Depositions are an inherent part of the pretrial discovery process. Usually, the taking of a deposition is not in lieu of court appearance and testimony.

Depositions of witnesses, including expert witnesses, are usually taken for "discovery" purposes. In other words, they are usually taken by the attorney opposing the party retaining or endorsing the expert in order to discover the physician's opinions. As such, different rules of examination, foundation, and qualifications apply to discovery depositions than to trial testimony. Therefore, a physician's pre-trial deposition is often not admissible at trial. This is especially so if the physician is otherwise available in the jurisdiction and amenable to compulsory attendance by the service of a subpoena. The attorney retaining or endorsing the medical expert naturally does not want to rely upon his opponent's questioning to present his or her evidence. The lawyer also wants to assure an orderly presentation of evidence in compliance with all rules of evidence to assure admissibility of the testimony. Further, the attorney must be allowed the flexibility of addressing new medico-legal issues that first arise during trial and

could not have been reasonably foreseen prior to trial. Finally, for the trier of fact to understand and evaluate medical testimony, especially complex or conflicting testimony, it is essential that they see that testimony live and that the medical expert appear in court.

8.2 - The party taking the deposition is responsible for timely payment of all reasonable charges for time spent traveling to and from the deposition and for attending, reviewing, correcting, and signing the deposition, unless there is an agreement or order to the contrary. The party retaining or endorsing the medical expert is responsible for the cost of the physician's time in preparing for the deposition.

The party taking the deposition must pay reasonable compensation for the deposition he or she has requested. This includes reasonable costs and fees associated with any travel to or from the deposition as well as an expert witness fee for attending, reviewing, correcting and signing the deposition. Preparation for the deposition, on the other hand, inures primarily to the benefit of the party retaining or endorsing the expert, and that party should be responsible for that preparation time. Presumably, such preparation

furthers the cause of the endorsing party. Also, it would be unworkable and inappropriate for the opposing party to exercise control over the amount of time the other party's expert is to spend in preparation for a deposition. Rather, the party retaining or endorsing the medical expert can and should discuss and agree with the physician concerning the amount of time to be spent in preparation for a deposition.

8.3 - Deposition costs and fees should be reasonable and should be agreed upon in advance of the deposition. Disputes should be noted at the outset and attempts should be made to amicably resolve such disputes or timely submit them to the court for resolution.

Deposition costs and expert witness fees should be reasonable based on the factors set forth in Section 9.2 of this code. Every effort should be made prior to the deposition to agree on the manner, timing, and amount of compensation. In the alternative, the party endorsing the expert may legitimately condition the deposition upon prior financial arrangements being agreed to or determined by the court as set forth in rule 26(b)(4) of the Federal Rules of Civil Procedure and SDCL §15-6-26(b)(4)(c). An attorney taking the

deposition of an opponent’s expert witness should never withhold or delay payment of that expert’s fee or engage in unnecessary conflict so as to discourage that expert witness from further involvement in the case, or as a means of “punishing” that expert for his or her testimony. When an agreement has not been reached and a dispute does arise, it should be promptly submitted to a judge or interprofessional committee for resolution. Any undisputed amounts should be remitted without delay.

9. PHYSICIAN COMPENSATION AND EXPERT WITNESS FEES

9.1 - Physicians and attorneys should strive to agree in advance concerning the nature and scope of the services to be performed, the terms and amounts of compensation to be paid for those services, and the responsibility for payment of that compensation. Absent an agreement, disputes may arise which will require resolution by the court or an interprofessional committee.

The physician is entitled to reasonable compensation for providing services in connection with litigation. The issues of fees, costs, and scope of employment for medico-legal services are frequent areas

of disagreement. This is usually due to lack of open communication and the absence of a prior agreement between the physician and the attorney.

Therefore, whenever possible, these issues should be clarified before services are rendered and whenever possible, confirmed by written agreement. The agreement should be tailored to fit the specific circumstances, but it is suggested that the following be included:

(1) The scope of services to be performed by the physician;

(2) The rate of compensation to be paid for the physician's services, including whether the fee will vary depending upon the services rendered, *e.g.*, research, review of documents, examination, dictating of report, travel or testimony;

(3) Whether advance payments or retainers are required and, if so, under what circumstances;

(4) The handling of costs and expenses;

(5) Cancellation terms and amounts; and

(6) The person or persons responsible for payment of those costs and fees.

Physicians are encouraged to develop office policies concerning medico-legal involvement, which can then be reduced to writing and provided to the attorney at the time of the initial request.

An attorney provided with such a written policy should immediately assent or object to the terms provided. It is improper for the attorney who does not object to continue to request the physician's services after being advised of the physician's policies for medico-legal involvement, and then later deny that he or she agreed to the terms of those policies. However, the physician should recognize that providing the attorney with the physician's policies merely constitutes an offer and does not bind the attorney or client until they expressly or impliedly agree to those terms.

If no agreement can be reached between a treating physician and an attorney, the physician must recognize that he or she can still be compelled to provide necessary medico-legal information and a court or interprofessional committee may be called upon to determine the amount and terms of compensation. A non-treating or consulting physician cannot simply refuse to participate absent an agreement with the attorney or his or her client.

9.2 - A physician is entitled to fair and reasonable compensation for providing expert testimony.

In determining what constitutes a fair and reasonable expert witness fee, some or all of the following factors should be considered:

(1) The amount of time spent, including review, preparation, drafting reports, travel, or testimony;

(2) The degree of knowledge, learning, or skill required;

(3) The amount of effort expended;

(4) The uniqueness of the expert's qualifications;

(5) The amount charged by similarly situated physicians;

(6) The amount of other professional fees lost; and

(7) The impact, if any, on the physician's practice because of scheduling difficulties, other commitments, or other problems.

The use of itemized billing by the physician to the attorney should be encouraged and will often expedite payment.

In workers' compensation proceedings, the amount the physician may charge for his or her testimony may be limited by administrative rule. In those circumstances, the physician may not charge a fee more than that allowed by the applicable administrative rule.

9.3 - A physician is never justified in charging exorbitant fees so as to capitalize on the patient's legal problem, or so as

to discourage requests for information. At the same time, a physician cannot be expected to lose money or suffer financially as a result of participation in the litigation process. The physician should recognize that it is the patient or client who is ultimately responsible for payment of such litigation costs, regardless of the outcome of the case. Hence, charges for medico-legal involvement should generally be no higher than the physician's charges for other medical services.

> A physician should neither gain nor lose financially as a result of his or her participation in the litigation process. An attorney should never expect the physician to sacrifice income merely because his or her patient is involved in litigation. The attorney should never abuse the power of the subpoena in the hopes of obtaining free or discounted expert testimony.
>
> On the other hand, expert witness fees should not be so high as to have the effect of preventing the patient from obtaining the doctor's medico-legal services, or as to create the appearance that the physician is attempting to capitalize on the patient's legal problem. Physicians should not seek to punish or deter attorneys or patients seeking the physician's

medical information. This merely further victimizes the patient who is compelled to seek compensation for injuries through litigation.

Even though the attorney may become obligated initially to pay the physician's expert witness fees, the physician should always be mindful that the patient is ultimately responsible for such litigation costs, regardless of the outcome of the case. Even in cases handled on a contingency fee basis, only the fee is contingent. While an attorney may advance these costs on behalf of the client, the lawyer's professional ethics require that the client remain ultimately responsible.

Therefore, fees charged for litigation-related services should be roughly equivalent to fees charged in the physician's practice for medically related services.

9.4 - In contracting for medico-legal services, the attorney is acting as an agent for the client. It is the client who remains ultimately responsible for such fees and costs. However, an attorney may ethically obligate himself or herself to pay the physician's fees and costs and, customarily, the attorney contacting or retaining a physician on behalf of a client is

personally obligated to see that the physician is paid for litigation-related services.

An attorney is only an agent for his or her client, and litigation costs and expert witness fees are contracted for by the attorney on behalf of the client. Under agency law, an agent is usually not responsible for debts contracted for or on behalf of a disclosed principal.

However, different rules apply to expert witnesses in the litigation setting. An attorney is ethically obligated to compensate the physician directly for medico-legal services he or she has requested. The attorney may also ethically advance or guarantee such litigation costs and expert witness fees, so long as the client remains ultimately responsible for payment.

Customarily, the attorney pays those expert witnesses or physicians he or she contacts on behalf of the client, even if the attorney is not obligated to do so. This is because the attorney is in a better position to assess the client's ability to pay and to collect such advanced costs from the client.

9.5 - Compensation of an expert witness may never be contingent upon the outcome or the content of the physician's

testimony, or the court’s acceptance of the witness as an expert witness.

A physician’s compensation should never be conditioned upon, or measured by, the amount of the patient’s recovery in damages in the litigation. Any contingent witness fee naturally compromises the integrity of the testimony of that witness. The physician is entitled to reasonable compensation regardless of the outcome of the case.

It goes without saying that the attorney cannot condition compensation upon the content of the physician’s testimony and thereby seek to purchase favorable testimony. This is clearly unethical conduct on the part of the attorney and should be reported to the court in which the action is pending, or the State Bar Disciplinary Board.

Because the attorney should be familiar with court rules governing competency of expert testimony and has a duty to inquire concerning the qualifications of his or her tendered expert, it is also inappropriate to condition the physician’s compensation upon the court’s acceptance of that physician as an expert witness.

9.6 - An expert witness fee is owed to the physician if the subject of the testimony arises out of the individual's role or status as a physician and cannot be conditioned upon the eliciting of expert "opinions."

The premise that an expert witness fee is due only if an expert opinion is elicited from the witness is not a valid assumption. A physician who comes into possession of facts or information solely because of his or her position as a physician is entitled to receive compensation as an expert when subpoenaed to testify to those facts in court. The physician's position and status at the time he or she comes into possession of relevant information determines whether the physician should be entitled to an expert witness fee.

9.7 - A physician has a duty to provide medical information and participate in his patient's litigation regardless of the status of the patient's bill for medical care and treatment. However, where possible, the attorney may assist the physician in the collection of outstanding fees for medical treatment.

Fees for medical care and treatment are exclusively the responsibility of the patient. It is

unethical for the attorney to advance these costs on behalf of the client.

A physician may not condition his involvement in litigation, *i.e.*, providing records, reports, or deposition or trial testimony upon payment of the patient's bill. A physician should never feel that he or she has some financial interest in the outcome of the case, due to an unpaid patient bill, which might appear to taint the objectivity of medical testimony. The physician should recognize that some patients are dependent upon a legal recovery to pay for past and future medical services. Further, public policy mandates that the physician provide necessary medical information and testimony to evaluate such claims. However, as a professional courtesy, the attorney may make reasonable and ethical efforts to assist the physician in obtaining payment for his or her services. The attorney should urge the client to pay the physician for the medical care received as soon as possible regardless of the status of the lawsuit. It is never proper for the attorney to advise the client that payment for medical care and treatment may justifiably be withheld until the lawsuit is completed.

The attorney may also request permission from the client to pay the physician for such services directly out of any recovery received in the litigation. This authorization for direct disbursements to the physician can often be set forth in the attorney-client fee agreement.

9.8 - Terms concerning cancellation of testimony should be discussed and agreed upon in advance. A physician is entitled to prompt notification of cancellation of testimony. Cancellation fees should be reasonably related to the actual loss to the physician.

Cancellation of testimony is often a source of interprofessional disputes. This usually can be alleviated by prior agreement between the physician and the attorney endorsing or retaining the physician. If the physician has a cancellation policy, the opposing attorney should be advised of that policy at the time a deposition is scheduled. The opposing attorney is then subject to the terms of the cancellation policy should he or she later be responsible for the cancellation of the deposition.

If a case is settled or continued, or the physician's testimony is otherwise cancelled, the

attorney who scheduled that physician's testimony should immediately notify the physician of that cancellation. This should preferably be initially done by telephone and followed by a confirming letter.

In the event of settlement, the cancellation notification should also include an inquiry concerning any outstanding fees and costs which should be withheld from the recovery. As a professional courtesy, it is often a good practice to advise the physician of the outcome of the case and the role, if any, the physician played in that resolution or recovery.

Cancellation policies should be reasonable under the circumstances. There should be agreement concerning what constitutes "reasonable notice" of cancellation such that a cancellation fee will not be charged.

Cancellation fees that are charged should be reasonably related to the actual loss to the physician in terms of lost medical fees and the impact on his or her practice. If the physician can use the canceled time productively, *e.g.*, for necessary administrative functions, billing, dictation of reports or hospital or medical records, updating medical literature, or seeing emergency patients, this factor should be heavily

considered in determining the need and amount of a cancellation fee.

10. DISPUTE RESOLUTION

10.1 - Interprofessional disputes should be promptly submitted to an interprofessional dispute committee. Disputants should cooperate in the submission, investigation and resolution of such disputes.

Regardless of the best efforts of both professions to avoid disagreements, disputes do arise. The Professional Liaison Committee of the State Bar of South Dakota is available to assist with the resolution of such disputes between physicians and attorneys. If a dispute arises, the disputants are encouraged to submit the controversy to this committee for review. The disputants are requested to submit written summaries of relevant facts along with pertinent documentation concerning the matter in controversy. Submission of the dispute should be done with fairness and candor, without rancor, and without unprofessional remarks or other conduct which would be further divisive to interprofessional relations.

Members of the committee are then assigned to investigate the disputes and make recommendations for

their resolution. The disputants should remember that these investigators are unpaid volunteers, and every effort should be made to cooperate in their investigation. When a final recommendation is made, the disputants will be advised in writing from the interprofessional committee involved. The recommendation of the interprofessional committee is not binding unless agreed to by the disputants.

Such disputes may be submitted to the following committee:

Professional Liaison Committee
State Bar of South Dakota
Medical Liaison Committee
222 East Capitol Avenue
Pierre, South Dakota 57501-2596
(605)224-7554

AUTHORIZATION FOR RELEASE OF
PROTECTED HEALTH INFORMATION

Patient Name: ____

Date of Birth: ___________

1. I authorize the use or disclosure of the above named individual's health information as described below.

2. The following individual(s) or organization(s) are authorized to make the disclosure:
____

____

3. The type of information to be used or disclosed is as follows (check the appropriate boxes and include other information where indicated).

   [] problem list
   [] medication list
   [] list of allergies
   [] immunization records
   [] most recent history
   [] most recent discharge summary
   [] lab results (please describe the dates or types of lab tests you would like disclosed):
   ____
   [] x-ray and imaging reports (please describe the dates or types of x-rays or images you would like disclosed):
   ____
   [] consultation reports from (please supply doctors' names):
   ____
   [] entire record
   [] other (please describe): ___________________________
   ____

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

5. The information identified above may be used by or disclosed to ______________________________________ and their agents and employees, and to managed care providers and managers, other physicians, potential expert witnesses and to other lawyers involved in the litigation giving rise to this request. The information may also be introduced as evidence in the litigation giving rise to this request.

6. This information for which I'm authorizing disclosure will be used for the following purposes:
 ____
 ____
 ____
 ____
 ____.

7. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department(s) of the persons or entities listed above in paragraph 2 and to ____________________________ at the address listed above. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

8. This authorization will expire: ___________________
 (insert date)
 __ upon completion of the investigation or adjudication of my _____________________________, whichever occurs later.

 If I fail to specify an expiration date or event, this authorization will expire six months from the date on which it was signed.

9. I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

10. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

11. I acknowledge receipt of a copy of this authorization.

______________________________ _______________

Signature of Patient or Patient Representative | Date

LITIGATION GLOSSARY

Introduction

This glossary has been prepared to assist members of the South Dakota State Medical Association in understanding some of the legal jargon often used during the course of litigation. It is not intended to be exhaustive or to be the complete answer in all instances. Physicians should consult their personal attorney for advice in specific situations.

AD DAMNUM - A Latin phrase meaning literally "to the damage." This is the technical name of that clause of a party's claim which contains a statement of the claimant's money loss or the damages which he claims.

ADVERSE WITNESS - The adverse party, or one of its managing officers, called as a witness by the opposing party in a trial. Since the law presumes that an adverse witness will be hostile or uncooperative, the attorney for the party calling an adverse witness may use leading questions. Ordinarily, on direct examination, the attorney for a party calling a witness may not use leading questions.

ANSWER - The formal document filed by the defendant in a civil action, setting forth his defenses and answering the allegations of the complaint.

APPEAL - The review by a higher court of the result of litigation

in a lower court or administrative agency. Although there are exceptions in the case of administrative practice, ordinarily the appellate court is confined to the record made in the lower tribunal, and new evidence is not considered by the appellate court.

ASSUMPTION OF THE RISK - A legal defense in a civil action which, if proved, bars the plaintiff's recovery on the theory that he has voluntarily placed himself in a position where he knows a risk of injury exists.

BURDEN OF PROOF - In civil actions, the party who asserts the affirmative of an issue must prove that issue by a preponderance of the evidence. In comparison, the burden of proof for the state in a criminal case is the greater burden of proof: beyond a reasonable doubt.

CIRCUMSTANTIAL EVIDENCE - When evidence of facts and circumstances is offered as a basis for an inference to be drawn therefrom as to a fact in issue, it is known as circumstantial evidence. In order for a claim to be established by circumstantial evidence alone, the facts established by circumstantial evidence must make the claim to be proved reasonably probable as against any and all other theories or claims which may be deduced therefrom.

CIVIL CASE - Litigation between private citizens for damages or for

equitable relief or between a private citizen and the government of a non-criminal nature.

<u>CLOSING ARGUMENT</u> - The summation of a civil or criminal case by attorneys for the litigants during which the attorneys are permitted to suggest the facts and inferences that should be drawn by the jury from the evidence. The closing argument is ordinarily one of the last phases of a trial before the jury retires to deliberate on its verdict.

<u>COLLATERAL SOURCE RULE</u> - A rule of evidence which prohibits the admission at trial of evidence of payments of certain elements of plaintiff's damages to the plaintiff from sources collateral to the defendant. For example, in a personal injury action, the collateral source rule would prohibit the admission into evidence of insurance payments of plaintiff's medical bills. This, in effect, permits the plaintiff a double recovery in certain circumstances (some health insurance policies require an insured to pay back monies recovered from responsible third persons, in which case no double recovery would occur). The justification for this rule is that the plaintiff should not be penalized for his foresight in securing insurance, and, as between the plaintiff and the wrongdoer, the wrongdoer should not be permitted to profit from the plaintiff's foresight.

COMMON LAW - As distinguished from law created by the enactments of legislatures, the common law comprises the body of those principles and rules which derive their authority from usages and customs of the past, or from the decisions of courts recognizing and enforcing those usages and customs. The common law was imported from England and is, to a certain degree, enforced by all courts in this country.

COMPLAINT - The formal document filed in a lawsuit setting forth the legal claim of the plaintiff.

CONTRIBUTORY NEGLIGENCE - Under South Dakota law, when more than slight, the contributory negligence of the claimant will bar his recovery. Contributory negligence exists when the claimant himself was negligent and when this negligence was a proximate cause of the injury.

COUNTER-CLAIM; PERMISSIVE OR COMPULSORY - A claim for relief made by the defendant against the plaintiff in civil litigation. A compulsory counter-claim arises from the same operative facts as the claim set forth in the complaint and must be asserted in that lawsuit or it will be lost. A permissive counter-claim involves any other claim based on other circumstances which may be asserted at the claimant’s option.

CROSS-CLAIM - A claim asserted between the parties of the same identity; e.g., between defendants or between plaintiffs in a

multi-party suit.

<u>CROSS-EXAMINATION</u> - Adverse examination of the opposing party’s witness designed principally to test the credibility of that witness. The cross examiner is entitled to use leading questions, which are not otherwise permitted.

<u>DAMAGES</u> - That sum of money which will reasonably and fairly compensate a claimant for the elements of detriment or damage proved by the evidence to have proximately resulted from the wrong (negligence or other legal theory) proven. A jury may not consider damages until it has decided in favor of the claimant on the question of liability. Each case is different as to those elements of damage that may be compensable. Generally speaking, in a tort action, only those damages which are foreseeable are awardable, while in a contract action, all damages proximately flowing from the breach of contract may be awarded without regard to foreseeability.

<u>DEFENDANT</u> - The person defending or denying; the party against whom relief or recovery is sought in an action or suit.

<u>DE MINIMUS NON CURAT LEX</u> - Latin. The law does not deal in trifles. Lawyers will many times refer to “De Minimus” arguments.

<u>DEPOSITION</u> - A statement taken under oath in question and answer form before a court reporter, with the opportunity for all

parties and their lawyers to be present and interrogate.

DIRECT EXAMINATION - Examination of a party’s own witness by his attorney. Leading questions may not be used.

DISCOVERY - The term describing generally the process by which parties to litigation ascertain facts and opinions known by the opposing parties and their witnesses. The most common tools in discovery are depositions, interrogatories, and requests for admission of facts and for the production of documents.

DISMISSAL WITH OR WITHOUT PREJUDICE - Dismissal by a court of a party’s claim or lawsuit without prejudice permits the party to reassert that claim at a later time, while a dismissal with prejudice is an adjudication on the merits of the claim and it may not be reasserted in the future.

EVIDENCE, RULES OF - Rules developed over the years by the courts governing the admissibility of evidence based upon experience as to that which is most likely to be credible and reliable. To be admissible, evidence must be credible, relevant to the issues being litigated, and material to the outcome of the litigation.

EXPERT WITNESS - A witness who has special knowledge, skill, experience, training, or education in a particular science, profession, or occupation may give his opinion as an expert as

to any matter in which he is skilled. Otherwise, unless they are qualified as experts, witnesses ordinarily may not give an opinion as to an issue being litigated, except as to matters of common experience.

<u>FAILURE TO DIAGNOSE</u> - A form of negligence giving rise to a medical malpractice claim where a physician fails to diagnose a condition which a physician of ordinary skill and diligence would have diagnosed.

<u>FRIVOLOUS SUIT</u> - An action which appears from bare inspection to be lacking in legal sufficiency and where, in any view of the facts pleaded, it does not present a justiciable controversy.

<u>GENERAL DAMAGES</u> - Compensatory damages are classified as either "general" or "special." General damages are those which are the natural and necessary result of the wrongful act or omission asserted as the foundation of liability and include those which follow as a matter of law from the statement of facts of the injury. Special damages are those which arise from the special circumstances of the case which, if properly pleaded, may be added to the general damages which the law presumes or implies from the mere invasion of the plaintiff's rights. Special damages are the natural, but not the necessary, result of the injury. The distinctions between general and special damages are principally important with

regard to the pleadings in damage actions. General damages, which necessarily result from the injury complained of, may be recovered under a general allegation of damage, whereas special damages must be specially pleaded.

In a personal injury action, general damages ordinarily include pain and suffering and damages for a permanent injury or disfigurement of the body. On the other hand, medical and hospital expenses, as well as lost earning and diminished capacity to work in the future, are regarded as special damages.

HEARSAY - Evidence not proceeding from the personal knowledge of the witness but from the mere repetition of what he has heard others say. It is unreliable under the rules of evidence because it is not subject to cross-examination since it does not derive its value from the credit of the witness, but rests mainly on the veracity and competency of other persons.

INFORMED CONSENT - A physician has the duty to make a reasonable disclosure to his patient of the significant risks of a particular treatment in view of the gravity of the patient's condition, the probabilities of success, and any alternative treatment or procedures, so that the patient has the information reasonably necessary to form the basis of an intelligent and informed consent to the proposed treatment or

procedure. A failure to do this constitutes negligence.

<u>INTERROGATORIES</u> - Written questions proposed to another party as part of discovery which must be answered in writing under oath within a specified time.

<u>IMPEACHMENT</u> - Calling the credibility of a witness into question by showing that on some former occasion he made a statement or acted in a manner inconsistent with his testimony in the present case on a matter material to the issues.

<u>JOINT AND SEVERAL LIABILITY</u> - A liability is said to be joint and several when the creditor may sue one or more of the parties to such liability separately, or all of them together at his option. The creditor may collect the entire liability from one or from all.

<u>LEADING QUESTION</u> - A question which, as part of the question, suggests the answer to that question.

<u>LOCALITY RULE</u> - The requirement that the standard of care governing a physician in a malpractice action be that standard of care utilized in the same or similar localities as that of the defendant.

<u>IN LOCO PARENTIS</u> - A Latin term, meaning literally in the place of a parent, describing one charged with a parent's rights, duties, and responsibilities toward another.

<u>MEASURE OF DAMAGES</u> - Those items of damage which may be considered

by the jury in assessing damages given by the court in its instructions to the jury, based upon the nature of the case and the character of the injury allegedly suffered by the plaintiff.

MOTION - A formal request to the court for a ruling on some aspect of the litigation between the parties. That ruling then becomes the "law of the case" governing all further proceedings by the litigants.

NEGLIGENCE - That lack of ordinary care or skill proximately resulting in injury to another.

OPENING STATEMENT - That portion of a trial in which the lawyers for the parties are permitted, without argument, to state for the jury what they expect the evidence to show, done in order to assist the jury in analyzing the evidence as it is presented during the trial. The opening statement is presented after the jury is selected but before evidence is presented to it.

PAIN AND SUFFERING DAMAGES - See definition of general damages.

PLAINTIFF - A person who brings an action; the party who complains or sues in a personal injury action and is so named on the record.

PRE-TRIAL CONFERENCE - A conference involving the judge and attorneys for the litigants occurring when the case is ready

for trial, at which the court rules on preliminary matters, plans the course of the trial, and sets a trial date. It is intended to clarify the issues and shorten the time necessary for trial.

PRIVILEGE - A rule of confidentiality established by court decision or legislative enactment preserving the relationship between a professional and his client or patient, justified on the basis that confidentiality is essential to a full disclosure of information necessary to administer to the client or patient.

PROXIMATE CAUSE - That cause which is an immediate cause and which, in natural or probable sequence, produced the injury or event complained of.

PUNITIVE DAMAGES - Damages awarded by way of punishment or example against one who has practiced oppression, fraud, or malice against another. They have no relationship to actual damages and are based upon the monetary worth of the oppressor and the perceived need for punishment by the jury. They are also called exemplary damages - damages awarded to set an example.

RES IPSA LOQUITUR - A Latin phrase meaning literally the thing speaks for itself. Whenever a thing which has caused an injury is shown to have been under the control and management of the defendant charged with negligence, and the occurrence is such as in the ordinary course of events does not happen if

due care has been exercised, the fact of the accident itself is deemed to afford sufficient evidence to support a recovery in the absence of any explanation by the defendant tending to show that the injury was not due to his want of care. A well known example is a piano falling out a window.

<u>SPECIAL DAMAGES</u> - See definition of general damages.

<u>STANDARD OF CARE</u> - In a malpractice action, the standard of care for a physician is:

(1) possession and exercise of reasonable and ordinary skill and diligence;

(2) such as are ordinarily possessed and exercised by the average members of that profession in good standing or, otherwise put, reputable physicians;

(3) in the same or similar localities where the defendant practices;

(4) in the same general line or practice; and

(5) with regard being had to the state of medical science at the time involved.

<u>STARE DECISIS</u> - A Latin term meaning to abide by, or adhere to, decided cases; the policy of courts to stand by precedent and not to disturb a settled point.

<u>STATUTE OF LIMITATIONS</u> - A legislative enactment involving a policy decision that lawsuits of certain specified categories must be brought within a particular term of years. The justification for statutes of limitation is to eliminate stale claims made

after evidence becomes unavailable and the memories of witnesses fade.

STIPULATION - An agreement, either in writing or in the trial record, between litigants through their attorneys.

SUBPOENA - Legal process issued by a court or in the name of a court to cause a witness to appear and give testimony.

SUBPOENA DUCES TECUM - A subpoena which, in addition to requiring testimony, also commands the witness to bring specified documents or things in his possession or control.

SUMMONS - The official court document served upon a litigant which notifies him that a lawsuit has been commenced and that he must respond or have judgment by default taken against him.

THIRD PARTY PRACTICE - That procedure outlined in the Rules of Civil Procedure permitting a party in litigation to bring in an outside party contending him to be responsible for all or a part of the loss giving rise to the litigation.

TORT - A private or civil wrong or injury. A wrong independent of contract. Three elements of every tort action are:

(1) existence or legal duty from defendant to plaintiff;

(2) breach of duty; and

(3) damage as a proximate result.

WRONGFUL BIRTH - An action commenced on behalf of parents of an infant for damages occasioned by a birth after supposed

sterilization. Although not recognized by all jurisdictions, New Jersey, New York, Pennsylvania, and Texas have permitted parents to recover.

WRONGFUL LIFE - An action asserted on behalf of a physically deformed infant born after supposed sterilization. Only one jurisdiction, California, presently recognizes a wrongful life action.

THE TELEPHONE IN THE DOCTOR'S OFFICE

Introduction

The telephone has become an indispensable tool in the practice of medicine, as well as in every other aspect of society. However, the telephone can be misused or abused. In this regard, the following items present some things for each practitioner to consider concerning the use of the telephone in his or her office. What follows is not intended to be the only answer to the problem or the potential problem. It is merely intended as a guideline to get each individual practitioner thinking about his or her own specific situation.

I. General consideration respecting the telephone.

A. Have a clinic policy on telephone calls which is made known to all employees. The publication "HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT MODEL PRIVACY AND SECURITY POLICIES AND PROCEDURES," published by the South Dakota State Medical Association in cooperation with the Illinois State Medical Society and ISMIE Mutual Insurance Company, and available on the web at www.sdsma.org contains various model policies and procedures which you may wish to consider.

B. Even if you have a HIPAA-compliant release form in hand, never give information to an unidentified voice on the

telephone. Always require identification, to include name, address and telephone number, from any person with whom you are not familiar.

C. Because the fact that a person is a patient of the clinic constitutes confidential "protected health information," clinic employees should be instructed not to give any information about patient charts or records to callers other than other treating physicians without having a signed authorization form.

D Two of the more common situations that can arise involve calls by attorneys and calls by the news media. However, some consideration shall be given to other potential callers, such as disgruntled patients and other physicians.

II. When a person identified with the news media calls asking for information:

A. Remember that only the patient can waive the physician-patient privilege, which must be done in writing. Therefore, if a call is about a patient, you should be very careful that you do not divulge privileged information, including the fact that the person who is the subject of the inquiry is a patient of the clinic.

B. News reporters are ordinarily very adept at prying

information from you. It must be remembered that the mere fact that a person is a patient of your clinic is confidential information. Generally speaking, the best response is to remind the reporter of the HIPAA-mandated confidentiality rules and to decline to answer any questions which relate to a specific patient.

C. There are usually several levels of information which a reporter will put in a story. Ordinarily, if you say something to a reporter "for attribution," the report will quote you directly. You can also talk to a reporter "for background." This ordinarily means that you will not be directly quoted but that you might be identified as a source. "Not for attribution" means that your name will not appear in the story, but that information which you give may appear in the story. Different reporters have different understandings of these terms. If the subject which you are going to discuss with the reporter is potentially sensitive, you should discuss the ground rules with the reporter before commenting. As always, remember that the wrongful disclosure of protected health information, including the identity of a patient, can result in a federal enforcement action and may result in the imposition of civil penalties.

D. Your employees should not discuss items for you with reporters.

III. When a lawyer calls representing your patient in the patient's own personal injury action against another person:

A. Only the patient can waive the physician-patient privilege. Insist on a HIPAA-compliant written waiver of the privilege from the patient prior to discussing the case with the lawyer.

B. You are not required to "drop everything" and disrupt your practice to talk to the lawyer. On the other hand, the lawyer ordinarily has your patient's best legal interest in mind, just as you have the client's best health interest in mind. Your patient ordinarily would not understand your failure to reasonably cooperate with the lawyer, assuming the lawyer is being reasonable with you.

C. The patient, through her attorney, is entitled to copies of all medical records dealing with her treatment, for which you may charge a reasonable fee for the administrative costs in preparing them. Keep in mind that the patient most often bears this cost.

D. For time spent rendering professional services (e.g., consulting with the lawyer, rendering medical reports for

your professional conclusions and diagnoses, and attendance at depositions), you are entitled to charge a reasonable fee. In practically all cases, this fee is ultimately paid by the patient, not by the lawyer.

E. Do not let the lawyer talk you into taking a position as to your patient's physical condition with which you feel professionally uncomfortable.

F. Sometimes lawyers talk about issuing subpoenas to physicians to obtain their testimony for depositions or at trial in an effort to avoid the payment of the physician's fee for professional services. We are unaware of this happening in practice very often. However, if you are served with a subpoena, you should consult with your personal attorney. There is respectable legal authority to the effect that you can refuse to testify if the person issuing the subpoena does not offer to pay your professional fee, since you are not required to provide professional services for nothing.

IV. When the lawyer representing a party in litigation adverse to your patient calls: (Ordinarily this would be the lawyer representing the defendant in a personal injury action which your patient as plaintiff has commenced.)

A. You shouldn't talk to him unless you have in your file a

HIPAA-compliant written waiver of the physician-patient privilege. Most waivers deal only with records. Even if a waiver is broader and presumably would permit you to talk to the defense attorney, you should probably first check with your patient's attorney.

B. Do not get specific and render specific opinions unless you have the chart in front of you.

C. You are likewise entitled to charge a reasonable fee for your services, which should ordinarily be billed to the attorney with whom you are talking.

V. When a lawyer calls representing your patient without identifying who the adverse party is:

A. He may very well be investigating a malpractice action against you. If that is the fact, so be it. It is unlikely that you will be able to talk him out of it.

B. With a proper waiver, the lawyer is entitled to copies of all medical records. While it is understandable that you would be concerned, and probably angry, in the long run you could hurt your case by refusing to cooperate. Do not withhold or alter records. Also, do not give written or oral opinions about the quality of your treatment of the patient or someone else's treatment of the patient.

C. Notify your insurance carrier.

D. Consult with your personal attorney.

APPENDIX

Chapter 36-4.

PHYSICIANS AND SURGEONS

36-4-1. Board of examiners created - Appointment and terms of members - Vacancies.
36-4-2. Composition of board - Qualifications of members.
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36-4-3. Officers of board - Executive secretary - Seal.
36-4-4. Meetings of board.
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36-4-10. Practitioners and officers exempt from chapter - Application to previously licensed physicians.
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36-4-20.6. Resident certificate defined.
36-4-20.7. Issuance of resident certificate - Application - Fee.
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36-4-40. Supervision and discipline of holder of permanent, unrestricted license to practice medicine or osteopathy.
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36-4-1. Board of examiners created - Appointment and terms of members - Vacancies.
There is hereby created a state board of medical and osteopathic examiners, hereinafter called the board of examiners, which board shall consist of six members to be appointed by the Governor for terms of five years. Each member shall hold office until his successor is appointed and qualified. All vacancies on the board shall be filled by appointment by the Governor, but the board must at all times include four doctors of medicine and one doctor of osteopathy.

36-4-2. Composition of board - Qualifications of members. The board of examiners shall include four doctors of medicine holding a degree of M.D. and one doctor of osteopathy holding the degree of D.O. Such members of the board must be licensed in the state of South Dakota and must be skilled and capable physicians in good standing.

36-4-2.1. Lay member of board - Appointment and term of office. The membership of the board of examiners shall include one lay member who is a user of the services regulated by the board. The term lay member who is a user refers to a person who is not licensed by the board but, where practical, uses the service licensed, and the meaning shall be liberally construed to implement the purpose of this section. The lay member shall be appointed by the Governor and shall have the same term of office as other members of the board.

36-4-3. Officers of board - Executive secretary - Seal. The board of medical and osteopathic examiners shall annually elect one of its number as president, one of its number as vice-president, and one of its number as secretary. The board may hire an executive secretary who shall have such duties as are provided by resolution of the board of examiners. The board shall adopt an official seal which shall contain the words "South Dakota State Board of Medical and Osteopathic Examiners."

36-4-4. Meetings of board. The board of examiners shall hold two regular meetings each year at a time to be fixed by the board, but special meetings at such other times as necessary may be held. All

meetings shall be held at such place within the state as the board shall determine.

36-4-4.1. Board continued within department of commerce and regulation - Records and reports. The board of medical and osteopathic examiners shall continue within the department of commerce and regulation, and shall retain all its prescribed functions, including administrative functions. The board shall submit such records, information and reports in the form and at such times as required by the secretary of commerce and regulation, except that the board shall report at least annually.

36-4-5. Compensation and expenses of board members - Fees held in special fund - Bond - Payments from fund. Out of the funds coming into the possession of the board of examiners, the members thereof shall receive the compensation and reimbursement of expenses provided by law. All fees received by the board shall be held by the secretary, who shall give a bond in such sum, for the faithful performance of his duties, as the board may from time to time direct, as a special fund to be used for defraying the expenses of the board in carrying out the provisions of this chapter. Payment from said fund shall be made only upon written orders issued and signed by the president and secretary, or the board may, by resolution, authorize an executive secretary to do so, which authority if given shall be considered by the board in setting the sum of such executive secretary's bond.

36-4-6. Equipment, supplies and services for board - Expenses restricted to revenue. The board of examiners shall have the power to expend the necessary funds for its offices, furniture, fixtures, supplies, administrative and stenographic services. Administrative personnel having responsibility over funds of the board of examiners shall furnish a bond for the faithful performance of their duties in such sum as the board shall from time to time direct. No expenses shall be incurred by the board in excess of the revenue derived from such office.

36-4-7. Annual report to Governor. The board of examiners shall make an annual report to the Governor.

36-4-8. Unlicensed practice of medicine as misdemeanor. Any person who practices medicine, or osteopathy, or any of the branches thereof without a license is guilty of a Class 1 misdemeanor.

36-4-8.1. Corporation prohibited from practice of medicine or osteopathy. Except as provided in chapter 47-11, it is the public policy of this state that a corporation may not practice medicine or osteopathy. A corporation is not engaged in the practice of medicine or osteopathy and is not in violation of §36-4-8 by entering into an employment agreement with a physician licensed pursuant to this chapter if the agreement or the relationship it creates does not:
(1) In any manner, directly or indirectly, supplant, diminish or regulate the physician's independent judgment concerning the practice of medicine or the diagnosis and treatment of any patient;

(2) Result in profit to the corporation from the practice of medicine itself, such as by the corporation charging a greater fee for the physician's services than that which he would otherwise reasonably charge as an independent practitioner, except that the corporation may make additional charges reasonably associated with the services rendered, such as facility, equipment or administrative charges; and
(3) Remain effective for a period of more than three years, after which it may be renewed by both parties annually.

36-4-8.2. Laser surgery constituting practice of medicine. Surgery constituting the practice of medicine includes the use of a laser or ionizing radiation for the purpose of cutting or otherwise altering human tissue for diagnostic, palliative, or therapeutic purposes.

36-4-9. Use of title and other acts constituting practice of medicine. For the purpose of this chapter, "practice of medicine or osteopathy" includes, but not by way of limitation, to append or prefix the letters M.D., or D.O. or the title of Doctor or Dr. or Specialist or Osteopath or any other sign or appellation in a medical sense to one's name or to profess publicly to be a physician or surgeon or to recommend, prescribe or direct for the use of any person any drug, medicine, apparatus, or other agency for the cure, relief or palliation of any ailment or disease of the mind or body or the cure or relief of any wound, fracture or bodily injury or deformity.

36-4-10. Practitioners and officers exempt from chapter - Application to previously licensed physicians. The provisions of this chapter do not apply to commissioned physicians or surgeons of the United States army, navy, air force, or marine hospital service or of the United States veterans' administration, or the United States public health service in the actual performance of their duties nor to dentists in the legitimate practice of their profession, nor to Christian Scientists as such who do not practice medicine, surgery or obstetrics by the use of any material, remedies or agencies. Medical and osteopathic physicians, legally licensed in this state on July 1, 1949, need not pass the examination referred to in this chapter. However, osteopathic physicians licensed prior to July 1, 1949, may not perform major operations.

36-4-11. Application for license - Qualifications of licensee - Examination - Educational requirements. Any person desiring to engage in the practice of medicine or osteopathy, surgery, or obstetrics in any of their branches in this state shall apply to the Board of Medical and Osteopathic Examiners for a license. The application shall contain such information as the board may require by rules adopted pursuant to chapter 1-26. The board of examiners shall grant a license to any applicant who gives satisfactory proof of being at least eighteen years of age and who is of good moral character if the applicant passes an examination, determined by the board by rule adopted pursuant to chapter 1-26, to establish medical competence and presents evidence of having graduated and received a diploma from a medical or osteopathic college approved by the board in accordance with rules adopted pursuant to chapter 1-26. If the diploma is from a medical or osteopathic college outside the United States, the board of examiners may require further proof of competence by rules

adopted pursuant to chapter 1-26. The applicant shall also present evidence satisfactory to the board of successful completion of a program as an intern or resident, or of equivalent service approved by the board, in a hospital approved by the board, for such time as the board requires by rule adopted pursuant to chapter 1-26.

36-4-12. Schools and colleges recognized - Inspection by board. Repealed by SL 1985, ch 297, §7.

36-4-12.1. Application of medical or osteopathic college for approval - Inspection. A medical or osteopathic college seeking approval by the board of medical and osteopathic examiners shall file with the board an application on forms provided by the board. It shall also provide such other or further information as the board requests in writing.

Prior to issuing any approval the board may require, in its sole discretion, that such school be inspected by a member or representative of the board. The school applying for approval shall pay all expenses incurred by the board in making such an inspection.

36-4-12.2. List of approved colleges. The board of medical and osteopathic examiners shall keep a written list of all medical and osteopathic colleges which are approved by the board.

36-4-12.3. Hearing on refusal to approve college. If a medical or osteopathic college applies to the board of medical and osteopathic examiners for approval and complies with all prerequisites, including a proper application, furnishing all information requested in writing, and provisions of the board relative to an on-site inspection, and the board determines not to grant such approval, such college shall be provided an opportunity for hearing pursuant to the provisions of chapter 1-26.

36-4-12.4. Information furnished by approved colleges. The board of medical and osteopathic examiners shall review its written list of approved medical and osteopathic colleges on or before the first day of July each year. The board may require any college on its approved list to submit, in writing, additional information requested by the board.

36-4-12.5. Hearing on refusal to renew approval of college. If a medical or osteopathic college has complied with all prerequisites for a renewal of its approval and the board of medical and osteopathic examiners decides not to renew the approval of such college, the board shall provide such college with an opportunity for hearing pursuant to the provisions of chapter 1-26.

36-4-13. Hospitals recognized for internship - Inspection by board. "Hospital approved by the board" means a hospital approved by the board of examiners pursuant to § 36-4-22.1, but a hospital shall not be denied approval without a hearing by the board in compliance with chapter 1-26, and the board may for the purpose of such hearing inspect said hospital; provided such hearing and inspection shall be held within ninety days after a request therefor.

36-4-14. National organizations recognized. Repealed by SL 1973, ch 241, §15.

36-4-15. False or fraudulent diploma or affidavit as misdemeanor. Any person who submits to the board of examiners any false, forged or fraudulent diploma or one of which he is not the lawful owner, or any false or forged affidavit of identification for the purpose of obtaining from such board any license required by this chapter is guilty of a Class 1 misdemeanor.

36-4-16. Return of fee on withdrawal of application or failure to examine. The board of examiners shall be authorized to return the examination fee in any case where the applicant has withdrawn his application prior to the date fixed for the examination, or where the board for any reason fails to examine an applicant through no fault on his part, but this section shall not apply where a license has been revoked.

36-4-17. Written examination required - Discrimination between systems of medicine prohibited - Minimum grade - Reexamination - Fee - Preservation of grades. The examination required by this chapter shall be in writing. The questions on all subjects shall be such as are answered alike by all schools of medicine or osteopathy. No license may be refused any applicant because of his adherence to any particular school of medicine. Each applicant shall be required to attain an average percentage of at least seventy-five percent of correct answers. Any applicant failing on such examination is eligible for a maximum of two subsequent examinations upon payment of the required fee at any regular meeting of the board of medical and osteopathic examiners or at such time and place as the board may designate. Before taking the examination, the applicant shall pay to the secretary of the board a fee to be set by the board in an amount not to exceed five hundred fifty dollars. All grades achieved shall be preserved by the secretary of the board for a period of at least three years.

36-4-18. Grant of license to practice - Type of practice stated on license. To each applicant successfully passing the examination required by this chapter and fulfilling all other requirements of this chapter, the board of examiners shall grant a license to practice medicine or osteopathic medicine, surgery and obstetrics in all of their branches, without limitations, in this state, but each license so granted shall state on the face thereof whether the licensee is licensed to practice medicine and surgery or osteopathic medicine and surgery. Such license shall be granted only by consent of the majority of the board.

36-4-19. License based on certificate from national board or another state - Fee. The Board of Medical and Osteopathic Examiners may, without examination, issue a license to any applicant holding a currently valid license or certificate issued to the applicant by the examining board of the District of Columbia, any state or territory of the United States, the National Board of Medical Examiners, the National Board of Osteopathic Physicians and Surgeons, or any province of Canada, from which the license was obtained by a written examination given by the board, if the legal requirements of the examining board at the time it issued the license or certificate were not less than

those of this state at the time the license is presented for registration.

However, the board may require the applicant to take either an oral or written examination and personally appear before the board, a member of the board, or its staff.

Each applicant applying under the provisions of this chapter shall pay to the secretary of the board a license fee not to exceed two hundred dollars.

36-4-19.1. Contents of application for license based on certificate from national board or another jurisdiction - Consideration by board. Applicants for license under the provisions of §36-4-19 shall subscribe to an oath in writing before an officer authorized by law to administer oaths, which shall be a part of such application, and the oath shall be made on statements in the application which shall state the following:

(1) That the license, certificate, or authority under which the applicant practiced medicine in the state, territory or province of Canada from which the applicant removed was at the time of such removal in full force and not canceled, suspended or revoked.

(2) That the applicant is the identical person to whom the said certificate, license or commission and the said medical diploma was issued.

(3) Whether proceedings have ever been instituted against the applicant for a cancellation, suspension or revocation of said certificate, license or authority to practice medicine in any state, territory or province of Canada.

(4) Whether the applicant has ever applied for and been refused a certificate, license, authority or commission to practice medicine by any state, territory or province of Canada and if so the reason for said refusal.

(5) That no prosecution is pending against the applicant in any state or federal court or court in Canada for any offense which under the law of the state of South Dakota would constitute a felony or would be a crime involving moral turpitude.

The application shall also be accompanied by such other information as the board by its rules and regulations require.

In determining whether a South Dakota license should be issued to the applicant, the board shall take into consideration the nature, circumstances or results of any action for cancellation, suspension, revocation or refusal of the license.

36-4-20. Temporary permits for supervised practice in state institution - Qualifications of applicants - Duration and renewal. If it appears to the state board of medical and osteopathic examiners by a resolution thereof duly made and adopted, that an urgent need exists in any state-owned and operated medical institution for the services of a practitioner of medicine, surgery and obstetrics and their branches, as a state employee, which cannot be adequately and effectively served by a regularly licensed practitioner, the board may, in its discretion, grant a temporary permit to an applicant who has satisfactorily passed a special examination and paid a fee of fifty dollars for said examination, notwithstanding that the applicant has not completed the period of internship or residence training in a hospital approved by the board and has failed or has been unable to satisfactorily show that he is a graduate of an approved medical or osteopathic college. The

temporary permit shall be issued and be effective for one year from the date of issuance of such permit. The temporary permit entitles the person to whom issued to engage in the practice of medicine, surgery, and obstetrics and their branches as a state employee under the supervision of a licensed physician in such state-owned and operated medical institution and not elsewhere. Such temporary permit may be renewed by the board upon application to it on an annual basis and the payment of an annual renewal fee of not to exceed fifteen dollars. Except as may otherwise be provided in this section, applications for such temporary permits shall be processed in the same manner as regular license applications under §36-4-11, and the holder of any such permit shall be subject to all restrictions, responsibilities and privileges inuring to regular licensees under this chapter.

36-4-20.1. Locum tenens certificate defined. A locum tenens certificate is a certificate allowing the holder thereof to practice medicine in this state for a limited period of time and subject to the requirements and conditions set forth in said certificate.

36-4-20.2. Petition and application for locum tenens certificate - Fee - Personal appearance required. A certificate for locum tenens practice may be issued by the board of examiners to an applicant who is a current holder of a valid license to practice medicine or osteopathy in any state or territory of the United States, the District of Columbia, or province of Canada, or who has graduated and received a diploma from an approved medical or osteopathic college and who has completed at least one year of an approved internship or residency program or its equivalent. When such applicant is not the holder of a currently valid license to practice medicine or osteopathy, as heretofore stated, the board may grant such certificate only after the applicant has satisfactorily passed a special examination for locum tenens certificate administered by the board. To obtain a locum tenens certificate, a petition must be presented to the board signed under oath, by a licensed physician practicing in this state and by the applicant requesting a locum tenens certificate which petition shall set forth the reasons why the applicant should be issued a locum tenens certificate. In addition to the petition, the locum tenens applicant must complete and submit to the board the application required by §36-4-19 accompanied by a fee of not to exceed fifty dollars made payable to the secretary of the board and appear personally at the office of the South Dakota state board of medical and osteopathic examiners or at the office of a member of the board.

36-4-20.3. Issuance of locum tenens certificate by single member of board - Notice to other members - Objections and cancellation. A member of the board of examiners, when satisfied that all requirements have been met and that the circumstances require the issuance, may issue a locum tenens certificate to the applicant, provided however, all other members of the board shall be notified by mail within three days of the issuance of any such certificate and any member of the board may within five days after receiving notice of the issuance of such certificate file written objections with the president of the board; the president shall within twenty-four hours after the receipt of any such objection mail copies thereof to all members of the board for their consideration and if within three days after the mailing of such copies a majority of the board file objections to the issuance thereof in

writing with the president, such certificate shall be deemed canceled.

36-4-20.4. Duration of locum tenens certificates - Privileges of certificate holder. Locum tenens certificates shall be issued for a period of not to exceed sixty days, and in the board of examiners discretion may set forth requirements and conditions governing the practice under it. The locum tenens certificate shall allow the holder to practice medicine in this state only for a period set forth in the certificate and according to any conditions and requirements which the board in its discretion incorporates onto the certificate.

36-4-20.5. Basic science certificate not required for locum tenens certificate. Repealed by SL 1986, ch 27, §41.

36-4-20.6. Resident certificate defined. A resident certificate is a certificate allowing the holder to practice medicine in this state for a limited period of time subject to the requirements and conditions set forth in the certificate.

36-4-20.7. Issuance of resident certificate - Application - Fee. The board of examiners may issue a resident certificate to an applicant who has satisfied all the requirements for licensure set forth in §36-4-11, except having successfully completed a program as an intern or resident, and has successfully completed the first year of a residency program. The applicant shall make application for the resident certificate to the board on forms provided by the board. The application shall be accompanied by an application fee of fifty dollars.

36-4-20.8. Term of resident certificate - Authorized practice of medicine. Any resident certificate is valid for a period not exceeding one year from the issuance thereof, if the certificate holder successfully continues in an approved residency program during the one-year period. The resident certificate shall allow the holder to practice medicine in this state in all functions involved in his residency program; to provide emergency room medical coverage on an irregular basis; and to provide short-term medical care to patients in the absence of their regularly licensed physician by agreement with the physician.

36-4-21. Additional license required of itinerant physician - Fee - Penalty without license as misdemeanor - Penalty. Repealed by SL 1977, ch 190, §142.

36-4-22. Recording of license in county of practice - Fraudulent recording as misdemeanor. Repealed by SL 1981, ch 273.

36-4-22.1. Board access to premises where medicine practiced - Inspection of drug records and inventories - Refusal as misdemeanor - Confidentiality. The board of examiners, or any of its officers, agents or employees so authorized, may enter and inspect, during business hours, any

place where medicine or osteopathy are practiced for the purpose of enforcing this chapter and rules adopted pursuant hereto. The refusal to allow an inspection is a Class 1 misdemeanor. Such inspection may include any medical or drug records, and the copying thereof, and inventories relating to drugs and controlled substances required to be kept under the provisions of chapter 34-20B. The board of examiners, its officers, agents and employees shall maintain the confidential nature of any records obtained pursuant to this section.

36-4-22.2. Report of facility suspending or revoking licensee's privilege to practice medicine therein - Immunity. Every facility licensed by the state where medicine is practiced which suspends or revokes the privilege of a licensee of the board of medical and osteopathic examiners to practice medicine therein for incompetence or unprofessional conduct as defined in this chapter shall report it in writing to the board including the factual basis of such revocation or suspension. Any report made to the board pursuant to this section shall be confidential and subject to the same restrictions set forth in §36-4-31.5 as evidence taken by the board on cancellation, revocation, suspension or limitation proceedings. A licensed facility, complying in good faith with this section, may not be held liable for any injury or damage proximately resulting from such compliance.

36-4-23. Advertising and printed material to show type of practice for which licensed - Violation as misdemeanor. No person practicing any of the healing arts shall use the title "doctor" or any contraction thereof, in connection with his business or profession, or any written or printed material, or in connection with any advertising, unless he add after his name the recognized abbreviation or specification of the branch of the healing art in which he is licensed to practice and is engaged. A violation of this section is a Class 1 misdemeanor.

36-4-24. Annual registration fee. Repealed by omission from SL 1969, ch 105, §5.

36-4-24.1. Annual renewal of license - Fee. Each person receiving a license under the provisions of this chapter shall apply, on a form provided by the Board of Medical and Osteopathic Examiners, for a renewal of the license on or before the first day of March each year. The renewal shall be issued by the secretary upon payment of a fee to be fixed annually by the board, not exceeding the sum of two hundred dollars. The renewal shall be in the form of a receipt acknowledging payment of the required fee and signed by the secretary of the board.

36-4-24.2. Forfeiture of license for failure to renew - Renewal on application. Failure of a person to renew his license on or before March first of each year shall constitute a forfeiture of the license held by such person. However, such license may be renewed at the discretion of the board of medical and osteopathic examiners upon the payment of the fee provided in §36-4-19 for the issuance of licenses by reciprocity and upon making the application provided in §36-4-19.1 required for reciprocity.

36-4-24.3. Practice without license and renewal prohibited - Violation as misdemeanor. No

person required to be licensed under the provisions of this chapter shall practice his profession in the state of South Dakota without such license and renewal pursuant to the provisions herein except those specifically excepted from the provisions of this chapter. A violation of this section is a Class 1 misdemeanor.

36-4-25. Practice of medicine - Immunity from liability for acts of members of professional committees hospital officials. There is no monetary liability on the part of, and no cause of action for damages may arise against, any member of a duly appointed peer review committee engaging in peer review activity comprised of physicians licensed to practice medicine or osteopathy under this chapter, or against any duly appointed consultant to a peer review committee or to the medical staff or the governing board of a licensed health care facility for any act or proceeding undertaken or performed within the scope of the functions of the committee, if the committee member or consultant acts without malice, has made a reasonable effort to obtain the facts of the matter under consideration, and acts in reasonable belief that the action taken is warranted by those facts. The provisions of this section do not affect the official immunity of an officer or employee of a public corporation.

36-4-26. Practice of medicine - Hospital and society liability not affected by immunity. Section 36-4-25 shall not be construed to confer immunity from liability on any professional society or hospital. In any case in which, but for the enactment of §36-4-25, a cause of action would arise against a hospital or professional society, such cause of action shall exist as if said section had not been enacted.

36-4-26.1. Practice of medicine - Proceedings of professional committees confidential and privileged - Availability to physician subject of proceedings. The proceedings, records, reports, statements, minutes, or any other data whatsoever, of any committee described in § 36-4-42, relating to the quality, type, or necessity of care rendered by a member of a hospital medical staff or by hospital personnel, or acquired in the evaluation of the competency, character, experience or performance of a physician, dentist or allied health professional seeking admission or reappointment to the medical staff of a hospital, are not subject to discovery or disclosure under chapter 15-6 or any other provision of law, and are not admissible as evidence in any action of any kind in any court or arbitration forum, except as hereinafter provided. No person in attendance at any meeting of any committee described in § 36-4-42 shall be required to testify as to what transpired at such meeting. The prohibition relating to discovery of evidence does not apply to deny a physician access to or use of information upon which a decision regarding the person's staff privileges or employment was based. The prohibition relating to discovery of evidence does not apply to deny any person or the person's counsel in the defense of an action against that person access to the materials covered under this section.

36-4-26.2. Practice of medicine - Patient records available to patient - Expert opinion as to

care of patient - Restrictions on use of expert testimony. Section 36-4-26.1 does not apply to observations made at the time of treatment by a health care professional present during the patient's treatment or to patient records prepared during the treatment and care rendered to a patient who is personally or by personal representative a party to an action or proceeding, the subject matter of which is the care and treatment of the patient. Furthermore, no member of any committee, department, section, board of directors, or group covered by § 36-4-26.1, who has participated in deliberations under that section involving the subject matter of the action, may testify as an expert witness for any party in any action for personal injury or wrongful death, the subject matter of which is the care and treatment of the patient. Notwithstanding membership on a committee, department, section, board of directors, or group covered by § 36-4-26.1, a health care professional observing or participating in the patient's treatment and care may testify as a fact or expert witness concerning that treatment and care, but may not be required to testify as to anything protected by § 36-4-26.1.

36-4-27. Violation of chapter as misdemeanor. Any person who falsely personates anyone licensed pursuant to this chapter is guilty of a Class 1 misdemeanor.

36-4-28. Grounds for refusal of license. The board of examiners shall have power, in compliance with chapter 1-26, to refuse to grant a license under this chapter for unprofessional, immoral or dishonorable conduct on the part of the applicant.

36-4-29. Grounds for cancellation, revocation, suspension or limitation of license. The South Dakota state board of medical and osteopathic examiners may cancel, revoke, suspend or limit the license of any physician, surgeon or osteopathic physician or surgeon issued under this chapter upon satisfactory proof in compliance with chapter 1-26 of such a licensee's gross incompetence, or unprofessional or dishonorable conduct or proof of a violation of this chapter in any respect. However, the board may not base a finding of unprofessional or dishonorable conduct solely on the basis that a licensee practices chelation therapy.

36-4-29.1. Summary suspension of license - Hearing. If the state board of medical and osteopathic examiners finds that public health, safety or welfare imperatively require emergency action, and incorporates a finding to that effect in its order, or has information filed with the board that a licensee improperly obtained a license from the board, summary suspension of a license may be ordered pending final action by the board of examiners. The board of examiners shall convene a hearing within fifteen days of the effective date of the summary suspension and take action as provided in §36-4-29.

36-4-30. Acts considered unprofessional conduct - Criminal prosecution. The term, unprofessional or dishonorable conduct, as used in this chapter includes:

(1) Producing or aiding or abetting a criminal abortion;
(2) Employing what is known as cappers or steerers;
(3) Obtaining any fee on the assurance that a manifestly incurable disease can be permanently

cured;

(4) Willfully betraying a professional confidence;

(5) All advertising of medical business in which untruthful or improbable statements are made or which are calculated to mislead or deceive the public;

(6) Conviction of any criminal offense of the grade of felony, any conviction of a criminal offense arising out of the practice of medicine or osteopathy, or one in connection with any criminal offense involving moral turpitude;

(7) Habits of intemperance or drug addiction, calculated in the opinion of the Board of Medical and Osteopathic Examiners to affect the licensee's practice of the profession;

(8) Refusal or neglect to report the existence of a diseased or unsanitary condition to the proper health authorities, as prescribed by the regulations of the board;

(9) Prescribing intoxicants, narcotics, barbiturates, or other habit-forming drugs to any person in quantities and under circumstances making it apparent to the board that the prescription was not made for legitimate medicinal purposes or prescribing in a manner or in amounts calculated in the opinion of the board to endanger the wellbeing of an individual patient or the public in general;

(10) Splitting fees or giving to any person furnishing a patient any portion of the fees received from the patient or paying or giving to any person consideration of any kind for furnishing a patient;

(11) Failure to disclose one's school of practice or one's professional academic degree when using a professional title or designation;

(12) Sustaining any physical or mental disability which renders the further practice of a licensee's profession dangerous;

(13) Failure to comply with state or federal laws on keeping records regarding possessing and dispensing of narcotics, barbiturates, and habit-forming drugs;

(14) Falsifying the medical records of a patient or any official record regarding possession and dispensing of narcotics, barbiturates, and habit-forming drugs or regarding any phase of medical treatment of a patient;

(15) Presenting to the board any license, certificate, or diploma which was obtained by fraud or deception practiced in passing a required examination or which was obtained by the giving of false statements or information on applying for the license;

(16) Illegally, fraudulently, or wrongfully obtaining a license required by this chapter by the use of any means, devices, deceptions, or helps in passing any examination or by making false statements or misrepresentations in any applications or information presented;

(17) Conviction of violating §34-23A-10.1;

(18) Performing medical services which have been declared, by declaratory ruling of the board, to be of no medical value;

(19) The exercise of influence within the physician-patient relationship for the purposes of engaging a patient in sexual activity. For the purposes of this subdivision, the patient is presumed incapable of giving free, full, and informed consent to sexual activity with the physician;

(20) Engaging in gross or immoral sexual harassment or sexual contact;
(21) Consistently providing or prescribing medical services or treatments which are inappropriate or unnecessary;
(22) Any practice or conduct which tends to constitute a danger to the health, welfare, or safety of the public or patients or engaging in conduct which is unbecoming a person licensed to practice medicine;
(23) Failure to fulfill a valid obligation to a federal or state student loan or scholarship program for medical school education designed to provide medical services to underserved geographical areas; and
(24) Discipline by another state, territorial, or provincial licensing board or the licensing board of the District of Columbia.

No person may be criminally prosecuted for conduct described in this section unless such conduct is otherwise unlawful.

36-4-31. Proceedings for cancellation, revocation or suspension of license. The proceedings for cancellation, revocation or suspension of a license shall be conducted in compliance with chapter 1-26. However, the board of medical and osteopathic examiners may dispense with the requirement of prior notice and an informal meeting set forth in §1-26-29 if the board finds that the public health, interest or safety require otherwise or that willful acts are alleged.

36-4-31.1 to 36-4-31.3. Omitted.

36-4-31.4. Reissuance of canceled, suspended or revoked license. Upon application, the board of examiners may reissue a license to practice to any person whose license has been canceled, suspended or revoked. A reissuance of a license which has been canceled or revoked shall not be made prior to one year after said cancellation or, revocation and the reissuance of any license may be made in such manner and form and under conditions as the board may require.

36-4-31.5. Evidence in proceedings on license confidential. Testimony of a witness or documentary evidence of any kind on cancellation, revocation, suspension or limitation proceedings are not subject to discovery or disclosure under chapter 15-6 or any other provision of law, and are not admissible as evidence in any action of any kind in any court or arbitration forum, except as hereinafter provided. No person in attendance at any hearing of the board of medical and osteopathic examiners considering cancellation, revocation, suspension or limitation of a license issued by it may be required to testify as to what transpired at such meeting. The prohibition relating to discovery of evidence does not apply to deny a physician access to or use of information upon which a decision regarding his staff privileges was based. The prohibition relating to discovery of evidence does not apply to any person or his counsel in the defense of an action against his access to the materials covered under this section.

36-4-31.6. Application of contested case procedure. If the grant, denial or renewal of a license to

practice medicine or osteopathic medicine was previously treated as a contested case resulting in a final decision, the provisions of chapter 1-26 concerning contested cases do not apply unless the board of medical and osteopathic examiners determines that there has been a substantial change of circumstance since the proceedings in the prior contested case.

36-4-32. Suspension of license for mental incompetence. In case any person holding a license to practice medicine or osteopathic medicine, surgery and obstetrics shall by any final order or adjudication of any court of competent jurisdiction be adjudged to be mentally incompetent or insane, his license shall be suspended by the board after proceedings in compliance with chapter 1-26, and anything in this chapter to the contrary notwithstanding, such suspension shall continue until the licensee is found or adjudged by such court to be restored to reason or until he is duly discharged as restored to reason in any other manner provided by law and has appeared before the board at a regular or special meeting of the board to apply for such reinstatement. The board may, in its discretion, establish such probationary conditions it deems necessary for the best interests of licensee.

36-4-33. Appeal from acts, rulings or decisions of board of examiners. Any party feeling aggrieved by any acts, rulings, or decisions of the board of examiners acting pursuant to §36-4-31, shall have the right to appeal the same under the provisions of chapter 1-26.

36-4-34. Injunction to restrain practice by licensee guilty of violations or unprofessional conduct or incompetent licensee - Election of remedies. Whenever it shall appear from evidence satisfactory to the board of examiners that any person has violated the provisions of this chapter or that any licensee under this chapter has been guilty of unprofessional or dishonorable conduct or is grossly incompetent, the board shall have the right to apply for an injunction in any court of competent jurisdiction to restrain such person or licensee from continuing to practice medicine, osteopathy, surgery, or obstetrics in any of their branches in this state. Application for an injunction is an alternate to criminal proceedings, and the commencement of one proceeding by the board constitutes an election.

36-4-35. Promulgation of rules by board. The board of examiners shall promulgate rules pursuant to chapter 1-26 pertaining to: licensure, fees and inspections.

36-4-36. Previously licensed physicians not affected. Nothing in this chapter shall in any way prohibit, interfere with or affect whatsoever in any way physicians and surgeons, osteopathic physicians and osteopaths licensed prior to July 1, 1949 from practicing their respective professions in all of the branches that their respective licenses permitted at the time said licenses were granted.

36-4-37. Transfer of active patient records - Destruction - Notice. Active patient records controlled by a physician licensed pursuant to this chapter or by his estate may not be transferred to any person not licensed under this chapter unless the records are transferred to the patient or the

patient's personal representative or designee, the patient's parent in the case of a minor, a health care facility licensed under chapter 34-12 or a corporation organized for the purpose of owning and operating a health care clinic. If active patient records cannot be so transferred, they shall be retained by the physician or estate in possession of them or destroyed. Prior to any transfer or destruction of active patient records, reasonable notice of at least thirty days shall be given by mail to the patient, the patient's parent in the case of a minor or the patient's personal representative at his last known address stating the proposed disposition of the records and giving a deadline prior to which the records may be claimed.

36-4-38. Destruction of inactive patient records. Nothing in §36-4-37 prevents a physician licensed pursuant to this chapter from destroying patient records which have become inactive or for which the whereabouts of the patient is no longer known to the physician.

36-4-39. Practice of medicine or osteopathy by holder of permanent, unrestricted license. Notwithstanding anything in this chapter to the contrary, any physician who is the holder of a permanent, unrestricted license to practice medicine or osteopathy in any state or territory of the United States, the District of Columbia or Province of Canada may practice medicine or osteopathy in this state without first obtaining a license from the board of medical and osteopathic examiners under one or more of the following circumstances:
(1) As a member of an organ harvesting team;
(2) On board an air ambulance and as a part of its treatment team;
(3) To provide one time consultation or teaching assistance for a period of not more than twenty-four hours; or
(4) To provide consultation or teaching assistance previously approved by the board of medical and osteopathic examiners for charitable organizations.

36-4-40. Supervision and discipline of holder of permanent, unrestricted license to practice medicine or osteopathy. Any physician practicing medicine or osteopathy under the circumstances permitted by §36-4-39 shall be subject to supervision and discipline by the board of medical and osteopathic examiners under this chapter in the same manner as any other licensee under this chapter and practice by a nonresident physician under the terms of §36-4-39 is considered to constitute submission by such physician to jurisdiction by the board.

36-4-41. Practice of medicine or osteopathy in South Dakota while located outside of state. Any nonresident physician or osteopath who, while located outside this state, provides diagnostic or treatment services through electronic means to a person located in this state under a contract with a health care provider licensed under Title 36, a clinic located in this state that provides health services, or a health care facility licensed under chapter 34-12-12, is engaged in the practice of medicine or osteopathy in this state. No nonresident physician or osteqpath who, while located outside this state, consults on an irregular basis with a licensee under this chapter who is located in this state, is engaged in the practice of medicine or osteopathy in this state.

36-4-42. Peer review committee defined. For the purposes of this section, a peer review committee is one or more persons acting as any committee of a state or local professional association or society, any committee of a licensed health care facility or the medical staff of a licensed health care facility, or any committee comprised of physicians within a medical care foundation, health maintenance organization, preferred provider organization, independent practice association, group medical practice, provider sponsored organization, or any other organization of physicians formed pursuant to state or federal law, that engages in peer review activity. For the purposes of this section, a peer review committee is also one or more persons acting as an administrative or medical committee, department, section, board of directors, shareholder or corporate member, or audit group, including the medical audit committee, of a licensed health care facility.

36-4-43. Peer review activities defined. For the purposes of this section, peer review activity is the procedure by which peer review committees monitor, evaluate, and recommend actions to improve the delivery and quality of services within their respective facilities, agencies, and professions, including recommendations, consideration of recommendations, actions with regard to recommendations, and implementation of actions. Peer review activity and acts or proceedings undertaken or performed within the scope of the functions of a peer review committee include:

(1) Matters affecting membership of a health professional on the staff of a health care facility or agency;

(2) The grant, delineation, renewal, denial, modification, limitation, or suspension of clinical privileges to provide health care services at a licensed health care facility;

(3) Matters affecting employment and terms of employment of a health professional by a health maintenance organization, preferred provider organization, independent practice association, or any other organization of physicians formed pursuant to state or federal law;

(4) Matters affecting the membership and terms of membership in a health professional association, including decisions to suspend membership privileges, expel from membership, reprimand, or censure a member, or other disciplinary actions;

(5) Review and evaluation of qualifications, competency, character, experience, activities, conduct, or performance of any health professional, including the medical residents of health care facility; and

(6) Review of the quality, type, or necessity of services provided by one or more health professionals or medical residents, individually or as a statistically significant group, or both.

Chapter 36-4A.

PHYSICIAN'S ASSISTANTS

Section

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36-4A-1. Definition of terms. Terms as used in this chapter, mean:

(1) "Assistant to the primary care physician," a person who is a graduate of an approved program of instruction in primary health care, who has passed a certification examination administered by the board, and is approved by the board to perform direct patient care services under the supervision of a primary care physician or physicians approved by the board to supervise such an assistant;

(2) "Assistant to the specialist physician," a person who is a graduate of an approved program for instruction in a recognized clinical specialty, who has passed a certification examination administered by the board and is approved by the board to perform direct patient care services in said specialty under the supervision of a specialist physician or physicians approved by the board to supervise such assistant;

(3) "Board," the State Board of Medical and Osteopathic Examiners;

(4) "Supervising physician," the physician, either primary care or specialist, with whom a physician assistant has a practice agreement ;

(5) "Physician assistant," a person who is either an assistant to the primary care physician or an assistant to the specialist physician;

(6) "Primary care physician," a physician, approved by the board, who supervises a particular assistant to the primary care physician;

(7) "Specialist physician," a physician in a given specialty of medicine, approved by the board, who supervises a particular assistant to a specialist physician.

36-4A-2. Supervision of physician assistant. Supervision of physician's assistant refers to the responsibility of the physician to observe, direct and review the work, records, and practice permitted by §§36-4A-21 to 36-4A-26, inclusive, to ensure the patient, the physician, and the

physician's assistant that good and safe treatment is rendered.

36-4A-3. Physician assistant program created. There is hereby created a state physician assistant program under the direction and control of the state board of medical and osteopathic examiners.

36-4A-3.1. Board to appoint advisory committee — Terms — Duties. The board shall appoint a physician assistant advisory committee composed of three physician assistants. Each committee member shall serve a term of three years, except initial appointees whose terms shall be staggered so that no more than one member's term expires in one year. A committee member may not be appointed to more than two consecutive terms. If a vacancy occurs, the board shall appoint a person to fill the unexpired term. The committee shall meet at least annually or as deemed necessary to conduct business. The advisory committee shall assist the board in evaluating standards of physician assistant care and the regulation of physician assistants pursuant to this chapter. The committee shall also make recommendations to the board regarding rules promulgated pursuant to this chapter.

36-4A-4. Unlawful practice as misdemeanor - Each violation as separate offense. Except as provided in §§36-4A-5 to 36-4A-7, inclusive, it is a Class 2 misdemeanor for any person not certified under this chapter to practice as a physician's assistant or to hold himself out to be a physician's assistant in this state. Each violation shall be considered a separate offense.

36-4A-5. Student and trainee activities not limited. Nothing in this chapter shall be construed to limit the activities and services of a physician's assistant in pursuing an approved course of study or a trainee serving in an approved physician's assistant traineeship.

36-4A-6. Federal employees' activities not limited - Christian Scientists. Nothing in this chapter shall be construed to limit the activities of employees of the United States army, air force, navy, or marine hospitals or of the United States veterans' administration, or the United States public health service in the performance of their duties, nor to the Christian Scientists as such who do not practice medicine, surgery, or obstetrics by the use of any material remedies or agencies.

36-4A-7. Employment of assistant by federal agency - Supervision required. Nothing in this chapter shall be construed to limit the employment of a physician's assistant by any federal agency, but the physician's assistant so employed must be individually supervised by a designated and approved physician. Such employment shall be subject to all the provisions of this chapter.

36-4A-8. Issuance of certificate - Fee - Qualifications. The board shall license as a physician assistant and issue an appropriate license to any person who files a verified application with the board signed by both the proposed supervising physician and the physician assistant to be licensed, upon a form prescribed by the board, renders payment of the required fee, and furnishes evidence to the board that the physician assistant applying for licensure :

(1) Is at least eighteen years of age;
(2) Is of good moral character;
(3) Is a resident of South Dakota;
(4) Has completed a course of study approved by the board at an accredited university, college, or school which includes the subjects of anatomy, physiology, biochemistry, pathology, pharmacology, microbiology, medicine, surgery, pediatrics, psychiatry, and obstetrics, and possesses a certificate of completion of the physician assistant courses of study from the institution;
(5) Has had at least two years' experience with patients in a clinical setting in an associated field such as military medicine, nursing, dentistry, pharmacy, etc. The board shall decide in each individual case as to what experience would be recognized as fulfillment of the requirement;
(6) Has passed an impartially administered examination given and graded by the board or one of equivalency authorized by the board. Such examination may be in writing or oral, or both, and shall fairly test the applicant's knowledge in theoretical and applied primary medical care as it applies to the practice of the physician assistant in at least the subjects of physical diagnosis, laboratory procedures, common childhood diseases and common medical diseases, emergency care and treatment, minor surgery, emergency obstetrics, and common psychiatric disorders. The applicant's professional skill and judgment in the utilization of medical and surgical techniques may also be examined; and
(7) (Deleted by SL 1999, ch 192, § 2)
(8) Has submitted verification that neither the physician assistant applicant nor the supervising physician named in the practice agreement are subject to any disciplinary proceeding or pending complaint before any medical or other licensing board unless such pending complaint is waived by the licensing board.

36-4A-8.1. Temporary permit - Fee - Expiration. Upon application and payment of a fifty dollar fee, the board may issue a temporary permit to practice as a physician's assistant to an applicant who has successfully completed an approved program and the curriculum requirements pursuant to §§36-4A-12 and 36-4A-13 and has submitted evidence to the board that he is a candidate accepted to write the examination required by §36-4A-8 or is awaiting the results of the first examination for which the applicant is eligible after graduation from an approved physician's assistant program. A temporary permit may be issued only once and is effective for a term of not more than eight months. A temporary permit expires on the occurrence of the following:
(1) Issuance of a regular certificate;
(2) Failure to pass the certifying examination; or
(3) Expiration of the term for which the temporary permit was issued.

36-4A-9. Licensure of person certified by another state. The board may certify as a physician's assistant in this state, without examination, a person who has been so certified or licensed by examination in another state of the United States which has requirements substantially equivalent to those in this chapter and who meets all requirements of this chapter other than examination.

36-4A-10. Assistants practicing when chapter enacted. The board may certify, as a physician's assistant in this state, without examination, those physician's assistants practicing in this state on July 1, 1973, except that such physician's assistants, shall be subject to the provisions of this chapter in so far as said chapter provides for a revocation of certificates and the causes therefor.

36-4A-11. Temporary practice by assistant from another state - Permit. Nothing in this chapter shall be construed to limit the practice in this state for a period of not more than six months by a person certified as a physician's assistant in another state with requirements for such certification substantially equivalent to those in this chapter, if such person first secures a permit from the board in a manner prescribed by the board, but the board may reduce such period to not less than thirty days.

36-4A-12. Educational program for a physician assistant. An educational program for instruction of a physician assistant shall be approved by the board.

36-4A-13. Curriculum for educational program for a physician assistant. The curriculum of an educational program for instruction of a physician assistant shall be approved by the board.

36-4A-14. Educational program for assistant to specialist - General requirements. An educational program for instruction as an assistant to the specialist physician in any recognized clinical specialty shall meet the following general requirements, as well as specific curriculum requirements for the particular specialty more specifically set forth in §36-4A-15, for approval:

(1) The program shall establish that its theoretical and clinical training program produces an assistant to the specialist physician necessary to the effective delivery of medical services within that specialty;

(2) Candidates for admission shall have successfully completed an approved high school course of study or have passed a standard equivalency test;

(3) Prior clinical experience in direct patient contact is required for each candidate;

(4) The educational program shall be established in educational institutions approved by the board which meet the standards of any accrediting agency recognized by the National Commission on Accrediting and which are affiliated with board approved clinical facilities;

(5) The educational program shall develop an evaluation mechanism satisfactory to the board to determine the effectiveness of its theoretical and clinical program compatible with state-wide standards, the results of which must be made available to the board annually;

(6) Course work may carry academic credit. Upon successful completion of the theoretical and clinical program the student may receive an associate of arts or science degree;

(7) The educational program shall establish equivalency and proficiency testing and other mechanisms whereby full academic credit is given for past education and experience in the courses of the curriculum required for the particular specialty, more specifically set forth herein;

(8) The director of the educational program must be a licensed physician who is certified as or eligible to be a member of the appropriate official national specialty board for the particular specialty and who holds a faculty appointment at the educational institution;
(9) Instructors in the theoretical program and clinical training program shall be competent in their respective fields of instruction and clinical training and be properly qualified;
(10) The educational program shall establish a definitive candidate selection procedure satisfactory to the board;
(11) The number of students enrolled in the theoretical program should not exceed the number that can be clinically supervised and trained;
(12) The educational program shall have an elective period, preferably near the end of the program, to permit the student to gain knowledge of subjects which pertain to the clinical specialty and the student's particular intended employment therein;
(13) The educational program shall establish a continuing clinical educational program for physician's assistants in the particular specialty.

36-4A-15. Educational program for assistant to specialist - Curriculum requirements. An approved educational program for instruction of an assistant to the specialist physician shall include the curriculum provided in §36-4A-13 and, in addition, adequate instruction in the special subjects approved by the given specialty advisory committee to the board of medical and osteopathic examiners.

36-4A-16. Approval of educational programs by board of examiners. Educational programs for instruction of an assistant to the primary care physician and assistant to the specialist physician must be approved by the board of medical and osteopathic examiners and schools offering such programs shall submit applications for approval on forms provided by said board.

36-4A-16.1. Medical school to administer state funds for development of programs. All state funds appropriated for the support and development of physician's assistants programs shall be administered under the direction and supervision of the university of South Dakota school of medicine.

36-4A-17. Change in educational programs - Notice to board. An educational program approved by the board as meeting the general educational requirements of §36-4A-12 or 36-4A-14 and specific curriculum requirements established in this chapter for educational programs for an assistant to the primary care physician or for a particular curriculum specialty shall notify the board whenever a change occurs in the directorship of the educational program or when major modifications in the curriculum are anticipated.

36-4A-18. Withdrawal of approval of educational program for noncompliance. Failure of an educational program to continue compliance with the general requirements of §36-4A-14 and the specific curriculum requirements for the particular specialty set forth in §36-4A-15 subsequent to

approval by the board may result in the board withdrawing said approval.

36-4A-19. Placement of physician's assistants by board. The South Dakota State Board of Medical and Osteopathic Examiners shall provide for the placement of physician's assistants. The board shall notify the physician who has made application to place a physician's assistant of the board's affirmative or negative decision regarding the placement. In placing physician's assistants the board may consider:
(1) The distance between the employer physician and the physician's assistant;
(2) The ability of the employer physician to adequately provide supervision as required by law and good medical practice; and
(3) The consistency between the type and scope of medical practice of the employer physician and the proposed medical practice of the physician's assistant.

In addition, if the proposed office of the physician's assistant is separate from the main office of the employer physician, the board may also consider the availability or nonavailability of medical services in the proposed location of the physician's assistant and such specific requirements as the board may provide as a condition precedent to approving a particular placement.

36-4A-19.1. Maximum number of assistants supervised by one physician - Exception when not in full time practice. Repealed by SL 1994, ch 292, §1.

36-4A-20. Practice agreement with supervising physician filed with board. A certified true copy of the proposed practice agreement between the supervising physician and the physician assistant outlining those activities in §§ 36-4A-21 to 36-4A-26, inclusive, which the physician assistant may perform, shall be filed with and approved by the board.

36-4A-20.1. Practice agreement not to include abortion. The board may not approve any practice agreement that includes abortion as a permitted procedure.

36-4A-21. Tasks allowed to primary care physician's assistant. An assistant to the primary care physician may perform, under the responsibility and supervision of the primary care physician, selected diagnostic and therapeutic tasks in each of five major clinical disciplines (medicine, surgery, pediatrics, psychiatry, and obstetrics).

36-4A-22. Specific tasks allowed to assistant to primary care physician. Specifically, and by way of limitations, an assistant to the primary care physician may:

(1) Take a complete, detailed, and accurate history; do a complete physical examination, when appropriate, to include pelvic and breast examinations specifically excluding endoscopic examinations; record pertinent data in acceptable medical form; and, if the physical examination is for participation in athletics, certify that the patient is healthy and able to

participate;

(2) Perform or assist in the performance of the following routine laboratory and governing techniques:
- (a) The drawing of venous or peripheral blood and the routine examination of the blood;
- (b) Urinary bladder catheterization and routine urinalysis;
- (c) Nasogastric intubation and gastric lavage;
- (d) The collection of and the examination of the stool;
- (e) The taking of cultures;
- (f) The performance and reading of skin tests;
- (g) The performance of pulmonary function tests excluding endoscopic procedures;
- (h) The performance of tonometry;
- (i) The performance of hearing screenings;
- (j) The taking of EKG tracings;

(3) Make a tentative medical diagnosis and institute therapy or referral; prescribe medications and provide drug samples or a limited supply of labeled medications, including controlled drugs or substances listed on Schedule II in chapter 34-20B for one period of not more than forty-eight hours, for symptoms and temporary pain relief; treat common childhood diseases; to assist in the follow-up treatment of geriatric and psychiatric disorders referred by the physicians. Medications or sample drugs provided to patients shall be accompanied with written administration instructions and appropriate documentation shall be entered in the patient's medical record;

(4) Perform the following routine therapeutic procedures:
- (a) Injections;
- (b) Immunizations;
- (c) Debridement, suture, and care of superficial wounds;
- (d) Debridement of minor superficial burns;
- (e) Removal of foreign bodies from the external surface of the skin (specifically excluding foreign bodies of the cornea);
- (f) Removal of sutures;
- (g) Removal of impacted cerumen;
- (h) Subcutaneous local anesthesia, excluding any nerve blocks;
- (i) Strapping, casting, and splinting of sprains;
- (j) Anterior nasal packing for epistaxis;
- (k) Removal of cast;
- (l) Application of traction;
- (m) Application of physical therapy modalities;
- (n) Incision and drainage of superficial skin infections;

(5) Assist the primary care physician in health maintenance of patients by:
   (a) Well-baby and well-child clinics to include initial and current booster immunization for communicable disease;
   (b) Pre- and post-natal surveillance to include clinics and home visits;
   (c) Family planning, counseling, and management;

(6) Institute emergency measures and emergency treatment or appropriate measures in situations such as cardiac arrest, shock, hemorrhage, convulsions, poisonings, and emergency obstetric delivery. Emergency measures includes writing a chemical or physical restraint order when the patient may do personal harm or harm others;

(7) Assist the primary care physician in the management of long-term care to include:
   (a) Ordering indicated laboratory procedures;
   (b) Managing a medical care regimen for acute and chronically ill patients within established standing orders. (Prescription of modifications needed by patients coping with illness or maintaining health, such as in diet, exercise, relief from pain, medication, and adaptation to handicaps or impairments);
   (c) Making referrals to appropriate agencies;

(8) Assist the primary care physician in the hospital setting by arranging hospital admissions under the direction of the physician, by accompanying the primary care physician on rounds, and recording the physician's patient progress notes; by accurately and appropriately transcribing and executing specific orders at the direction of the physician; by assistance at surgery; by compiling detailed narrative and case summaries; by completion of the forms pertinent to the patient's medical record;

(9) Assist the primary care physician in the office in the ordering of drugs and supplies, in the keeping of records, and in the upkeep of equipment;

(10) Assist the primary care physician in providing services to patients requiring continuing care (nursing home, extended care, and home care) including follow-up visits after the initial treatment by the physician;

(11) Assist the primary care physician in the completion of official documents such as death certificates, birth certificates, and similar documents required by law, including signing the documents;

(12) Take X-rays to be read by a physician. A physician's assistant may not administer injections in conjunction with the taking of any X-rays.

36-4A-23. Additional tasks when qualification demonstrated. In addition to the tasks

performable listed in §36-4A-22 an assistant to the primary care physician may be permitted to perform, under the supervision of the primary care physician, such other tasks, except those expressly excluded herein, for which adequate training and proficiency can be demonstrated in a manner satisfactory to the board.

36-4A-24. Tasks allowed to assistant to specialist. An assistant to the specialist physician may perform, under the responsibility and supervision of the specialist physician, selected diagnostic and therapeutic tasks in the major clinical disciplines.

36-4A-25. Specific tasks allowed to assistant to specialist. Specifically, and by way of limitations, an assistant to the specialist physician may perform those tasks authorized for the assistant to the primary care physician under subdivisions 36-4A-22 (1), (2), (4) and (6), provided, however, that the assistant to the specialist physician may remove superficial foreign bodies of the cornea. An assistant to the specialist physician may also assist at major surgery.

36-4A-26. Additional tasks allowed assistant to specialist when qualification demonstrated. In addition to the tasks performable listed in §36-4A-25 an assistant to the specialist physician may be permitted to perform, under the supervision of the specialist physician, such other tasks, except those expressly excluded herein, for which adequate training and proficiency can be demonstrated in a manner satisfactory to the board.

36-4A-27. Practice of auxiliary professions not authorized. Nothing in this chapter shall be construed to authorize physician's assistants to perform those specific functions and duties delegated by law to those persons licensed as chiropractors under chapter 36-5, dentists and dental hygienists under chapter 36-6A, optometrists under chapter 36-7, podiatrists under chapter 36-8 or pharmacists under chapter 36-11.

36-4A-28. Hospital rules applicable. In the event any physician's assistant shall render services in a hospital and related institutions as licensed pursuant to the provisions of chapter 34-12, the assistant shall be subject to the rules and regulations of that hospital and related institutions.

36-4A-29. Physician's supervision and responsibility - Methods. The physician, by direct and indirect supervision, continuous monitoring, and evaluation accepts initial and continuing responsibility for the physician's assistant or assistants responsible to the physician until such relationship is terminated. This supervision may be by personal contact or indirect contact by telecommunication. If the office of a physician's assistant is separate from the main office of the employer physician, the supervision shall include at least one-half business day per week of on-site personal supervision by a supervising physician. A physician's assistant who is issued a temporary permit pursuant to §36-4A-8.1 shall initially receive thirty days of on-site, direct supervision by a supervising physician. Thereafter, and until expiration of the temporary permit, the supervision shall include at least two one-half business days per week of on-site personal supervision by a supervising

physician.

36-4A-29.1. Application for modification of physician's supervision - Method and frequency - Number of physician's assistants. In consideration of the health care needs of urban and rural residents, a supervising physician may apply to the board for authority to modify the method and frequency of supervision of a physician assistant as required by § 36-4A-29. The board may grant the modifications it considers appropriate based upon its finding of adequate supervision, training, and proficiency.

A supervising physician may apply to the board for permission to supervise more than one physician assistant. The board shall establish the number of assistants, up to four FTE, to be supervised by a supervising physician based upon its finding that adequate supervision will exist under the arrangement proposed by the supervising physician.

The board may consider a joint application for both modification of supervision and the number of assistants supervised as provided in this section.

Nothing in this section is intended to diminish the professional and legal responsibility of a supervising physician toward the physician's patients as provided in § 36-4A-30.

36-4A-30. Physician not relieved of professional responsibility. Nothing in this chapter shall be construed to relieve the physician of the professional or legal responsibility for the care and treatment of his patients.

36-4A-31. Renewal of physician assistant's license - Form. Every person holding a license as a physician assistant under the provisions of this chapter shall renew his license annually on or before the fifteenth day of July. Renewal of a license shall be requested by every person licensed as a physician assistant upon a form which shall be furnished to him by the board of medical and osteopathic examiners. The request for renewal shall include such proof, as may be required by the board, of continuance of the qualifications for original licensure including the information set forth in subdivisions 36-4A-8 (7) and (8) and payment of the annual renewal fee.

36-4A-32. Continuing education required for renewal - Report on practice - Termination of contract. A renewal request shall be accompanied by the prescribed fee together with evidence satisfactory to the board of the completion during the preceding twelve months of at least thirty hours of post-graduate studies in family medicine approved by the board. Such request shall be further accompanied by a letter from both physician and physician's assistant indicating the location and scope of practice of the physician's assistant. The board shall be further notified in writing, by both the physician and physician's assistant within seventy-two hours of termination of any such working contract and the reasons for such terminations.

36-4A-33. Suspension of license not renewed - Reinstatement. Any license not renewed pursuant to §36-4A-31 shall be suspended. A license so suspended may be reinstated during the following twelve months by payment of the renewal fee and a reinstatement fee as fixed by the board. Thereafter, a license so suspended may be reinstated only upon payment of all delinquent renewal fees and a reinstatement fee fixed by the board pursuant to §36-4A-34, following specific approval by the board.

36-4A-34. Fees payable. The fees in connection with a certificate as a physician's assistant shall be as follows:

(1) For certificate by examination, not less than twenty-five dollars nor more than seventy-five dollars;
(2) For re-examination within one year, not less than fifteen dollars nor more than forty-five dollars;
(3) For certificate by reciprocity, not less than twenty-five dollars nor more than seventy-five dollars;
(4) For renewal of a certificate, not more than one hundred dollars;
(5) For reinstatement of a certificate, not less than five dollars nor more than twenty-five dollars;
(6) For reissuance of a lost or destroyed certificate, following approval of the board, ten dollars.

36-4A-35. Fixing of fees by board. Not later than the first day of April of each fiscal year, the board shall promulgate rules pursuant to chapter 1-26 to set fees in each of the above categories within the stated limits in an amount which will produce sufficient revenue for the ensuing fiscal year not to exceed one hundred twenty percent of the anticipated expenses of the board for the operation of the physician's assistant program by the board for that year.

36-4A-36. Collection and crediting of fees - No refund. All fees received by the board and all fines collected under the provisions of this chapter shall be paid to the board of medical and osteopathic examiners who shall credit the same to the state board of medical examiner's fund. No fee shall be refunded.

36-4A-37. Grounds for refusal, revocation or suspension of license. The South Dakota state board of medical and osteopathic examiners shall have the right to deny the issuance or renewal of a license or suspend or revoke the license of any physician's assistant issued under this chapter upon satisfactory proof, in compliance with chapter 1-26, of such person's:

(1) Gross incompetence or unprofessional or dishonorable conduct as defined in §36-4-30;
(2) Violation of this chapter in any respect;
(3) Failure to notify the board, in writing, of the termination of the contract with his employer physician within seven days after such termination;
(4) Rendering medical services beyond the specific tasks allowed to the physician's assistant; or
(5) Rendering medical services without supervision of a physician as required by law and the

rules and regulations of the board.

36-4A-38. Unprofessional or dishonorable conduct defined. The terms "unprofessional or dishonorable conduct" as used in this chapter shall be as those terms are defined in §36-4-30.

36-4A-39. Right of appeal from board. Any party feeling aggrieved by any acts, rulings, or decision of said board acting pursuant to §36-4A-37, shall have the right to appeal the same under the provisions of chapter 1-26.

36-4A-40. Suspension of license for mental incompetence. The provisions of §36-4-32 shall apply to physician's assistants.

36-4A-41.Reissuance of canceled, revoked, or suspended license. Upon application, the board may reissue a license to practice to any person whose licensure which has been canceled, suspended or revoked. A reissuance of a license which has been canceled or revoked shall not be made prior to one year after said cancellation or revocation and the reissuance of any license may be made in such manner and form and under conditions as the board may require.

36-4A-42. Promulgation of rules by board. The board shall promulgate rules pursuant to chapter 1-26 pertaining to: certification of physician assistants, placement of physician assistants and disciplinary proceedings.

36-4A-43. Locum tenens license. A locum tenens license allows the holder thereof to practice as a physician's assistant in this state for a limited period of time and is subject to the requirements and conditions set forth in the license.

36-4A-44. Fee for locum tenens license - Personal appearance required. Each new applicant for a locum tenens license shall submit a licensure fee of fifty dollars made payable to the secretary of the board and appear personally at the office of the board or at the office of a member of the board.

36-4A-45. Requirements to receive locum tenens license - Petition. The board may issue a license for locum tenens to an applicant who holds a valid physician's assistant license in any state or territory of the United States, the District of Columbia, or province of Canada or who has successfully completed an approved program and the curriculum requirements pursuant to §§36-4A-12 and 36-4A-13. To obtain a locum tenens license, the applicant shall present a petition to the board signed under oath by a licensed physician practicing in this state and by the applicant requesting a locum tenens license. The petition shall set forth the reasons why the applicant should be issued a locum tenens license. In addition to the petition, the locum tenens applicant shall complete and submit to the board the application required by §36-4A-8. A new petition shall be submitted to the board for each locum tenens practice location.

36-4A-46. Renewal of locum tenens license. Any person holding a locum tenens license under the provisions of this chapter shall renew the license annually on or before the fifteenth day of July upon a form which shall be furnished to the person by the board. The request for renewal shall include proof, as may be required by the board, of continuance of the qualifications for original licensure and payment of an annual renewal fee of fifty dollars.

36-4A-47. Post graduate studies required for renewal of locum tenens license. A renewal request pursuant to §36-4A-46 shall be accompanied by evidence satisfactory to the board of the completion during the preceding twelve months of at least thirty hours of post-graduate studies in family medicine which has been approved by the board.

36-4A-48. Application by physician's assistant for locum tenens license - Requirements. Any physician's assistant applying for a locum tenens certificate shall have practiced a minimum of three hundred hours in the preceding twenty-four months and shall meet locum tenens certification requirements as set forth in §§36-4A-43 to 36-4A-47, inclusive.

36-4A-49. Substitution of certain terms throughout the Code. The term, employer physician, wherever it is used in chapter 36-4A means supervising physician. The Code Commission in future supplements and revisions of the South Dakota Codified Laws shall substitute the term, supervising physician, and its derivatives for the term, employer physician, and its derivatives.

The term, employment contract, wherever it is used in chapter 36-4A means practice agreement. The Code Commission in future supplements and revisions of the South Dakota Codified Laws shall substitute the term, practice agreement, and its derivatives for the term, employment contract, and its derivatives.

The term, physician's assistant, wherever it is used in chapter 36-4A means physician assistant. The Code Commission in future supplements and revisions of the South Dakota Codified Laws shall substitute the term, physician assistant, and its derivatives for the term, physician's assistant, and its derivatives.

The term, certification, wherever it is used in chapter 36-4A means licensure. The Code Commission in future supplements and revisions of the South Dakota Codified Laws shall substitute the term, licensure, and its derivatives for the term, certification, and its derivatives.

Chapter 36-9A.

NURSE PRACTITIONERS AND MIDWIVES

Section

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36-9A-1. Definition of terms. Terms as used in this chapter mean:

(5) "Approved program," an educational program of study which meets the requirements established by this chapter and by the boards for licensure under this chapter;

(6) "Boards," the South Dakota Board of Nursing and the South Dakota Board of Medical and Osteopathic Examiners;

(7) "License," the written authorization by the boards required to practice the specialties of nurse practitioner or nurse midwife;

(8) "Nurse midwife," a provider duly authorized under this chapter to practice the nursing specialty of nurse midwifery as defined in § 36-9A-13;

(9) "Nurse practitioner," a provider duly authorized under this chapter to practice the specialty of nurse practitioner as defined in § 36-9A-12;

(10) The feminine gender as used in this chapter shall also apply to the masculine and neuter ;

(11) "Collaboration," the act of communicating pertinent information or consulting with a physician licensed pursuant to chapter 36-4, with each provider contributing their respective expertise to optimize the overall care delivered to the patient.

36-9A-2. Board license required to practice as nurse practitioner or nurse midwife. No person may practice or offer to practice as a nurse practitioner or nurse midwife in this state unless the person is currently licensed to practice by the boards.

36-9A-2.1. Temporary permit to practice. Upon application and payment of the required fee the boards may issue a temporary permit to practice as a nurse practitioner or nurse midwife to an applicant who is waiting for the results of the first examination the applicant is eligible to take after completion of an approved program. An applicant issued a temporary permit under this section shall initially receive thirty days of on-site, direct supervision by a supervising physician. Thereafter, and until expiration of the temporary permit, the supervision shall include two one-half business days per week of on-site personal supervision by a supervising physician. The permit shall become invalid upon notification to the applicant of the results of the first examination.

36-9A-2.2. License to practice of person licensed under laws of other state. Upon application and payment of the required fee the boards may issue a license to practice as a nurse practitioner or nurse midwife by endorsement to an applicant who has been licensed as a nurse practitioner or nurse midwife under the laws of another state, territory, or foreign country, if in the opinion of the boards the applicant meets the qualifications required of nurse practitioners or nurse midwives in this state.

36-9A-2.3. Temporary permit issued to person licensed under laws of other state. Upon application and payment of the required fee the boards may issue a temporary permit to an applicant holding a current license as a nurse practitioner or nurse midwife from any other state or territory awaiting endorsement. This permit shall bear an issuance date and a date when it becomes invalid, a period not to exceed one hundred twenty days.

36-9A-3. Unlicensed practice permitted in certain situations. This chapter does not prohibit the performance of the functions of a nurse practitioner or nurse midwife by an unlicensed person if performed:

(1) In an emergency situation;

(2) By a legally qualified person from another state employed by the United States government and performing the person's official duties in this state;

(3) By a person enrolled in an approved program for the preparation of nurse practitioners or nurse midwives, as a part of that approved program.

36-9A-4. Licensing requirements. No person may be licensed to practice as a nurse practitioner or nurse midwife unless the person:

(1) Is currently licensed by the Board of Nursing as a registered nurse;

(2) Has completed an approved program for the preparation of nurse practitioners or nurse midwives; and

(5) Has passed any examination, written or oral, or both, which the boards in their discretion may require.

36-9A-5. Joint control by nursing board and medical and osteopathic examiners board.
The practice in this state as a nurse practitioner or nurse midwife shall be subject to the joint control

and regulation of the South Dakota Board of Nursing and the South Dakota Board of Medical and Osteopathic Examiners. The joint boards may license, supervise the practice, and revoke or suspend licenses or otherwise discipline any person applying for or practicing as a nurse practitioner or nurse midwife.

36-9A-5.1. Board to appoint advisory committee — Terms — Duties. The Board of Nursing shall appoint an advanced practice nurse advisory committee composed of two certified nurse midwives and four certified nurse practitioners. Committee members shall be selected from a list of nominees by the Board of Nursing. Each committee member shall serve a term of three years, except initial appointees whose terms shall be staggered so that no more than two member's terms expire in one year. A committee member may not be appointed to more than two consecutive terms. If a vacancy occurs the board shall appoint a person to fill the unexpired term. The committee shall meet at least annually, or as deemed necessary, to conduct business. The advisory committee shall assist the boards in evaluating standards of advanced practice nursing care and the regulation of nurse practitioners and nurse midwives pursuant to this chapter. The committee shall also make recommendations to the boards regarding rules promulgated pursuant to this chapter.

36-9A-6. Quorum required of boards - Concurrence required for action - Record of proceedings. A quorum is required of each board in order to transact any business. For the purposes of this chapter, a majority vote of each respective board is required for taking any action, and any action requires the concurrence of both boards. The boards shall keep a record of all of their proceedings relative to this chapter.

36-9A-7. Subpoena and inspection powers of boards. In administering the provisions of this chapter, the boards shall have those powers granted them by §36-4-22.1.

36-9A-8. Delegation of activities to members or employees. The boards may delegate to their respective members or employees such activities, not inconsistent with the provisions of this chapter, as will expedite the functions of the boards.

36-9A-9. Filing of application for licensure - Form - Fee - Issuance of license. An applicant for licensure as a nurse practitioner or nurse midwife shall file with the boards an application, verified by oath, on a form prescribed by the boards and accompanied by the prescribed fee. If the boards find that the applicant has satisfied all requirements, the boards shall issue to the applicant a license to practice as a nurse practitioner or nurse midwife.

36-9A-10. Certification prior to act - Requirements. Repealed by SL 1995, ch 218, § 10.

36-9A-11. Titles - Use of. A person licensed to practice as a nurse practitioner in this state may use the title "certified nurse practitioner" and the abbreviation "CNP." A person licensed to practice as a nurse midwife in this state may use the title "certified nurse midwife" and the abbreviation "CNM."

36-9A-12. Medical functions delegated to nurse practitioner. A nurse practitioner may perform the following overlapping scope of advanced practice nursing and medical functions pursuant to § 36-9A-15, including:

(1) The initial medical diagnosis and the institution of a plan of therapy or referral;
(2) The prescription of medications and provision of drug samples or a limited supply of labeled medications, including controlled drugs or substances listed on Schedule II in chapter 34-20B for one period of not more than forty-eight hours, for treatment of causative factors and symptoms. Medications or sample drugs provided to patients shall be accompanied with written administration instructions and appropriate documentation shall be entered in the patient's medical record;
(3) The writing of a chemical or physical restraint order when the patient may do personal harm or harm others;
(4) The completion and signing of official documents such as death certificates, birth certificates, and similar documents required by law; and
(5) The performance of a physical examination for participation in athletics and the certification that the patient is healthy and able to participate in athletics.

36-9A-13. Medical functions delegated to nurse midwife. A nurse midwife may perform the following overlapping scope of advanced practice nursing and medical functions pursuant to § 36-9A-15, including:
(1) Management of the prenatal and postpartum care of the mother-baby unit;
(B) Management and direction of the birth;
(g) Provision of appropriate health supervision during all phases of the reproductive life span to include family planning services, menopausal care, and cancer screening and prevention ; and
(h) Prescription of appropriate medications and provision of drug samples or a limited supply of appropriate labeled medications for individuals under the nurse midwife's care pursuant to the scope of practice defined in this section, including controlled drugs or substances listed on Schedule II in chapter 34-20B for one period of not more than forty-eight hours. Medications or sample drugs provided to patients shall be accompanied with written administration instructions and appropriate documentation shall be entered in the patient's medical record.

36-9A-13.1. Advanced practice nursing functions. The nurse practitioner or nurse midwife advanced practice nursing functions include:
(a) Providing advanced nursing assessment, nursing intervention, and nursing case management;
(b) Providing advanced health promotion and maintenance education and counseling to clients, families, and other members of the health care team;

(c) Utilizing research findings to evaluate and implement changes in nursing practice, programs, and policies; and

(d) Recognizing limits of knowledge and experience, planning for situations beyond expertise, and consulting with or referring clients to other health care providers as appropriate.

These advanced practice nursing functions are under the jurisdiction of the Board of Nursing.

36-9A-14. Practice of Pharmacy prohibited. Nothing in this chapter shall authorize a nurse practitioner or nurse midwife to practice pharmacy as defined in chapters 36-11.

36-9A-15. "Collaborative agreement" defined. The term, collaborative agreement, as used in this chapter, means a written agreement authored and signed by the nurse practitioner or nurse midwife and the physician with whom the nurse practitioner or nurse midwife is collaborating. A collaborative agreement defines or describes the agreed upon overlapping scope of advanced practice nursing and medical functions that may be performed, consistent with § 36-9A-12 or 36-9A-13, and contains such other information as required by the boards. A copy of each collaborative agreement shall be maintained on file with and be approved by the boards prior to performing any of the acts contained in the agreement.

36-9A-16. Medical functions described in practice agreement. Repealed by SL 1999, ch 192, § 17.

36-9A-17. Advanced practice nursing and medical functions - Collaborative agreement required. A nurse practitioner or nurse midwife may perform the overlapping scope of advanced practice nursing and medical functions only under the terms of a collaborative agreement with a physician licensed under chapter 36-4. Any collaborative agreement shall be maintained on file with the boards. Collaboration may be by direct personal contact, or by a combination of direct personal contact and indirect contact via telecommunication, as may be required by the boards. If the collaborating physician named in a collaborative agreement becomes temporarily unavailable, the nurse practitioner or nurse midwife may perform the agreed upon overlapping scope of advanced practice nursing and medical functions in consultation with another licensed physician designated as a substitute.

36-9A-17.1. Modification of collaboration - Method and frequency. The boards may authorize those modifications in the method and frequency of collaboration of a nurse practitioner or nurse midwife required by that they consider appropriate based upon a finding of adequate collaboration, training, and proficiency. The boards may permit a physician to establish a collaborative relationship with more than one nurse practitioner or nurse midwife and shall establish the number of nurse practitioners or nurse midwives, up to four FTE, based upon a finding that adequate collaboration will exist under the modification proposed.

Nothing in this section is intended to diminish the professional and legal responsibility of a

collaborating physician or the nurse practitioner or nurse midwife as provided in §§ 36-9A-17.

36-9A-17.2. Collaborative agreement not to include abortion. The boards may not approve any collaborative agreement that includes abortion as a permitted procedure.

36-9A-18. Medical functions - Settings for performance. Repealed by SL 1995, ch 218, § 13.

36-9A-19. Hospital services - Rules and regulations. In the event a nurse practitioner or nurse midwife shall render services in a hospital or a related institution licensed pursuant to the provisions of chapters 34-12, she shall be subject to the rules and regulations of that hospital or related institution.

36-9A-20. Practice status altered - New or amended collaborative agreement required. If a nurse practitioner or nurse midwife intends to alter practice status by reason of a change in setting, modification, or expansion of the functions the nurse practitioner or nurse midwife is authorized to perform, or for any other reason, the nurse practitioner or nurse midwife shall submit a new or amended collaborative agreement to the boards for approval before any change may be permitted.

36-9A-21. Education program requirements. Repealed by SL 1982, ch 274, §6.

36-9A-21.1. List of approved programs. The boards shall promulgate pursuant to chapter 1-26 a list of approved programs for nurse practitioners and nurse midwives. The boards may consult accrediting associations in establishing the list.

36-9A-22. Renewal of license. The license of every person licensed under the provisions of this chapter shall be renewed biennially, except as provided in §36-9A-25. The expiration date shall be established by the boards.

36-9A-23. Notice of renewal — Issuance of renewal license. The boards shall mail a notice for renewal of license to every license holder at least ninety days prior to the expiration date of the person's license. The license holder shall, before the expiration date, return to the boards the notice and the prescribed fee. Upon receipt of the notice and fee, the boards shall issue to the license holder a renewal certificate that includes the effective period of the renewal stated on the certificate.

36-9A-24. Reinstatement of lapsed license. A license holder who fails to renew the license as provided in §§ 36-9A-22 and 36-9A-23 may be reinstated upon the terms and conditions prescribed by the boards and upon payment of the prescribed fee.

36-9A-25. Inactive status - Request for. The holder of a current license may file with the boards a written application, together with the prescribed fee, requesting inactive status and stating the reasons for the request.

36-9A-26. Fees. The boards shall collect in advance the following nonrefundable fees from applicants:

(a) For initial licensure or endorsement from another state, not more than one hundred dollars;
(3) For biennial renewal of license, not more than fifty dollars;
(4) For reinstatement of a lapsed license, the current renewal fee and not more than one hundred dollars;
(5) For providing a transcript, not more than five dollars;
(5) For effecting a name change upon the records of the license holder, not more than ten dollars;
2) For issuance of a duplicate license, not more than twenty dollars;
4) For issuing a temporary permit, not more than fifteen dollars;
(8) For placing a license on inactive status, not more than ten dollars;
(2) For endorsement to another state, territory, or foreign country, not more than fifteen dollars.

36-9A-27. Deposit of fees - Withdrawal - Report of receipts and expenditures. All fees received by the boards, and money collected under this chapter, shall be deposited in a bank as authorized by the boards. The funds are subject to withdrawal as authorized by the boards. A report of all receipts and expenditures of funds shall be made at the close of each fiscal year to the state auditor and filed in his office.

36-9A-28. Balance of fees - Use - Deficit shared between boards. Any balance of fees received by the boards after payment of compensation and expenditures shall be held and used by the boards only in administering this chapter. Any deficit created upon payment of any compensation and expenditures shall be shared equally between the boards.

36-9A-29. Revocation or suspension of license - Grounds. The boards may deny, revoke, or suspend any license or application for licensure to practice as a nurse practitioner or nurse midwife in this state, and may take such other disciplinary or corrective action as the boards deem appropriate upon proof that the license holder or applicant has:

(1) Committed fraud, deceit, or misrepresentation in procuring or in attempting to procure a license;
(2) Aided or abetted an unlicensed person to practice as a nurse practitioner or nurse midwife;
(3) Engaged in practice as a nurse practitioner or nurse midwife under a false or assumed name and failed to register that name pursuant to chapter 37-11, or impersonated another license holder of a like or different name;
(4) Become addicted to the habitual use of intoxicating liquors or controlled drugs as defined by chapter 34-20B to such an extent as to incapacitate the license holder or

applicant from the performance of professional duties;

(5) Negligently, willfully, or intentionally acted in a manner inconsistent with the health and safety of persons entrusted to the license holder's care;

(6) Had authorization to practice as a nurse practitioner or nurse midwife denied, revoked, or suspended or had other disciplinary action taken in another state;

(7) Failed to maintain on file with the boards a copy of each collaborative agreement accurately containing the current information regarding the license holder's practice status required by the boards;

(8) Practiced as a nurse practitioner or nurse midwife without a valid license;

(9) Engaged in the performance of advanced practice nursing and medical functions beyond the scope of practice authorized by any current collaborative agreement or by § 36-9A-12 or 36-9A-13;

(10) Violated any provisions of this chapter or the rules and regulations of the boards promulgated hereunder.

36-9A-30. Revocation or suspension of license - Initiation of proceedings. The proceedings for revocation or suspension of a license may be initiated if the boards have information that any person may have been guilty of any misconduct as provided in §36-9A-29, or is guilty of gross incompetence or unprofessional or dishonorable conduct.

36-9A-31. Revocation or suspension of license - Procedure. Any proceeding relative to the revocation or suspension of a license shall conform to the procedures set forth in chapter 1-26-26. A license may be revoked or suspended only at a hearing attended by a quorum of the members of each board.

36-9A-32. Revocation or suspension of license - Physical or mental condition of holder - Examination. The boards may take action authorized by §36-9A-29 upon a satisfactory showing that the physical or mental condition of the license holder or applicant is determined by a competent medical examiner to be such as to jeopardize or endanger the health of those entrusted to such person's care. The boards may demand an examination of the license holder or applicant by a competent medical examiner selected by the boards at their expense. If a license holder fails to submit to the examination, the failure constitutes immediate grounds for suspension of that person's license.

36-9A-33. Appeal of revocation or suspension. An aggrieved party may appeal pursuant to chapter 1-26.

36-9A-34. Reissuance of revoked or suspended license. A revoked or suspended license may be reissued at the discretion of the boards upon a finding of good cause.

36-9A-35. Prohibited acts. No person may:

(1) Practice or offer to practice as a nurse practitioner or nurse midwife without being licensed under this chapter;

II. Sell or fraudulently obtain or furnish a diploma, license, renewal of license, or any other record necessary to practice under this chapter or aid or abet in such actions;

I. Practice as a nurse practitioner or a nurse midwife under cover of any diploma, license, renewal of license, or other record necessary to practice under this chapter that was issued unlawfully or under fraudulent representation;

II Use in connection with that person's name a sign, card, device, or other designation tending to imply that the person is a nurse practitioner or nurse midwife without being licensed under this chapter;

II Practice as a nurse practitioner or nurse midwife during the time that the person's license has lapsed or has been revoked or suspended. A violation of this section is a Class 1 misdemeanor.

36-9A-36. Proof of single act only required. It shall be necessary to prove in any prosecution only a single act prohibited by law, or a single holding out, or a single attempt, without proving a general course of conduct in order to constitute a violation of this chapter.

36-9A-37. Prosecution of violations. The boards may prosecute all persons violating this chapter and may incur the necessary expenses.

36-9A-38. Enjoining violations. Enjoining violations. The boards may apply for an injunction in the circuit court for the county of the person's residence to enjoin any person who:

A. Is unlawfully practicing as a nurse practitioner or nurse midwife without a license issued by the boards;

A. Is practicing as a nurse practitioner or nurse midwife under a license that has lapsed or has been suspended or revoked;

A. Is engaging as a nurse practitioner or nurse midwife in the performance of medical functions beyond the scope of practice authorized by §36-9A-12 or 36-9A-13, or by that person's current practice agreement approved by the boards; or

A. Is, by reason of a physical or mental condition, endangering, or threatening to endanger, the health or safety of those entrusted to that person's care as a nurse practitioner or nurse midwife.

36-9A-39. Temporary injunction - Grounds. Upon the filing of a verified complaint, the court, if satisfied by affidavit or otherwise, that the person is or has been engaging in unlawful or dangerous practice as described in §36-9A-38, may issue a temporary injunction, without notice or bond, enjoining that person from further practice as a nurse practitioner or nurse midwife.

36-9A-40. Injunction an alternative to criminal proceedings. An action for injunction is an alternative to criminal proceedings, and the commencement of one proceeding by the boards

constitutes an election.

36-9A-41. Promulgation of rules by boards. The boards may promulgate rules pursuant to chapter 1-26 pertaining to: licensure and licenses, collaborative practice, prescriptive authority, and disciplinary proceedings.
:
36-9A-42. Locum tenens license. A locum tenens license allows the holder to practice as a nurse practitioner or nurse midwife in this state for a limited period of time and subject to the requirements and conditions set forth in the license.

36-9A-43. Requirements for receiving locum tenens license - Petition. The boards may issue a locum tenens license to an applicant who holds a valid nurse practitioner or nurse midwife license in any state or territory of the United States, the District of Columbia, or province of Canada, or who has successfully completed an approved program pursuant to § 36-9A-4. To obtain a locum tenens license, the applicant shall present a petition to the boards signed under oath by a licensed physician practicing in this state and by the applicant requesting a locum tenens license. The petition shall set forth the reasons why the applicant should be issued a locum tenens license. In addition to the petition, the locum tenens applicant shall submit to the board a licensure fee of fifty dollars and the application required by § 36-9A-9. A new petition shall be submitted to the boards for each locum tenens practice location.

36-9A-44. Renewal of locum tenens license. Any person holding a locum tenens license under the provisions of this chapter shall renew the license annually on or before the fifteenth day of July upon a form which shall be furnished to the person by the boards. The request for renewal shall include proof, as may be required by the boards, of continuance of the qualifications for original licensure and payment of an annual renewal fee of fifty dollars.

36-9A-45. Post-graduate studies required to renew locum tenens license. A renewal request pursuant to §36-9A-4 shall be accompanied by evidence satisfactory to the boards of the completion during the preceding twelve months of at least thirty hours of post-graduate studies in family medicine which have been approved by the boards.

36-9A-46. Application by nurse practitioner or midwife for locum tenens license. Any nurse practitioner or nurse midwife applying for a locum tenens license shall have practiced a minimum of three hundred hours in the preceding twenty-four months and shall meet locum tenens licensure requirements as set forth in §§36-9A-42 to 36-9A-45, inclusive.

South Dakota Department of Health
Office of Disease Prevention

Reportable Diseases in South Dakota

(Effective 27 Dec 2004)

The South Dakota Department of Health is authorized by SDCL 34-22-12 and ARSD 44:20 to collect and process mandatory reports of communicable diseases by physicians, hospitals, laboratories, and institutions. Instructions for reporting. (Download poster version of South Dakota reportable diseases list; use ADOBE)

Category 1: Report immediately on suspicion of disease

Anthrax *(Bacillus anthracis)*
Botulism *(Clostridium botulinum)*
Cholera *(Vibrio cholerae)*
Diphtheria *(Corynebacterium diphtheriae)*
Enterohemorrhagic *E. coli* *(EHEC)* shiga-toxin producing *(Escherichia coli)*, includes *E. coli O157:H7*
Measles *(paramyxovirus)*
Meningococcal disease, invasive *(Neisseria meningitidis)*
Pertussis *(Bordetella pertussis)*
Plague *(Yersinia pestis)*
Poliomyelitis *(picornavirus)*
Rabies, human and animal *(rhabdovirus)*
Ricin toxin
Rubella and congenital rubella syndrome *(togavirus)*
Smallpox *(Variola)*
Tularemia *(Francisella tularensis)*
Typhoid *(Salmonella typhi)*

Category II: Report within three days

Acquired immunodeficiency syndrome (AIDS)
Arboviral encephalitis, meningitis and infection *(West Nile, St. Louis, Eastern and Western equine, California serotype, Japanese, Powassan)*
Brucellosis *(Brucella spp.)*
Campylobacteriosis *(Campylobacter spp.)*
Chancroid *(Haemophilus ducreyi)*
Chicken pox/Varicella *(herpesvirus)*
Chlamydia infections *(Chlamydia trachomatis)*
Cryptosporidiosis *(Cryptosporidum parvum)*
Cyclosporiasis *(Cyclospora cayetanesis)*
Dengue fever *(flavivirus)*
Drug resistant organisms:
- Methicillin-resistant *Staphylococcus aureus* (MRSA), invasivie
- Vancomycin-resistant and -intermediate *Staphylococcus aureus*

Influenza: all lab confirmed cases, pediatric deaths and
- weekly reports of number of rapid antigen influenza positive tests and total number tested

Legionellosis *(Legionella spp.)*
Leprosy/Hansen's disease *(Mycobacterium leprae)*
Listeriosis *(Listeria monocytogenes)*
Lyme disease *(Borrelia burgdorferi)*
Malaria *(Plasmodium spp.)*
Melioidodosis *(Burholderia pseudomallei)*
Mumps *(Paramyxovirus)*
Nipah virus *(Paramyxovirus)*
Psittacosis *(Chlamydophila psittaci)*
Q fever *(Coxiella burnetii)*
Rocky Mountain spotted fever *(Rickettsia rickettsii)*
Salmonellosis *(Salmonella spp.)*
Shigellosis *(Shigella spp.)*
Staphylococcus

Viral Hemmorrhagic Fevers *(Filoviruses, arenaviruses)*
Outbreaks:
- Acute upper respiratory illness
- Diarrheal disease
- Foodborne
- Illnesses in child care settings
- Nosocomial
- Rash illness
- Waterborne

Syndromes suggestive of bioterrorism and other public health threats
Unexplained illnesses or deaths in humans or animals

(VRSA *and* VISA)
- Drug resistant *Streptococcus pneumoniae* (DRSP), invasive

Ehrlichiosis *(Ehrlichia spp.)*
Epsilon toxin of *Clostridium perfringens*
Giardiasis *(Giardia lamblia / intestinalis)*
Glanders *(Burkholderia mallei)*
Gonorrhea *(Neisseria gonorrhoeae)*
***Haemophilus influenzae* type b disease, invasive**
Hantavirus pulmonary syndrome *(hantavirus)*
Hemolytic uremic syndrome
Hepatitis, acute viral A, B, C, D, and E
Hepatitis, chronic viral B and C
Hepatitis B infection, perinatal
***Herpes simplex* virus infection,** neonatal or genital
Human immunodeficiency virus infection (HIV)

enterotoxin B
Streptococcal Group A, invasive
Streptococcal Group B, invasive
***Streptococcus pneumoniae,* invasive,** in a child less than 5 years of age
Syphilis *(Treponema pallidum)*
Tetanus *(Clostridium tetani)*
Toxic shock syndrome
Transmissible spongiform encephalopathies
Trichinosis *(Trichinella sprialis)*
Tuberculosis *(Mycobacterium tuberculosis and Mycobacterium bovis)* active disease and latent infection (positive skin test)
Typhus fever *(Rickettsia prowazekii)*
Vaccine Adverse Events
Yellow fever *(flavivirus)*

WHEN TO REPORT

Category I diseases are reportable immediately by telephone on recognition or strong suspicion of disease.

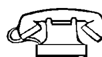
Category II diseases are reportable immediately by telephone, mail, or fax within 3 days of recognition or strong suspicion of disease.

WHAT TO REPORT: Disease reports must include as much of the following as is known:

- Disease or condition diagnosed or suspected
- Case's name, age, date of birth, sex, race, address, and occupation
- Date of disease onset
- Pertinent laboratory results and date of specimen collection
- Attending physician's name, address and phone number
- Name and phone number of person making the report

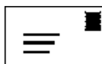
HOW TO REPORT

Secure website: www.state.sd.us/doh/diseasereport



Telephone: 1-800-592-1804 confidential answering-recording device, or **1-800-592-1861** or **605-773-3737** for a disease surveillance person during normal business hours; after hours to report Category I diseases, call **605-280-4810**

Fax: 605-773-5509



Mail or **courier,** address to: Infectious Disease Surveillance, Office of Disease Prevention, Department of Health, 615 East 4th Street, Pierre, SD 57501; marked *"Confidential Disease Report"*

Fetal Alcohol Syndrome (SDCL 34-24-27) Report to Office of Data, Statistics and Vital Records, 600 E. Capitol Ave, Pierre 57501 (605) 773-5683.

The following bacterial isolates should be sent to the **South Dakota Public Health Laboratory** (call **605-773-3368**)

**Bacillus anthracis*
Bordetella pertussis
**Brucella* spp.
*Burkholderia spp.
Campylobacter spp.
Escherichia coli, shiga-toxin producing
**Francisella tularensis*
Haemophilus influenzae type b
Listeria monocytogenes
Neisseria meningitidis
Salmonella spp.
Shigella spp.
Vancomycin intermediate/resistant *Staphylococcus aureus*
**Yersinia pestis*

* Select Agent Rule 42 CFR 72.6 (Federal Register 10/24/96)

South Dakota Confidential Disease Report

South Dakota Department of Health
Office of Disease Prevention
SDCL 34-22-12 and ARSD 44:20
Reportable Disease List

Instructions:

- Please fill out the form as completely as possible before submission.
- Use the **Tab** key to move to the next field.
- Only press the **Enter** key when you are ready to submit the form.
- Note: Fields with an asterisk(*) are required.

Report Type: New / Update Report Date: 11/8/2005

Patient Information

*Last Name: *First Name: *Gender: - - Select - -

Address:

City: State: SD County: - - Select - -

Telephone: Date of Birth: (mm/dd/yyyy)

Race: - - Select - - Ethnicity: - - Select - -

Occupation: Other Phone:

Disease Information

*Disease or Condition: - - Select - - Category I Diseases are in RED, Category II Diseases are in BLUE

Date of Onset: (mm/dd/yyyy)

Has Diagnosis been confirmed by Laboratory Test? Yes No Name of Lab:

Specimen Source: Date Collected: (mm/dd/yyyy)

Was Patient Hospitalized? Yes No Date Admitted: (mm/dd/yyyy)

Name of Hospital:

Hospital Address:

Hospital Phone:

Outcome: Survived Expired

Additional Lab Information

Specimen Submitted Is: Original material Serum Pure Isolate

Specific Agent Identified:

Is Isolate resistant to any Antimicrobial Agent? Yes No Not Done

Type of Antimicrobial: - - Select - - B-lactam: Ampicillin B-lactam: cefotaxime (Press Ctrl + click to select multiple items)

Attending Health Care Provider

Health Care Provider: Phone:

Comments:

*Person Reporting:

*Facility: *Phone:

Submit Form Reset Form