ARTICLE 20:47

PHYSICIANS AND SURGEONS

Chapter

20:47:01 Definitions, repealed.

20:47:02 Operation of board, transferred.

20:47:03 Licensure.

20:47:04 Inspections.

20:47:05 Declaratory rulings, transferred.

20:47:06 Fees.

20:47:07 Physician best practices.

CHAPTER 20:47:07

PHYSICIAN BEST PRACTICES

20:47:07:01. Best practices defined

20:47:07:02. Best practices for the prescription of controlled substances for the treatment of pain.

20:47:07:03. Best practices for medical records when prescribing controlled substances for the treatment of pain

20:47:07:01. Best practices defined. "Best practices" means a process or procedure established in this article as a guideline to physicians. Failure to comply with best practices established in this article is not grounds for cancellation, revocation or suspension of a medical license. Failure to comply with best practices may be justified based on the circumstances of a particular case or on the applicable community standards. Compliance with best practices is a

defense to a proceeding for cancellation, revocation or suspension of a medical license that is based upon medical treatment for which best practices have been established.

Source:

General Authority: SDCL 36-4-35.

Law Implemented: SDCL 36-4-28, 36-4-29, 36-4-30.

20:47:07:02. Best practices for the prescription of controlled substances for the treatment of pain. All patients have a level or risk of addiction to controlled substances prescribed for the treatment of pain, that can only be estimated initially, with the estimate modified over time as more information is obtained concerning the efficacy of the treatment and the patient's on-going or increasing risk of addiction. The best practices for the prescription of controlled substances for the treatment of pain follow this process and procedure:

(1) A medical diagnosis is made with an appropriate differential;

(2) A complete patient assessment, including assessment of the risk for substance use disorders, is performed;

(3) A proposed treatment plan that includes disclosure of the level or risk of addition and alternative treatment methods, is discussed with the patient and written informed consent from the patient is obtained;

(4) A written treatment agreement, signed by both the physician and the patient, is established that sets forth the expectations and obligations of the patient and the treating physician;

(5) An appropriate trial of opioid therapy, with or without adjunctive medications, is initiated. During this trial period, the efficacy of the opioid therapy is tested to determine

whether the treatment goals can be met in terms of reduction of pain and restoration of function;

(6) The written treatment plan is revised as necessary based upon the results of the trial of opioid therapy and discussed with the patient. The revised written treatment plan sets forth the expectations and obligations of the patient and the treating physician, and signed by both;

(7) Regular assessments of pain and function are conducted, initially every month, and after treatment goals are being met, a minimum of every 6 months, which include:

(a) A full reassessment of the patient's pain score and level of function;

(b) Evaluation of the patient in terms of the "5 a's": analgesia, activity, adverse effects, aberrant behaviors, and affect;

(c) Review of the pain diagnosis and any comorbid conditions, including substance use disorders;

(d) Adjustment of the treatment regimen based upon the entire reassessment.

(8) If treatment goals of reduction of pain and restoration of function are not met, the physician shall adjust the opioid dose, substitute a different opioid, add an adjunctive therapy, or discontinue the use of opioids and select an alternative approach to pain management; and

(9) In no cases should a physician continue to prescribe opioids at the same level or in the same manner, with no alternative therapies being explored, when a patient's treatment goals are not being met.

Source:

General Authority: SDCL 36-4-35.

Law Implemented: SDCL 36-4-28, 36-4-29, 36-4-30.

References: Federation of State Medical Boards Model Policy for the Use of Opioid

Analgesics in the Treatment of Chronic Pain; Federation of State Medical Boards Model Policy on Data 2000 and Treatment of Opioid Addiction in the Medical Office. Copies may be obtained at http://www.fsmb.org/policy/advocacy-policy/policy-documents

20:47:07:02. Best practices for medical records when prescribing controlled substances for the treatment of pain. The best practices for medical records when a physician prescribes controlled substances for the treatment of pain include each of the following listed items:

(1) Copies of the signed informed consent and treatment agreement required by ARSD 20:47:07:01(3), (4) and (6);

(2) The patient's medical history;

(3) The results of all physical examinations and all laboratory tests;

(4) The results of all risk assessments, including results of any screening instruments used;

(5) A description of the treatments provided, including all medications prescribed or administered, with the date of prescription or administration, the name and type of the medication; and the dosage and quantity of medication prescribed or administered. The medical records must include all prescription orders for opioid analgesics and other controlled substances, whether written or telephoned;

(6) Instructions to the patient, including discussions of risks and benefits with the patient and any significant others, and written instructions for the use of all medications;

(7) Results of ongoing assessments of patient progress or lack of progress in terms of pain management and functional improvement;

(8) Notes on evaluations by and consultations with specialists;

(9) Any other information used to support the initiation, continuation, revision, or termination of treatment and the steps taken in response to any aberrant medication use behaviors;

(10) Medical records of past hospitalizations or treatments by other providers, to the extent obtained by the physician;

(11) Authorization for release of information to other treatment providers; and

(12) Name, address and telephone number of the patient's pharmacy.

Source:

General Authority: SDCL 36-4-35.

Law Implemented: SDCL 36-4-29, 36-4-30.

References: Federation of State Medical Boards Model Policy for the Use of Opioid Analgesics in the Treatment of Chronic Pain; Federation of State Medical Boards Model Policy on Data 2000 and Treatment of Opioid Addiction in the Medical Office.

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PHYSICIANS AND SURGEONS

Chapter

20:47:01 Definitions, repealed.

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20:47:08 Ethics

CHAPTER 20:47:08

ETHICS

20:47:08:01. Professional ethical standards and conduct.

20:47:08:02. Violation.

20:47:08:03. Ethical considerations.

20:47:08:03. Professional ethical standards and conduct. A licensee under SDCL 36-4

shall comply with the following professional ethical standards and conduct.

(1) A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights.

(2) A physician shall uphold the standards of professionalism, be honest in all professional interactions, and strive to report physicians deficient in character or competence, or engaging in fraud or deception, to appropriate entities.

(3) A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.

(4) A physician shall respect the rights of patients, colleagues, and other health professionals, and shall safeguard patient confidences and privacy within the constraints of the law.

(5) A physician shall continue to study, apply, and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.

(6) A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care.

(7) A physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health.

(8) A physician shall, while caring for a patient, regard responsibility to the patient as paramount.

(9) A physician shall support access to medical care for all people.

Source:

General Authority: SDCL 36-4-35.

Law Implemented: SDCL 36-4-11, 36-4-28, 36-4-29, 36-4-29.1, 36-4-30.

20:47:08:02. Violations. A violation of any of the ethical standards and conduct are considered unprofessional conduct as defined by SDCL 36-4-30(22).

Source:

General Authority: SDCL 36-4-35.

Law Implemented: SDCL 36-4-11, 36-4-28, 36-4-29, 36-4-29.1, 36-4-30.

20:47:08:03. Ethical considerations. The Board may utilize the annotations and opinions included in Code of Medical Ethics of the American Medical Association 2012-2013 edition as guidance in determining whether a licensee has violated professional ethical standards and conduct.

Source:

General Authority: SDCL 36-4-35.

Law Implemented: SDCL 36-4-11, 36-4-28, 36-4-29, 36-4-29.1, 36-4-30.

Reference: Code of Medical Ethics of the American Medical Association 2012-2013 edition, Annotations prepared by the southern Illinois University School of Medicine Copies may be viewed at the Board's office or obtained from American Medical Association by calling 1-800-621-8335 or website at www.amabookstore.org.

ARTICLE 20:52

~~PHYSICIAN'S~~ PHYSICIAN ASSISTANTS

Chapter

20:52:01 Physician assistant license.

20:52:02 Ethics.

CHAPTER 20:52:02

ETHICS

Section

20:52:02:01 Code of ethics.

20:52:02:02 Violations.

20:52:02:03 Ethical considerations.

20:52:02:01. Code of ethics. A licensee under SDCL 36-4A shall comply with the following code of ethics.

Statement of Values of the Physician Assistant Profession

- Physician assistants hold as their primary responsibility the health, safety, welfare, and dignity of all human beings.
- Physician assistants uphold the tenets of patient autonomy, beneficence, nonmaleficence, and justice.
- Physician assistants recognize and promote the value of diversity.
- Physician assistants treat equally all persons who seek their care.

- Physician assistants hold in confidence the information shared in the course of practicing medicine.
- Physician assistants assess their personal capabilities and limitations, striving always to improve their medical practice.
- Physician assistants actively seek to expand their knowledge and skills, keeping abreast of advances in medicine.
- Physician assistants work with other members of the health care team to provide compassionate and effective care of patients.
- Physician assistants use their knowledge and experience to contribute to an improved community.
- Physician assistants respect their professional relationship with physicians.
- Physician assistants share and expand knowledge within the profession.

The PA and Patient

PA Role and Responsibilities

Physician assistant practice flows out of a unique relationship that involves the PA, the physician, and the patient. The individual patient–PA relationship is based on mutual respect and an agreement to work together regarding medical care. In addition, PAs practice medicine with physician supervision; therefore, the care that a PA provides is an extension of the care of the supervising physician. The patient–PA relationship is also a patient–PA–physician relationship.

The principal value of the physician assistant profession is to respect the health, safety, welfare, and dignity of all human beings. This concept is the foundation of the patient–PA relationship.

Physician assistants have an ethical obligation to see that each of their patients receives appropriate care. PAs should be sensitive to the beliefs and expectations of the patient. PAs should recognize that each patient is unique and has an ethical right to self-determination.

Physician assistants are professionally and ethically committed to providing nondiscriminatory care to all patients. While PAs are not expected to ignore their own personal values, scientific or ethical standards, or the law, they should not allow their personal beliefs to restrict patient access to care. A PA has an ethical duty to offer each patient the full range of information on relevant options for their health care. If personal moral, religious, or ethical beliefs prevent a PA from offering the full range of treatments available or care the patient desires, the PA has an ethical duty to refer a patient to another qualified provider. That referral should not restrict a patient's access to care. PAs are obligated to care for patients in emergency situations and to responsibly transfer patients if they cannot care for them.

Physician assistants should always act in the best interests of their patients and as advocates when necessary. PAs should actively resist policies that restrict free exchange of medical information. For example, a PA should not withhold information about treatment options simply because the option is not covered by insurance. PAs should inform patients of financial incentives to limit care, use resources in a fair and efficient way, and avoid arrangements or financial incentives that conflict with the patient's best interests.

The PA and Diversity

The physician assistant should respect the culture, values, beliefs, and expectations of the patient.

Nondiscrimination

Physician assistants should not discriminate against classes or categories of patients in the delivery of needed health care. Such classes and categories include gender, color, creed, race, religion, age, ethnic or national origin, political beliefs, nature of illness, disability, socioeconomic status, physical stature, body size, gender identity, marital status, or sexual orientation.

Initiation and Discontinuation of Care

In the absence of a preexisting patient–PA relationship, the physician assistant is under no ethical obligation to care for a person unless no other provider is available. A PA is morally bound to provide care in emergency situations and to arrange proper follow-up. PAs should keep in mind that contracts with health insurance plans might define a legal obligation to provide care to certain patients.

A physician assistant and supervising physician may discontinue their professional relationship with an established patient as long as proper procedures are followed. The PA and physician should provide the patient with adequate notice, offer to transfer records, and arrange for continuity of care if the patient has an ongoing medical condition. Discontinuation of the professional relationship should be undertaken only after a serious attempt has been made to clarify and understand the expectations and concerns of all involved parties.

If the patient decides to terminate the relationship, they are entitled to access appropriate information contained within their medical record.

Informed Consent

Physician assistants have a duty to protect and foster an individual patient's free and informed choices. The doctrine of informed consent means that a PA provides adequate information that is comprehendible to a competent patient or patient surrogate. At a minimum, this should include the nature of the medical condition, the objectives of the proposed treatment, treatment options, possible outcomes, and the risks involved. PAs should be committed to the concept of shared decision making, which involves assisting patients in making decisions that account for medical, situational, and personal factors.

In caring for adolescents, the PA should understand all of the laws and regulations in his or her jurisdiction that are related to the ability of minors to consent to or refuse health care.

Adolescents should be encouraged to involve their families in health care decision making. The PA should also understand consent laws pertaining to emancipated or mature minors. (See the section on *Confidentiality*.)

When the person giving consent is a patient's surrogate, a family member, or other legally authorized representative, the PA should take reasonable care to assure that the decisions made are consistent with the patient's best interests and personal preferences, if known. If the PA believes the surrogate's choices do not reflect the patient's wishes or best interests, the PA should work to resolve the conflict. This may require the use of additional resources, such as an ethics committee.

Confidentiality

Physician assistants should maintain confidentiality. By maintaining confidentiality, PAs respect patient privacy and help to prevent discrimination based on medical conditions. If

patients are confident that their privacy is protected, they are more likely to seek medical care and more likely to discuss their problems candidly.

In cases of adolescent patients, family support is important but should be balanced with the patient's need for confidentiality and the PA's obligation to respect their emerging autonomy.

Adolescents may not be of age to make independent decisions about their health, but providers should respect that they soon will be. To the extent they can, PAs should allow these emerging adults to participate as fully as possible in decisions about their care. It is important that PA's be familiar with and understand the laws and regulations in their jurisdictions that relate to the confidentiality rights of adolescent patients. (See the section on *Informed Consent*.)

Any communication about a patient conducted in a manner that violates confidentiality is unethical. Because written, electronic, and verbal information may be intercepted or overheard, the PA should always be aware of anyone who might be monitoring communication about a patient.

PAs should choose methods of storage and transmission of patient information that minimize the likelihood of data becoming available to unauthorized persons or organizations. Computerized record keeping and electronic data transmission present unique challenges that can make the maintenance of patient confidentiality difficult. PAs should advocate for policies and procedures that secure the confidentiality of patient information.

The Patient and the Medical Record

Physician assistants have an obligation to keep information in the patient's medical record confidential. Information should be released only with the written permission of the patient or the patient's legally authorized representative. Specific exceptions to this general rule may exist

(e.g., workers compensation, communicable disease, HIV, knife/gunshot wounds, abuse, and substance abuse). It is important that a PA be familiar with and understands the laws and regulations in his or her jurisdiction that relate to the release of information. For example, stringent legal restrictions on release of genetic test results and mental health records often exist.

Both ethically and legally, a patient has certain rights to know the information contained in his or her medical record. While the chart is legally the property of the practice or the institution, the information in the chart is the property of the patient. Most states have laws that provide patients access to their medical records. The PA should know the laws and facilitate patient access to the information.

Disclosure

A physician assistant should disclose to his or her supervising physician information about errors made in the course of caring for a patient. The supervising physician and PA should disclose the error to the patient if such information is significant to the patient's interests and well-being. Errors do not always constitute improper, negligent, or unethical behavior, but failure to disclose them may.

Care of Family Members and Co-workers

Treating oneself, co-workers, close friends, family members, or students whom the physician assistant supervises or teaches may be unethical or create conflicts of interest. For example, it might be ethically acceptable to treat one's own child for a case of otitis media but it probably is not acceptable to treat one's spouse for depression. PAs should be aware that their judgment might be less than objective in cases involving friends, family members, students, and

colleagues and that providing “curbside” care might sway the individual from establishing an ongoing relationship with a provider. If it becomes necessary to treat a family member or close associate, a formal patient-provider relationship should be established, and the PA should consider transferring the patient’s care to another provider as soon as it is practical. If a close associate requests care, the PA may wish to assist by helping them find an appropriate provider.

There may be exceptions to this guideline, for example, when a PA runs an employee health center or works in occupational medicine. Even in those situations, the PA should be sure they do not provide informal treatment, but provide appropriate medical care in a formally established patient-provider relationship.

Genetic Testing

Evaluating the risk of disease and performing diagnostic genetic tests raise significant ethical concerns. Physician assistants should be informed about the benefits and risks of genetic tests.

Testing should be undertaken only after proper informed consent is obtained. If PAs order or conduct the tests, they should assure that appropriate pre- and post-test counseling is provided.

PAs should be sure that patients understands the potential consequences of undergoing genetic tests − from impact on patients themselves, possible implications for other family members, and potential use of the information by insurance companies or others who might have access to the information. Because of the potential for discrimination by insurers, employers, or others, Pas should be particularly aware of the need for confidentiality concerning genetic test results.

Reproductive Decision Making

Patients have a right to access the full range of reproductive health care services. Physician assistants have an ethical obligation to provide balanced and unbiased clinical information about reproductive health care.

When the PA's personal values conflict with providing full disclosure or providing certain services, the PA need not become involved in that aspect of the patient's care. By referring the patient to a qualified provider who is willing to discuss and facilitate all treatment options, the PA fulfills their ethical obligation to ensure the patient’s access to all legal options.

End of Life

Among the ethical principles that are fundamental to providing compassionate care at the end of life, the most essential is recognizing that dying is a personal experience and part of the life cycle.

Physician Assistants should provide patients with the opportunity to plan for end of life care.

Advance directives, living wills, durable power of attorney, and organ donation should be discussed during routine patient visits.

PAs should assure terminally-ill patients that their dignity is a priority and that relief of physical and mental suffering is paramount. PAs should exhibit non-judgmental attitudes and should assure their terminally-ill patients that they will not be abandoned. To the extent possible, patient or surrogate preferences should be honored, using the most appropriate measures consistent with their choices, including alternative and non-traditional treatments. PAs should explain palliative and hospice care and facilitate patient access to those services. End of life care

should include assessment and management of psychological, social, and spiritual or religious needs.

While respecting patients' wishes for particular treatments when possible, PAs also must weigh their ethical responsibility, in consultation with supervising physicians, to withhold futile treatments and to help patients understand such medical decisions.

PAs should involve the physician in all near-death planning. The PA should only withdraw life support with the supervising physician's agreement and in accordance with the policies of the health care institution.

The PA and Individual Professionalism

Conflict of Interest

Physician assistants should place service to patients before personal material gain and should avoid undue influence on their clinical judgment. Trust can be undermined by even the appearance of improper influence. Examples of excessive or undue influence on clinical judgment can take several forms. These may include financial incentives, pharmaceutical or other industry gifts, and business arrangements involving referrals. PAs should disclose any actual or potential conflict of interest to their patients.

Acceptance of gifts, trips, hospitality, or other items is discouraged. Before accepting a gift or financial arrangement, PAs might consider the guidelines of the Royal College of Physicians, "Would I be willing to have this arrangement generally known?" or of the American College of Physicians, "What would the public or my patients think of this arrangement?"

Professional Identity

Physician assistants should not misrepresent directly or indirectly, their skills, training, professional credentials, or identity. Physician assistants should uphold the dignity of the PA profession and accept its ethical values.

Competency

Physician assistants should commit themselves to providing competent medical care and extend to each patient the full measure of their professional ability as dedicated, empathetic health care providers. PAs should also strive to maintain and increase the quality of their health care knowledge, cultural sensitivity, and cultural competence through individual study and continuing education.

Sexual Relationships

It is unethical for physician assistants to become sexually involved with patients. It also may be unethical for PAs to become sexually involved with former patients or key third parties. Key third parties are individuals who have influence over the patient. These might include spouses or partners, parents, guardians, or surrogates.

Such relationships generally are unethical because of the PA's position of authority and the inherent imbalance of knowledge, expertise, and status. Issues such as dependence, trust, transference, and inequalities of power may lead to increased vulnerability on the part of the current or former patients or key third parties.

Gender Discrimination and Sexual Harassment

It is unethical for physician assistants to engage in or condone any form of gender discrimination. Gender discrimination is defined as any behavior, action, or policy that adversely affects an individual or group of individuals due to disparate treatment, disparate impact, or the creation of a hostile or intimidating work or learning environment.

It is unethical for PAs to engage in or condone any form of sexual harassment. Sexual harassment is defined as unwelcome sexual advances, requests for sexual favors, or other verbal or physical conduct of a sexual nature when:

- Such conduct has the purpose or effect of interfering with an individual's work or academic performance or creating an intimidating, hostile or offensive work or academic environment, or
- Accepting or rejecting such conduct affects or may be perceived to affect professional decisions concerning an individual, or
- Submission to such conduct is made either explicitly or implicitly a term or condition of an individual's training or professional position.

The PA and Other Professionals

Team Practice

Physician assistants should be committed to working collegially with other members of the health care team to assure integrated, well-managed, and effective care of patients. PAs should strive to maintain a spirit of cooperation with other health care professionals, their organizations, and the general public.

Illegal and Unethical Conduct

Physician assistants should not participate in or conceal any activity that will bring discredit or dishonor to the PA profession. They should report illegal or unethical conduct by health care professionals to the appropriate authorities.

Impairment

Physician assistants have an ethical responsibility to protect patients and the public by identifying and assisting impaired colleagues. “Impaired” means being unable to practice medicine with reasonable skill and safety because of physical or mental illness, loss of motor skills, or excessive use or abuse of drugs and alcohol.

PAs should be able to recognize impairment in physician supervisors, PAs, and other health care providers and should seek assistance from appropriate resources to encourage these individuals to obtain treatment.

PA–Physician Relationship

Supervision should include ongoing communication between the physician and the physician assistant regarding patient care. The PA should consult the supervising physician whenever it will safeguard or advance the welfare of the patient. This includes seeking assistance in situations of conflict with a patient or another health care professional.

Complementary and Alternative Medicine

When a patient asks about an alternative therapy, the PA has an ethical obligation to gain a basic understanding of the alternative therapy being considered or being used and how the

treatment will affect the patient. If the treatment would harm the patient, the PA should work diligently to dissuade the patient from using it, advise other treatment, and perhaps consider transferring the patient to another provider.

The PA and the Health Care System

Workplace Actions

Physician assistants may face difficult personal decisions to withhold medical services when workplace actions (e.g., strikes, sick-outs, slowdowns, etc.) occur. The potential harm to patients should be carefully weighed against the potential improvements to working conditions and, ultimately, patient care that could result. In general, PAs should individually and collectively work to find alternatives to such actions in addressing workplace concerns.

PAs as Educators

All physician assistants have a responsibility to share knowledge and information with patients, other health professionals, students, and the public. The ethical duty to teach includes effective communication with patients so that they will have the information necessary to participate in their health care and wellness.

PAs and Research

The most important ethical principle in research is honesty. This includes assuring subjects' informed consent, following treatment protocols, and accurately reporting findings. Fraud and dishonesty in research should be reported so that the appropriate authorities can take action.

Physician assistants involved in research must be aware of potential conflicts of interest. The patient's welfare takes precedence over the desired research outcome. Any conflict of interest should be disclosed.

In scientific writing, PAs should report information honestly and accurately. Sources of funding for the research must be included in the published reports.

Plagiarism is unethical. Incorporating the words of others, both verbatim or by paraphrasing, without appropriate attribution is unethical and may have legal consequences. When submitting a document for publication, any previous publication of any portion of the document must be fully disclosed.

PAs as Expert Witnesses

The physician assistant expert witness should testify to what he or she believes to be the truth. The PA's review of medical facts should be thorough, fair, and impartial.

The PA expert witness should be fairly compensated for time spent preparing, appearing, and testifying. The PA should not accept a contingency fee based on the outcome of a case in which testimony is given or derive personal, financial, or professional favor in addition to compensation.

The PA and Society

Lawfulness

Physician assistants have the dual duty to respect the law and to work for positive change to laws that will enhance the health and well-being of the community.

Executions

Physician assistants, as health care professionals, should not participate in executions because to do so would violate the ethical principle of beneficence.

Access to Care / Resource Allocation

Physician assistants have a responsibility to use health care resources in an appropriate and efficient manner so that all patients have access to needed health care. Resource allocation should be based on societal needs and policies, not the circumstances of an individual patient–PA encounter. PAs participating in policy decisions about resource allocation should consider medical need, cost-effectiveness, efficacy, and equitable distribution of benefits and burdens in society.

Community Well Being

Physician assistants should work for the health, well-being, and the best interest of both the patient and the community. Sometimes there is a dynamic moral tension between the well-being of the community in general and the individual patient. Conflict between an individual patient's best interest and the common good is not always easily resolved. In general, PAs should be committed to upholding and enhancing community values, be aware of the needs of the community, and use the knowledge and experience acquired as professionals to contribute to an improved community.

Conclusion

The American Academy of Physician Assistants recognizes its responsibility to aid the PA profession as it strives to provide high quality, accessible health care. Physician assistants wrote these guidelines for themselves and other physician assistants. The ultimate goal is to honor patients and earn their trust while providing the best and most appropriate care possible. At the same time, PAs must understand their personal values and beliefs and recognize the ways in which those values and beliefs can impact the care they provide.

Source:

General Authority: SDCL 36-4A-42

Law implemented: SDCL 36-4A-37

Reference: American Academy of Physician Assistants Guidelines for Ethical Conduct for the Physician Assistant Profession, 2013. Copies may be obtained from https://www.aapa.org/WorkArea/DownloadAsset.aspx?id=815.

20:52:02:02. Violations. A violation of any of the ethical standards and conduct are considered unprofessional conduct as defined by SDCL 36-4A-37.

Source:

General Authority: SDCL 36-4A-42

Law implemented: SDCL 36-4A-37

20:52:02:03. Ethical considerations. The board may utilize the annotations and opinions

included in the guidelines for ethical conduct for the physician assistant profession, 2013 edition as guidance in determining whether a licensee has violated professional ethical standards and conduct.

Source:

General Authority: SDCL 36-4A-42

Law implemented: SDCL 36-4A-37

ARTICLE 20:63

ATHLETIC TRAINERS

Chapter

20:63:01 General provisions.

20:63:02 Licensure requirements.

20:63:03 Continuing education.

20:63:04 Ethics.

CHAPTER 20:63:04

ETHICS

Section

20:63:04:01 Ethics

20:63:04:02 Violations.

20:63:04:03 Ethical considerations.

20:63:04:01. Ethics. A licensee under SDCL 36-29 shall comply with the following code of ethics.

Practice Standards

Standard 1: Direction

The Athletic Trainer renders service or treatment under the direction of a physician.

Standard 2: Prevention

The Athletic Trainer understands and uses preventive measures to ensure the highest quality of care for every patient.

Standard 3: Immediate Care

The Athletic Trainer provides standard immediate care procedures used in emergency situations, independent of setting.

Standard 4: Clinical Evaluation and Diagnosis

Prior to treatment, the Athletic Trainer assesses the patient's level of function. The patient's input is considered an integral part of the initial assessment. The Athletic Trainer follows standardized clinical practice in the area of diagnostic reasoning and medical decision making.

Standard 5: Treatment, Rehabilitation and Reconditioning

In development of a treatment program, the Athletic Trainer determines appropriate treatment, rehabilitation and/ or reconditioning strategies. Treatment program objectives include long- and short-term goals and an appraisal of those which the patient can realistically be expected to achieve from the program. Assessment measures to determine effectiveness of the program are incorporated into the program.

Standard 6: Program Discontinuation

The Athletic Trainer, with collaboration of the physician, recommends discontinuation of the athletic training service when the patient has received optimal benefit of the program. The Athletic Trainer, at the time of discontinuation, notes the final assessment of the patient's status.

Standard 7: Organization and Administration

All services are documented in writing by the Athletic Trainer and are part of the patient's permanent records. The Athletic Trainer accepts responsibility for recording details of the patient's health status.

Code of Professional Responsibility

Code 1: Patient Responsibility

The Athletic Trainer or applicant:

1.1 Renders quality patient care regardless of the patient's race, religion, age, sex, nationality, disability, social/economic status or any other characteristic protected by law

1.2 Protects the patient from harm, acts always in the patient's best interests and is an advocate for the patient's welfare

1.3 Takes appropriate action to protect patients from Athletic Trainers, other healthcare providers or athletic training students who are incompetent, impaired or engaged in illegal or unethical practice

1.4 Maintains the confidentiality of patient information in accordance with applicable law

1.5 Communicates clearly and truthfully with patients and other persons involved in the patient's program, including, but not limited to, appropriate discussion of assessment results, program plans and progress

1.6 Respects and safeguards his or her relationship of trust and confidence with the patient and does not exploit his or her relationship with the patient for personal or financial gain

1.7 Exercises reasonable care, skill and judgment in all professional work

Code 2: Competency

The Athletic Trainer or applicant:

2.1 Engages in lifelong, professional and continuing educational activities

2.2 Participates in continuous quality improvement activities

2.3 Complies with the most current BOC recertification policies and requirements

Code 3: Professional Responsibility

The Athletic Trainer or applicant:

3.1 Practices in accordance with the most current BOC Practice Standards

3.2 Knows and complies with applicable local, state and/or federal rules, requirements, regulations and/or laws related to the practice of athletic training

3.3 Collaborates and cooperates with other healthcare providers involved in a patient's care

3.4 Respects the expertise and responsibility of all healthcare providers involved in a patient's care

3.5 Reports any suspected or known violation of a rule, requirement, regulation or law by him/herself and/or by another Athletic Trainer that is related to the practice of athletic training, public health, patient care or education

3.6 Reports any criminal convictions (with the exception of misdemeanor traffic offenses or traffic ordinance violations that do not involve the use of alcohol or drugs) and/or professional suspension, discipline or sanction received by him/herself or by another Athletic Trainer that is related to athletic training, public health, patient care or education

3.7 Complies with all BOC exam eligibility requirements and ensures that any information provided to the BOC in connection with any certification application is accurate and truthful

3.8 Does not, without proper authority, possess, use, copy, access, distribute or discuss certification exams, score reports, answer sheets, certificates, certificant or applicant files, documents or other materials

3.9 Is candid, responsible and truthful in making any statement to the BOC, and in making any statement in connection with athletic training to the public

3.10 Complies with all confidentiality and disclosure requirements of the BOC

3.11 Does not take any action that leads, or may lead, to the conviction, plea of guilty or plea of nolo contendere (no contest) to any felony or to a misdemeanor related to public health, patient care, athletics or education; this includes, but is not limited to: rape; sexual abuse of a child or patient; actual or threatened use of a weapon of violence; the prohibited sale or distribution of controlled substance, or its possession with the intent to distribute; or the use of the position of an Athletic Trainer to improperly influence the outcome or score of an athletic contest or event or in connection with any gambling activity

3.12 Cooperates with BOC investigations into alleged illegal or unethical activities; this includes but is not limited to, providing factual and non-misleading information and responding to requests for information in a timely fashion

3.13 Does not endorse or advertise products or services with the use of, or by reference to, the BOC name without proper authorization

Code 4: Research

The Athletic Trainer or applicant who engages in research:

4.1 Conducts research according to accepted ethical research and reporting standards established by public law, institutional procedures and/or the health professions

4.2 Protects the rights and well-being of research subjects

4.3 Conducts research activities with the goal of improving practice, education and public policy relative to the health needs of diverse populations, the health workforce, the organization and administration of health systems and healthcare delivery

Code 5: Social Responsibility

The Athletic Trainer or applicant:

5.1 Uses professional skills and knowledge to positively impact the community

Code 6: Business Practices

The Athletic Trainer or applicant:

6.1 Refrains from deceptive or fraudulent business practices

6.2 Maintains adequate and customary professional liability insurance

Source:

General Authority: SDCL 36-29-17

Law Implemented: SDCL 36-29-19

Reference: Board of Certification Standards of Professional Practice, 2006. Copies may be obtained from http://www.bocatc.org/resources/standards-of-professional-practice.

20:63:04:02. Violations. A violation of any of the ethical standards and conduct is considered unprofessional conduct as defined by SDCL 36-29-18.

Source:

General Authority: SDCL 36-29-17

Law Implemented: SDCL 36-29-19

20:63:04:03. Ethical considerations. The board may utilize the annotations and opinions included in the board of certification standards of professional conduct, 2006 as guidance in determining whether a licensee has violated professional ethical standards and conduct.

Source:

General Authority: SDCL 36-29-17

Law Implemented: SDCL 36-29-19

ARTICLE 20:64

OCCUPATIONAL THERAPISTS AND OCCUPATIONAL THERAPY ASSISTANTS

Chapter

20:64:01 Definitions.

20:64:02 Licensure requirements.

20:64:03 Supervision.

20:64:04 Continuing competency.

20:64:05 Ethics

CHAPTER 20:64:05

ETHICS

Section

20:64:05:01 Ethics

20:64:05:02 Violations

20:64:05:03 Ethical considerations

20:64:05:01. Ethics. A licensee under SDCL 36-31 shall comply with the following code of ethics.

Principle 1. Occupational therapy personnel shall demonstrate a concern for the well-being and safety of the recipients of their services.

Principle 2. Occupational therapy personnel shall intentionally refrain from actions that cause harm.

Principle 3. Occupational therapy personnel shall respect the right of the individual to self-determination.

Principle 4. Occupational therapy personnel shall provide services in a fair and equitable manner.

Principle 5. Occupational therapy personnel shall comply with institutional rules, local, state, federal, and international laws and AOTA documents applicable to the profession of occupational therapy.

Principle 6. Occupational therapy personnel shall provide comprehensive, accurate, and objective information when representing the profession.

Principle 7. Occupational therapy personnel shall treat colleagues and other professionals with respect, fairness, discretion, and integrity.

Source:

General Authority: SDCL 36-31-13

Law implemented: SDCL 36-31-14

Reference: American Occupational Therapy Association Occupational Therapy Code of Ethics and Standards, 2010. Copies may be obtained from https://www.aota.org/-/media/Corporate/Files/AboutAOTA/OfficialDocs/Ethics/Code%20and%20Ethics%20Standards%202010.pdf.

20:64:05:02. Violations. A violation of any of the ethical standards and conduct is considered unprofessional conduct as defined by SDCL 36-31-14.

Source:

General Authority: SDCL 36-31-13

Law Implemented: SDCL 36-31-14

20:64:05:03. Ethical considerations. The board may utilize the American Occupational Therapy Association Occupational Therapy Code of Ethics and Standards, 2010 edition as guidance in determining whether a licensee has violated professional ethical standards and conduct.

Source:

General Authority: SDCL 36-31-13

Law Implemented: SDCL 36-31-14

ARTICLE 20:66

PHYSICAL THERAPISTS AND PHYSICAL THERAPIST ASSISTANTS

Chapter

20:66:01 Fees.

20:66:02 Ethics.

CHAPTER 20:66:02

ETHICS

Section

20:66:02:01 Code of ethics.

20:66:02:02 Violations.

20:66:02:03 Ethical considerations.

20:66:02:01. Ethics. A licensee under SDCL 36-10 shall comply with the following code of ethics.

Principle #1: Physical therapists shall respect the inherent dignity and rights of all individuals.

1A. Physical therapists shall act in a respectful manner toward each person regardless of age, gender, race, nationality, religion, ethnicity, social or economic status, sexual orientation, health condition, or disability.

1B. Physical therapists shall recognize their personal biases and shall not discriminate against others in physical therapist practice, consultation, education, research, and administration.

Principle #2: Physical therapists shall be trustworthy and compassionate in addressing the rights and needs of patients/clients.

2A. Physical therapists shall adhere to the core values of the profession and shall act in the best interests of patients/clients over the interests of the physical therapist.

2B. Physical therapists shall provide physical therapy services with compassionate and caring behaviors that incorporate the individual and cultural differences of patients/clients.

2C. Physical therapists shall provide the information necessary to allow patients or their surrogates to make informed decisions about physical therapy care or participation in clinical research.

2D. Physical therapists shall collaborate with patients/clients to empower them in decisions about their health care.

2E. Physical therapists shall protect confidential patient/ client information and may disclose confidential information to appropriate authorities only when allowed or as required by law.

Principle #3: Physical therapists shall be accountable for making sound professional judgments.

3A. Physical therapists shall demonstrate independent and objective professional judgment in the patient's/clients best interest in all practice settings.

3B. Physical therapists shall demonstrate professional judgment informed by professional standards, evidence (including current literature and established best practice), practitioner experience, and patient/client values.

3C. Physical therapists shall make judgments within their scope of practice and level of expertise and shall communicate with, collaborate with, or refer to peers or other health care professionals when necessary.

3D. Physical therapists shall not engage in conflicts of interest that interfere with professional judgment.

3E. Physical therapists shall provide appropriate direction of and communication with physical therapist assistants and support personnel.

Principle #4: Physical therapists shall demonstrate integrity in their relationships with patients/clients, families, colleagues, students, research participants, other health care providers, employers, payers, and the public.

4A. Physical therapists shall provide truthful, accurate, and relevant information and shall not make misleading representations.

4B. Physical therapists shall not exploit persons over whom they have supervisory, evaluative or other authority (e.g., patients/clients, students, supervisees, research participants, or employees).

4C. Physical therapists shall discourage misconduct by health care professionals and report illegal or unethical acts to the relevant authority, when appropriate.

4D. Physical therapists shall report suspected cases of abuse involving children or vulnerable adults to the appropriate authority, subject to law.

4E. Physical therapists shall not engage in any sexual relationship with any of their patients/clients, supervisees, or students.

4F. Physical therapists shall not harass anyone verbally, physically, emotionally, or

sexually.

Principle #5: Physical therapists shall fulfill their legal and professional obligations.

5A. Physical therapists shall comply with applicable local, state, and federal laws and regulations.

5B. Physical therapists shall have primary responsibility for supervision of physical therapist assistants and support personnel.

5C. Physical therapists involved in research shall abide by accepted standards governing protection of research participants.

5D. Physical therapists shall encourage colleagues with physical, psychological, or substance-related impairments that may adversely impact their professional responsibilities to seek assistance or counsel.

5E. Physical therapists who have knowledge that a colleague is unable to perform their professional responsibilities with reasonable skill and safety shall report this information to the appropriate authority.

5F. Physical therapists shall provide notice and information about alternatives for obtaining care in the event the physical therapist terminates the provider relationship while the patient/client continues to need physical therapy services.

Principle #6: Physical therapists shall enhance their expertise through the lifelong acquisition and refinement of knowledge, skills, abilities, and professional behaviors.

6A. Physical therapists shall achieve and maintain professional competence.

6B. Physical therapists shall take responsibility for their professional development based

on critical self-assessment and reflection on changes in physical therapist practice, education, health care delivery, and technology.

6C. Physical therapists shall evaluate the strength of evidence and applicability of content presented during professional development activities before integrating the content or techniques into practice.

6D. Physical therapists shall cultivate practice environments that support professional development, lifelong learning, and excellence.

Principle #7: Physical therapists shall promote organizational behaviors and business practices that benefit patients/clients and society.

7A. Physical therapists shall promote practice environments that support autonomous and accountable professional judgments.

7B. Physical therapists shall seek remuneration as is deserved and reasonable for physical therapist services.

7C. Physical therapists shall not accept gifts or other considerations that influence or give an appearance of influencing their professional judgment.

7D. Physical therapists shall fully disclose any financial interest they have in products or services that they recommend to patients/clients.

7E. Physical therapists shall be aware of charges and shall ensure that documentation and coding for physical therapy services accurately reflect the nature and extent of the services provided.

7F. Physical therapists shall refrain from employment arrangements, or other arrangements, that prevent physical therapists from fulfilling professional obligations to

patients/ clients.

Principle #8: Physical therapists shall participate in efforts to meet the health needs of people locally, nationally, or globally.

8A. Physical therapists shall provide pro bono physical therapy services or support organizations that meet the health needs of people who are economically disadvantaged, uninsured, and underinsured.

8B. Physical therapists shall advocate reducing health disparities and health care inequities, improve access to health care services, and address the health, wellness, and preventive health care needs of people.

8C. Physical therapists shall be responsible stewards of health care resources and shall avoid overutilization or underutilization of physical therapy services.

8D. Physical therapists shall educate members of the public about the benefits of physical therapy and the unique role of the physical therapist.

Source:

General Authority: SDCL 36-10-36

Law Implemented: SDCL 36-10-39; 36-10-40

Reference: Code of Ethics of the American Physical Therapy Association, 2010. Copies may be obtained from http://www.apta.org/uploadedFiles/APTAorg/About_Us/Policies/Ethics/CodeofEthics.pdf .

20:66:02:02. Violations. A violation of any of the ethical standards and conduct is considered unprofessional conduct as defined by SDCL 36-10-40

Source:

General Authority: SDCL 36-10-36

Law Implemented: SDCL 36-10-39; 36-10-40

20:66:02:02. Ethical considerations. The board may utilize the annotations and opinions included in the Code of Ethics of the American Physical Therapy Association as guidance in determining whether a licensee has violated professional ethical standards and conduct.

Source:

General Authority: SDCL 36-10-36

Law Implemented: SDCL 36-10-39; 36-10-40

ARTICLE 20:70

RESPIRATORY CARE PRACTITIONERS

Chapter

20:70:01 Fees.

20:70:02 Continuing education.

20:70:03 Ethics/

CHAPTER 20:70:03

ETHICS

Section

20:70:03:01 Ethics.

20:70:03:02. Violations.

20:70:03:03. Ethical considerations.

20:70:03:01. Ethics. A licensee under SDCL 36-4C shall comply with the following code of ethics.

- Demonstrate behavior that reflects integrity, supports objectivity, and fosters trust in the profession and its professionals.
- Seek educational opportunities to improve and maintain their professional competence and document their participation accurately.
- Perform only those procedures or functions in which they are individually competent and which are within their scope of accepted and responsible practice.

- Respect and protect the legal and personal rights of patients, including the right to privacy, informed consent and refusal of treatment.
- Divulge no protected information regarding any patient or family unless disclosure is required for the responsible performance of duty authorized by the patient and/or family, or required by law.
- Provide care without discrimination on any basis, with respect for the rights and dignity of all individuals.
- Promote disease prevention and wellness.
- Refuse to participate in illegal or unethical acts.
- Refuse to conceal, and will report, the illegal, unethical, fraudulent, or incompetent acts of others.
- Follow sound scientific procedures and ethical principles in research.
- Comply with state or federal laws which govern and relate to their practice.
- Avoid any form of conduct that is fraudulent or creates a conflict of interest, and shall follow the principles of ethical business behavior.
- Promote health care delivery through improvement of the access, efficacy, and cost of patient care.
- Encourage and promote appropriate stewardship of resources.

Source:

General Authority: SDCL 36-4C-14

Law Implemented: SDCL 36-4C-18; 36-4C-15

Reference: Statement of Ethics and Professional Conduct of the American Association for Respiratory Care, 2012. Copies may be obtained from http://c.aarc.org/resources/position_statements/documents/AARCStatementofEthicsandProfessionalConduct.pdf.

20:70:03:02. Violations. A violation of any of the ethical standards and conduct is considered unprofessional conduct as defined by SDCL 36-4C-15.

Source:

General Authority: SDCL 36-4C-14

Law Implemented: SDCL 36-4C-18; 36-4C-15

20:70:03:03. Ethical considerations. The board may utilize the annotations and opinions included in the Statement of Ethics and Professional Conduct of the American Association for Respiratory Care as guidance in determining whether a licensee has violated professional ethical standards and conduct.

Source:

General Authority: SDCL 36-4C-14

Law Implemented: SDCL 36-4C-18; 36-4C-15

CHAPTER 20:78:05

CONTESTED CASE HEARING PROCEDURES

Section

20:78:05:01 Applicability.

20:78:05:02 Petitions for hearing.

20:78:05:03 Filing of petitions for hearing.

20:78:05:04 Scheduling of hearing.

20:78:05:05 Hearing procedure.

20:78:05:06 Final board decision.

20:78:05:07 Notice of decision.

20:78:05:08 Assessment of costs of disciplinary hearings.

20:78:05:09 Board member conflict of interest.

20:78:05:10 Board member potential conflict of interest.

20:78:05:09. Board member conflict of interest. A board member: who is personally related to a party involved in a contested case proceeding or disciplinary action by two degrees of consanguinity; or who has a direct financial interest in a party involved in a contested case proceeding or disciplinary action through employment or by contract; or who directly supervises and is responsible for peer review of a party involved in a contested case proceeding or disciplinary action; or whose spouse is employed by or directly contracts with a party involved in a contested case proceeding or disciplinary action; may not participate in the proceeding or action concerning that party. The member shall make an oral statement of recusal on the record at the initiation of the hearing. A recused member may not participate in board discussions or decision-making

regarding that contested case proceeding or disciplinary action.

Source:

General Authority: SDCL 36-4-35, 36-4A-42, 36-4B-35, 36-10-36, 36-10B-3, 36-29-17, 36-31-13, 36-36-12.

Law Implemented: SDCL 36-4-27, 36-4-28, 36-4-29, 36-4-30, 36-4-32, 36-4A-37, 36-4A-38, 36-4A-39, 36-4A-40, 36-4B-28, 36-4B-31, 36-4B-32, 36-4B-33, 36-10-38, 36-10-39, 39-10-40, 36-10-41, 36-10-44, 36-10-45, 36-10-46, 36-10-49, 36-10B-13, 36-10B-14, 36-29-18, 36-29-19, 36-29-20, 36-29-21, 36-29-22, 36-29-25, 36-29-26,36-29-27, 36-31-14, 36-31-15, 36-31-16, 36-31-17, 36-31-18, 36-31-21, 36-31-22, 36-36-6, 36-36-13.

20:78:05:10. Board member potential conflicts of interests. A potential conflict of interest is an indirect financial interest, or a personal relationship or another interest in a party involved in a contested case proceeding or disciplinary action that is different from that of the general public, that a reasonable person would believe might result in bias or prejudgment. Board members shall disclose any potential conflict of interest in a contested case proceeding or disciplinary action on the record at the initiation of the hearing, or during the hearing if they become aware of the existence of a potential conflict of interest at that time. Upon its own motion or the motion of a party, and considering the rule of necessity should maintenance of a quorum be an issue, the board may recuse a member with a potential conflict of interest if it determines that the potential conflict of interest raises an unacceptable risk of bias or prejudgment in the contested case proceeding or disciplinary action.

Source:

General Authority: SDCL 36-4-35, 36-4A-42, 36-4B-35, 36-10-36, 36-10B-3, 36-29-17,

36-31-13, 36-36-12.

Law Implemented: SDCL 36-4-27, 36-4-28, 36-4-29, 36-4-30, 36-4-32, 36-4A-37, 36-4A-38, 36-4A-39, 36-4A-40, 36-4B-28, 36-4B-31, 36-4B-32, 36-4B-33, 36-10-38, 36-10-39, 39-10-40, 36-10-41, 36-10-44, 36-10-45, 36-10-46, 36-10-49, 36-10B-13, 36-10B-14, 36-29-18, 36-29-19, 36-29-20, 36-29-21, 36-29-22, 36-29-25, 36-29-26, 36-29-27, 36-31-14, 36-31-15, 36-31-16, 36-31-17, 36-31-18, 36-31-21, 36-31-22, 36-36-6, 36-36-13.

ARTICLE 20:82

GENETIC COUNSELORS

Chapter

20:82:01 Definitions

20:82:02 Licensure Requirements

20:82:03 Ethics

CHAPTER 20:82:01

DEFINITIONS

Section

20:82:01:01 Definitions.

20:82:01:01. Definitions. Words defined in SDCL 36-36-1 have the same meaning when used in this article.

Source:

General Authority: SDCL 36-36-12

Law Implemented: SDCL 36-36-1; 36-36-2; 36-36-3

CHAPTER 20:82:02

LICENSURE REQUIREMENTS

Section

20:82:02:01 Fees.

20:82:02:01. Fees. The following fees for licensure as a genetic counselor shall be charged:

(1) An applicant applying for the initial license shall pay a fee of $200;

(2) An applicant for renewal of a license shall pay a fee of $100;

(3) An applicant for a temporary license shall pay a fee of $100.

Source:

General Authority: SDCL 36-36-12

Law Implemented: SDCL 36-36-5, 36-36-11, 36-36-9

CHAPTER 20:82:03

ETHICS

Section

20:82:03:01 Ethics.

20:82:03:02 Violations.

20:82:03:03 Ethical considerations.

20:82:03:01. Ethics. All licensees under SDCL 36-36 shall comply with the following code of ethics.

Section I: Genetic Counselors Themselves

Genetic counselors value competence, integrity, veracity, dignity, and self-respect in themselves as well as in each other. Therefore, in order to be the best possible human resource to themselves, their clients, their colleagues, and society, genetic counselors strive to:

1. Seek out and acquire sufficient and relevant information required for any given situation.
2. Continue their education and training.
3. Keep abreast of current standards of practice.

4. Recognize the limits of their own knowledge, expertise, and therefore competence in any given situation.
5. Accurately represent their experience, competence and credentials, including training and academic degrees.
6. Acknowledge and disclose circumstances that may result in a real or perceived conflict of interest.
7. Avoid relationships and activities that interfere with professional judgment or objectivity.
8. Be responsible for their own physical and emotional health as it impacts on their professional performance

Section II: Genetic Counselors and Their Clients

The counselor-client relationship is based on values of care and respect for the client's autonomy, individuality, welfare, and freedom. The primary concern of genetic counselors is the interests of their clients. Therefore, genetic counselors strive to:

1. Serve those who seek services regardless of personal or external interests or biases.
2. Clarify and define their professional role(s) and relationships with clients, and provide an accurate description of their services.
3. Respect their clients' beliefs, inclinations, circumstances, feelings, family relationships and cultural traditions.
4. Enable their clients to make informed decisions, free of coercion, by providing or illuminating the necessary facts, and clarifying the alternatives and anticipated consequences.
5. Refer clients to other qualified professionals when they are unable to support the clients.
6. Maintain information received from clients as confidential, unless released by the client or

disclosure is required by law.

7. Avoid the exploitation of their clients for personal advantage, profit, or interest.

Section III: Genetic Counselors and Their Colleagues

The genetic counselors' relationships with other genetic counselors, students, and other health professionals are based on mutual respect, caring, cooperation, and support. Therefore, genetic counselors strive to:

1. Share their knowledge and provide mentorship and guidance for the professional development of other genetic counselors, students and colleagues.
2. Respect and value the knowledge, perspectives, contributions, and areas of competence of colleagues and students, and collaborate with them in providing the highest quality of service.
3. Encourage ethical behavior of colleagues.
4. Assure that individuals under their supervision undertake responsibilities that are commensurate with their knowledge, experience and training.
5. Maintain appropriate limits to avoid the potential for exploitation in their relationships with students and colleagues.

Section IV: Genetic Counselors and Society

The relationships of genetic counselors with society include interest and participation in activities that have the purpose of promoting the well-being of society and access to health care. Therefore, genetic counselors, individually or through their professional organizations, strive to:

1. Keep abreast of societal developments that may endanger the physical and psychological health of individuals.

2. Promote policies that aim to prevent discrimination.
3. Oppose the use of genetic information as the basis for discrimination.
4. Participate in activities necessary to bring about socially responsible change.
5. Serve as a source of reliable information and expert opinion for policymakers and public officials.
6. Keep the public informed and educated about the impact on society of new technological and scientific advances and the possible changes in society that may result from the application of these findings.
7. Support policies that assure ethically responsible research.
8. Adhere to laws and regulations of society. However, when such laws are in conflict with the principles of the profession, genetic counselors work toward change that will benefit the public interest.

Source:

General Authority: SDCL 36-36-12

Law Implemented: SDCL 36-36-13

Reference: Code of Ethics of the National Society of Genetic Counselors, 2006. Copies may be obtained from http://nsgc.org/p/cm/ld/fid=12.

20:82:03:02. Violations. A violation of any of the ethical standards and conduct is considered unprofessional conduct as defined by SDCL 36-36-13.

Source:

General Authority: SDCL 36-36-12

Law Implemented: SDCL 36-36-13

20:82:03:03. Ethical considerations. The board may utilize the annotations and opinions included in the code of ethics of the national society of genetic counselors, 2006 as guidance in determining whether a licensee has violated professional ethical standards and conduct.

Source:

General Authority: SDCL 36-36-12

Law Implemented: SDCL 36-36-13

ARTICLE 20:83

NUTRITION AND DIETETICS

Chapter

20:83:01 Definitions.

20:83:02 Licensure requirements.

20:83:03 Ethics.

CHAPTER 20:83:01

DEFINITIONS

Section

20:83:01:01 Definitions.

20:83:01:01. Definitions. Words defined in SDCL 36-10B-1 have the same meaning when used in this article.

Source:

General Authority: SDCL 36-10B-3

Law Implemented: SDCL 36-10B-1

CHAPTER 20:83:02

LICENSURE REQUIREMENTS

Section

20:83:02:01 Fees for licensure or renewal.

20:83:02:01. Fees for licensure or renewal. The following fees for licensure as a licensed nutritionist shall be charged:

(1) An applicant applying for the initial license shall pay a fee of $75;

(2) An applicant for renewal of license shall pay a fee of $35;

(3) An applicant for late renewal of a license shall pay a fee of $100;

(4) An applicant for a temporary permit shall pay a fee of $50.

Source:

General Authority: 36-10B-3

Law Implemented: 36-10B-8

CHAPTER 20:83:03

ETHICS

Section

20:83:03:01 Code of ethics.

20:83:03:02 Violations.

20:83:03:03 Ethical considerations.

20:83:03:01. Code of ethics. A licensee under SDCL 36-10B shall comply with the following code of ethics.

Principles

1. The practitioner conducts himself/herself with honesty, integrity, and fairness.
2. The practitioner supports and promotes high standards of professional practice. The practitioner accepts the obligation to protect clients, the public, and the profession by

upholding the Code of Ethics for the Profession of Dietetics and by reporting perceived violations of the Code through the processes established by the American Dietetic Association (ADA) and its credentialing agency, the Commission on Dietetic Registration (CDR).

3. The practitioner considers the health, safety, and welfare of the public at all times. The practitioner will report inappropriate behavior or treatment of a client by another dietetics practitioner or other professionals.
4. The practitioner complies with all laws and regulations applicable or related to the profession or to the practitioner's ethical obligations as described in this Code.
    a. The practitioner must not be convicted of a crime under the laws of the United States, whether a felony or a misdemeanor, an essential element of which is dishonesty.
    b. The practitioner must not be disciplined by a state for conduct that would violate one or more these principles
    c. The practitioner must not commit an act of misfeasance of malfeasance that is directly related to the practice of the profession as determined by a court of competent jurisdiction, a licensing board, or an agency of a governmental body.
5. The practitioner provides professional services with objectivity and with respect for the unique needs and values of individuals.
    a. The practitioner does not, in professional practice, discriminate against others on the basis of race, ethnicity, creed, religion, disability, gender, age, gender identity, sexual orientation, national origin, economic status, or any other legally protected category.
    b. The practitioner provides services in a manner that is sensitive to cultural differences.
    c. The practitioner does not engage in sexual harassment in connection with

professional practice

6. The practitioner does not engage in false or misleading practices or communications.
    a. The practitioner does not engage in false or deceptive advertising of his or her services.
    b. The practitioner promotes or endorses specific goods or products only in a manner that is not false and misleading.
    c. The practitioner provides accurate and truthful information in communicating with the public.
7. The practitioner withdraws from professional practice when unable to fulfill his or her professional duties and responsibilities to clients and others.
    a. The practitioner withdraws from practice when he/ she has engaged in abuse of a substance such that it could affect his or her practice.
    b. The practitioner ceases practice when he or she has been adjudged by a court to be mentally incompetent.
    c. The practitioner will not engage in practice when he or she has a condition that substantially impairs his or her ability to provide effective service to others.
8. The practitioner recognizes and exercises professional judgment within the limits of his or her qualifications and collaborates with others, seeks counsel, or makes referrals as appropriate.
9. The practitioner treats clients and patients with respect and consideration.
    a. The practitioner provides sufficient information to enable clients and others to make their own informed decisions.
    b. The practitioner respects the client's right to make decisions regarding the recommended plan of care, including consent, modification, or refusal.

10. The practitioner protects confidential information and makes full disclosure about any limitations on his or her ability to guarantee full confidentiality.
11. The practitioner, in dealing with and providing services to clients and others, complies with the same principles set forth above in Principles #3-7.
12. The practitioner practices dietetics based on evidence-based principles and current information.
13. The practitioner presents reliable and substantiated information and interprets controversial information without personal bias, recognizing that legitimate differences of opinion exist.
14. The practitioner assumes a life-long responsibility and accountability for personal competence in practice, consistent with accepted professional standards, continually striving to increase professional knowledge and skills and to apply them in practice.
15. The practitioner is alert to the occurrence of a real or potential conflict of interest and takes appropriate action whenever a conflict arises.
    a. The practitioner makes full disclosure of any real or perceived conflict of interest.
    b. When a conflict of interest cannot be resolved by disclosure, the practitioner takes such other action as may be necessary to eliminate the conflict, including recusal from an office, position, or practice situation.
16. The practitioner permits the use of his or her name for the purpose of certifying that services have been rendered only if he or she has provided or supervised the provision of those services.
17. The practitioner accurately presents professional qualifications and credentials.
    a. The practitioner, in seeking, maintaining, and using credentials provided by CDR, provides accurate information and complies with all requirements imposed by CDR. The dietetics practitioner uses CDR-awarded credentials ("RD" or "Registered

Dietitian"; "DTR" or "Dietetic Technician, Registered"; "CS" or "Certified Specialist"; and "FADA" or "Fellow of the American Dietetic Association") only when the credential is current and authorized by the CDR.

b. The practitioner does not aid any other person in violating any CDR requirements, or in representing himself or herself as CDR-credentialed when he or she is not.

18. The practitioner does not invite, accept, or offer gifts, monetary incentives, or other considerations that affect or reasonably give an appearance of affecting his/her professional judgment.

Clarification of Principle:

a. Whether a gift, incentive, or other item of consideration shall be viewed to affect, or give the appearance of affecting, a dietetics practitioner's professional judgment is dependent on all factors relating to the transaction, including the amount or value of the consideration, the likelihood that the practitioner's judgment will or is intended to be affected, the position held by the practitioner, and whether the consideration is offered or generally available to persons other than the practitioner.

b. It shall not be a violation of this principle for a practitioner to accept compensation as a consultant or employee or as part of a research grant or corporate sponsorship program, provided the relationship is openly disclosed and the practitioner acts with integrity in performing the services or responsibilities.

c. This principle shall not preclude a dietetics practitioner from accepting gifts of nominal value, attendance at educational programs, meals in connection with educational exchanges of information, free samples of products, or similar items, as long as such items are not offered in exchange for or with the expectation of, and do

not result in, conduct or services that are contrary to the practitioner's professional judgment.

d. The test for appearance of impropriety is whether the conduct would create in reasonable minds a perception that the dietetics practitioner's ability to carry out professional responsibilities with integrity, impartiality, and competence is impaired.

19. The practitioner demonstrates respect for the values, rights, knowledge, and skills of colleagues and other professionals.

    a. The practitioner does not engage in dishonest, misleading, or inappropriate business practices that demonstrate a disregard for the rights or interests of others.

    b. The practitioner provides objective evaluations of performance for employees and coworkers, candidates for employment, students, professional association memberships, awards, or scholarships, making all reasonable efforts to avoid bias in the professional evaluation of others.

Source:

General Authority: SDCL 36-10B-3

Law Implemented: SDCL 36-10B-13

Reference: American Dietetic Association Commission on Dietetic Registration Code of Ethics for the Profession of Dietetics and Process for Consideration of Ethics Issues, 2009. Copies may be obtained from http://www.eatrightpro.org/~/media/eatrightpro%20files/career/code%20of%20ethics/coe.ashx.

20:83:03:02. Violations. A violation of any of the ethical standards is considered unprofessional conduct as defined by SDCL 36-10B-13.

Source:

General Authority: SDCL 36-10B-3

Law Implemented: SDCL 36-10B-13

20:83:03:03. Ethical considerations. The board may utilize the American Dietetic Association Commission on Dietetic Registration Code of Ethics for the Profession of Dietetics and Process for Consideration of Ethics Issues, 2009 as guidance in determining whether a licensee has violated professional ethical standards and conduct.

Source:

General Authority: SDCL 36-10B-3

Law Implemented: SDCL 36-10B-13

From: Michael Puumala
To: SDBMOE
Subject: Comment on Best Practices proposal for 3/11/15
Date: Monday, March 09, 2015 9:12:22 AM

March 9th , 2015

To the SD Board of Medical and Osteopathic Examiners;

I am concerned about the proposed regulation concerning the Best Practice for the use of controlled substances for pain control. The reference for the proposal is taken from a protocol for treatment of chronic pain. Unfortunately, the proposal does not use the word chronic. It would therefore be applied to the treatment of pain in any situation. Thus a signed treatment plan etc. would be needed for the prescription of one narcotic pain pill. This would affect the emergency room, most clinics, and hospitals. As written, proposal would also apply to any narcotic given during anesthesia for surgery. As written, the proposal would also apply to administration of local anesthetic used for repairing lacerations, or even for an IV start.

While I realize that in the definition of Best Practices it is noted that the proposal would not apply to every situation, it is my belief that the proposal as written would not apply to most situations. It would seem counterproductive to have this on the books given this lack of usefulness.

It would seem that the proposal was written for treatment of chronic pain. I would suggest that either the proposal should be clearly identified as being for the treatment of chronic pain, or the proposal should be written in a way that that better reflexes the treatment of pain in the non-chronic situation.

Sincerely,

Michael Puumala MD FAASN FACS

Avera
McKennan Hospital
& University Health Center

1325 S. Cliff Ave.
P.O. Box 5045
Sioux Falls, SD 57117-5045
605-322-8000

AveraMcKennan.org

March 2, 2015

South Dakota Board of Medical and Osteopathic Examiners
101 N. Main Avenue Suite 301
Sioux Falls, SD 57104

Dear SDBMOE:

I am writing this letter in response to your public hearing notice for Proposed Administrative Rules. I read with interest Chapter 20:47:07 Physician Best Practices for the Prescription of Controlled Substances for the Treatment of Pain and Best Practices for Medical Records when Prescribing Controlled Substances for the Treatment of Pain. In general, I applaud your efforts to encourage best practices and developing standardized procedures for prescribing Opioid related analgesics for pain. I do however have a couple of concerns regarding the wording of this chapter that I would like to bring to your attention.

First, I think the wording is quite broad and could create multiple challenges particularly if it is applied to non-opioid containing narcotics such as a substance like valium. Likewise with the broad generic nature of this chapter, I do not believe that it applies well at all to the inpatient prescribing of opioid and non-opioid containing analgesics and other controlled substances. Therefore, I would highly recommend that verbage be included in this chapter to make it clear that it was pertaining to the outpatient prescribing of narcotics. Additionally, the implementation of these best practices could be somewhat challenging given our current electronic medical record environment. I would hope that the folks trying to pass these best practice recommendations would be cognizant of that and allow clinics the adequate time to develop EMR templates and other workflow mechanisms to meet the requirements of these best practices.

Again, I applaud the Board of Medical and Osteopathic Examiners efforts to improve the practices around the prescribing of opioid containing analgesics for pain control and hope that you would take my comments into consideration when drafting the final recommendations.

Please do not hesitate to reach out to me should you have any questions or concerns.

Sincerely,

M. Elliott, MD

Mike Elliott, MD
Senior Vice President Medical Affairs/CMO

ME/bkd

Avera
McKennan Hospital
& University Health Center

1325 S. Cliff Ave.
PO Box 5045
Sioux Falls, SD 57117-5045

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South Dakota Board Of Medical & Osteopathic Examiners
101 N Main Ave Ste 301
Sioux Falls, SD 57104-6411

RE: Proposed Rules – ARSD Ch. 20:47:07 and 20:47:08

Dear Board Members:

I am writing in my capacity as President of the South Dakota State Medical Association ("SDSMA"). SDSMA is a professional organization of more than 2,000 physicians, residents and medical students, all of whom are dedicated to protecting the health care interests of patients and advancing the effectiveness of physicians throughout South Dakota.

This is intended as SDSMA's written testimony on the proposed rules described below. SDSMA respectfully reserves the right to appear and provide additional live testimony at the March 11, 2015 rules hearing.

While SDSMA greatly appreciates the efforts of the Board and its staff to provide guidance on the complex issues described in the proposed "Best Practices" rules, SDSMA believes the proposed rules are so generalized and vague that they are much more likely to result in unintended consequences and confusion than provide useful guidance.

SDSMA's concerns, presented in the same order as the rules themselves, are as follows:

<u>Proposed ARSD 20:47:07:01 – "Best practices defined."</u>

While this proposed rule first states that failure to comply is not a grounds for disciplinary action, it goes on to provide that a physician may be called upon to "justify" a failure to comply. The proposed rule also provides that compliance with established best practices constitutes a defense to a disciplinary action.

SDSMA believes these seemingly contradictory statements of policy will lead to confusion and cause physicians to believe they are required to comply with the generalized "best practices" established in the rules even if the physician's well-reasoned medical judgment calls for a different approach.

Furthermore, SDSMA objects to proposed ARSD 20:47:07:01 and the adoption of best practices generally as being inconsistent with AMA policy concerning the adoption of health care standards (see policy H-450.935 - Health Care Standards), and in particular subpart 2 of that policy, wherein the AMA

> supports the position that any practice guidelines, parameters, best practices models, or similar set of principles or clinical recommendations, whether developed or issued by government or non-government organizations, including those that result from any comparative effectiveness research or evidence-based medicine system, do not, and should expressly state that they do not, establish standard of care or create specific requirements for physicians that restrict the exercise of their clinical judgment.

<u>Proposed ARSD 20:47:07:02 - "Best practices for the prescription of controlled substances for the treatment of pain."</u>

Proposed rule 20:47:07:02 includes several provisions which give rise to SDSMA's concern that the proposal is too generalized and vague:

1. The proposed regulation makes no distinction between different types of pain – whether acute, chronic, related to a terminal illness, or other. As the Board is aware, the best course of treatment often depends on the type of pain being experienced by the patient.

2. The proposal – in steps one through nine – suggests that these steps must be followed in the order set out in the proposed rule, both in terms of "process" and "procedure." Depending on the clinical indication, many of these "process" points make little objective or clinical sense. For example, it appears that an acute care situation (e.g., a broken arm) would require both a signed patient agreement and a trial of opioid therapy, neither of which would be indicated under the existing standard of care.

3. The following considerations and questions further demonstrate why the proposed rule should be withdrawn given its vagueness:

- For subpart 1, how many acute situations (or terminal ones) truly require a differential diagnosis?

- For subpart 2, for example, is a hospice patient's risk of substance use disorder relevant?
- For subpart 3, what form would "informed consent" take? Again, shouldn't there be different considerations depending on the diagnosis and type of pain?
- For subpart 4, while this may make sense for long-term opioid therapy for chronic pain, it likely does not make sense for acute or terminal conditions.
- For subpart 5, even for chronic pain, is this the appropriate focus? Depending on the condition, some patients may be able to have function "restored," but that may not be the goal.
- For subpart 6, this is probably fine for long-term, chronic opioid-related therapy, but not for other pain treatment scenarios.
- For subpart 7, depending on the patient, this level of oversight may not be necessary, and it may lead to some patients not being able to obtain care. Similarly, this requirement should not apply to acute or terminal conditions.

Proposed ARSD 20:47:07:03[1] – "Best practices for medical records when prescribing controlled substances for the control of pain."

The concept of maintaining accurate and complete medical records of course makes sense, but as with proposed 20:47:07:02, this proposal appears to SDSMA to be overly broad and vague. For example, "pain" may not be the primary diagnosis; "cancer", "broken bone", "fibromyalgia", or some other condition might be the primary reason for treatment. Do the same record-keeping requirements apply when there is a primary diagnosis other than "pain?"

Proposed ARSD 20:47:07:03(1) includes cross-references to proposed ARSD 20:47:07:02(4) and (6)[2]; those provisions of proposed 20:47:07:02 are problematic for the reasons described above.

The proposed rule states that each of the numbered subsections must be addressed. Does that mean that risk assessments are necessary for every condition? For chronic, long-term opioid therapy, many of the listed items might make sense, but again the proposal seems to be overbroad and as a result would interfere with the practitioner's well-reasoned professional judgment.

---

[1] The proposed rule is numbered 20:47:07:02; SDSMA assumes it was intended to be numbered 20:47:07:03.

[2] The proposed rule cross-references to 20:47:07:01, but SDSMA assumes it was intended to be a cross-reference to 20:47:07:02.

General Comments Concerning Proposed Best Practices Rules

In addition to SDSMA's substantive issues about the rules themselves, SDSMA has equally-important concerns about the concept of codifying "best practices" in administrative rules. First, as noted above, inserting generalized "best practices" into rules unduly interferes with the physician-patient relationship because the physician may not feel free to craft a treatment plan that is at odds with the codified "best practices," but is best for the patient.

Second, putting "best practices" in rule means further rule-making or legislation would be required to modify those "best practices" as medicine evolves. As a result, the advance of medicine will be slowed. If the Board elects to proceed with the adoption of "best practices" as proposed, which SDSMA opposes, SDSMA joins with the AMA in urging the Board to "set and make publicly available a regular schedule for review and update and to include the level of evidence supporting the guidelines." AMA Policy H-450.935.

Third, our research and that of the AMA indicates that since the FSMB began promoting the new guidelines in July 2013, only 10 states have adopted a version of them. SDSMA respectfully submits that this lack of adoption of the guidelines is an indication of a lack of professional consensus as to the substance of the proposed guidelines.

Finally, I have enclosed a copy of the full American Medical Association policy on the adoption of best practices and similar policy statements, as well as a letter from the AMA dated March 4, 2015 which expresses many of the same concerns about the substance of the proposed rules and the practice of incorporating best practices into administrative rule.

Proposed ARSD Ch. 20:47:08 – Ethics.

As to the proposed adoption of the AMA's model rules of ethics for physicians, SDSMA supports and applauds the Board's effort so to do.

Thank you for the opportunity to provide SDSMA's perspective on the proposed rules. For the reasons stated above, SDSMA strongly encourages the Board to reject proposed ARSD Ch. 20:47:07 in its entirety. SDSMA supports the adoption of proposed ARSD Ch. 20:47:08.

Sincerely,

Mary Milroy, MD, President
South Dakota State Medical Association

AMA
AMERICAN MEDICAL ASSOCIATION

JAMES L. MADARA, MD
EXECUTIVE VICE PRESIDENT, CEO

ama-assn.org
T (312) 464-5000

March 4, 2015

Mary Milroy, MD
President
South Dakota State Medical Association
2600 W. 49th Street, Suite 200
PO Box 7406
Sioux Falls, SD 57117-7406

Dear Dr. Milroy:

Per your request, the American Medical Association (AMA) has reviewed the proposed amendments to Article 20:47 of South Dakota's regulations pertaining to physicians and surgeons, and we make the following observations.

The proposed "Best practices for the prescription of controlled substances for the treatment of pain," raises several areas for concern. At a threshold level, the AMA is concerned that the proposed regulation provides overly broad, vague recommendations about how physicians are expected to treat patients with pain. The proposed regulation also provides no distinction between different types of pain – whether acute, chronic, related to a terminal illness, or other condition(s).

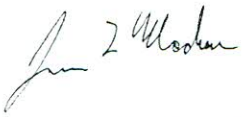
The AMA does not believe it is appropriate to establish standards of care or create specific requirements for physicians that restrict the exercise of their clinical judgment. The highly prescriptive, overly vague directions contained in the proposed regulation, however, do just that, and are not in the best interests of South Dakota's patients or the physicians who care for them.

Similarly, the proposed "Best practices for medical records when prescribing controlled substances for the treatment of pain" also lacks specificity with respect to the different needs of patients who present with different conditions. The AMA certainly supports proper documentation, but the highly prescriptive processes and procedures simply may not be appropriate or applicable in all situations and therefore should not be codified as a best practice.

The AMA has worked with federal and state policymakers in support of combating prescription drug abuse, misuse, overdose and death on many levels. We strongly support efforts to enhance education and ensure appropriate prescribing of controlled substances, including for pain. While we commend the medical board for its interest in this area, we strongly recommend that the medical board withdraw the proposed regulation for the reasons stated above

If you have any questions regarding the recommendations and comments in this letter, please contact Daniel Blaney-Koen, JD, Senior Legislative Attorney, Advocacy Resource Center, at daniel.blaney-koen@ama-assn.org or 312-464-4954.

Sincerely,



James L. Madara, MD

cc: South Dakota State Medical Association

From: Stephen G. Eckrich
To: SDBMOE
Subject: Comment on proposed rule for prescribing opioids
Date: Tuesday, February 24, 2015 5:03:03 PM

Dear SDBMOE:

As a practicing physician who prescribes opioid narcotics for the treatment of pain in the acute and post-operative setting, I am writing to oppose the proposed rule on opioid prescriptions because the rule does not differentiate between the use of opioids for the chronic treatment of pain and their use for acute and post-surgical pain. It would appear that the Board's intent was to address the use of these medications for the treatment of chronic pain, as the article referenced at the end of the rule clearly refers to chronic pain; however, there is nothing in the body of the rule which differentiates between these two, vastly different uses of narcotic pain medications. To state that in order for me to prescribe opioids post injury or post-surgery in a "best practice" manner would require that I obtain an informed consent from the patient, with an outlined treatment plan, and discussion of the alternatives, is just not realistic nor in the patient's best interest. In an acute injury scenario, it is challenge enough to impart a minimum understanding of the choices for treatment and their rationale to a patient who is already in pain, frightened, and unfamiliar with the medical system. To then add another layer of anxiety and concern over how exactly there pain will be handled is just not realistic.

If it was the Board's intent to have this rule apply only to the use of opioids to treat chronic pain, however that may be defined, then that must be clearly stated in the proposed rule. As the rule is written, it does not address these two fundamentally distinct uses of narcotics to treat pain, and should be amended to reflect that. In the absence of such an amendment, it should be rejected.

Stephen Eckrich, MD
Rapid City, SD

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From: Steven Giuseffi
To: SDBMOE; SDBMOE
Subject: Concern about SD narcotic prescription proposed rule
Date: Wednesday, February 25, 2015 6:03:28 PM

South Dakota Medical Board:

I am concerned about the proposed rule for

"Best practices for the prescription of controlled substances for the treatment of pain."

Such a rule would have broad implications for surgeons who frequently prescribe short-term opioid pain medications for acute trauma or post-operative pain management.
The requirements to specifically document opioid dependence risk, develop a written and signed opioid agreement between patient and provider, and follow mandated follow-up appointment intervals would be onerous for surgeons while not benefitting patients that receive limited narcotics for acute pain.

While these rules would appear to be appropriate for long-term chronic pain management, they are inappropriate for short-term narcotic dispersal.
I'm concerned that the above rule does not appear to distinguish between the prescription of narcotics for acute traumatic events and/or post-surgical pain versus chronic pain.
Failure to make this distinction would dramatically affect my practice and that of my colleagues in a negative way without providing patient benefit.

Please consider revising the rule to distinguish between opioid prescription for acute versus chronic pain management and apply these requirements only for long-term opioid prescription.

Sincerely,

Steven A. Giuseffi, MD
Orthopedic Surgery
Black Hills Orthopedic and Spine Center
Rapid City, SD

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From: Carinna Fehlman
To: SDBMOE
Subject: rules for the Registered Dietitian
Date: Sunday, March 08, 2015 10:35:26 PM

I support the inclusion of the AND code of ethics into the proposed rules for the Registered Dietitian/Licensed Nutritionist in South Dakota.

Carinna Fehlman, RD, LN

From: diane marshall
To: SDBMOE
Subject: Fw: SD RD Rule proposal
Date: Friday, March 06, 2015 4:31:08 PM

"I support the inclusion of the AND code of ethics into the proposed rules for the Registered Dietitian/Licensed Nutritionist in South Dakota".

diane marshall

From: riley, donna
To: SDBMOE
Subject: AND Code of Ethics to the SD LN law
Date: Monday, March 09, 2015 9:51:45 AM
Attachments: image001.png

To the SDBMOE,

I would like to voice my support of the adoption of the Academy of Nutrition and Dietetics Code of Ethics to the SD Licensed Nutritionist law. The code of ethics will establish professional, practice and ethical standards that are needed for the SD licensure law to guide Licensed Nutritionists and protect the public.

Donna Riley, RD, LN, CDE
Diabetes Education Coordinator
Regional Medical Clinic
640 Flormann Street
Rapid City, SD 57701
605-755-3388
Regional Health

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From: EPhillips@regionalhealth.com
To: SDBMOE
Subject: AND Code of ethics
Date: Monday, March 09, 2015 8:56:41 AM

Good morning,

As I am in Rapid City, I cannot be present for the meeting with RDs from SDAND on the 11th.
I would still like for the board to know that I am in favor of updating and adopting the proposed AND code of ethics into the rules for Registered Dietitian/Licensed Nutritionist in South Dakota.

Sincerely,
Elizabeth Phillips, RDN CSR LN
Regional Dialysis Center
640 Flormann St, Suite 401
Rapid City, SD 57701

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From: Larson,Georgia
To: SDBMOE
Subject: Ethics
Date: Friday, March 06, 2015 3:23:27 PM

I support the inclusion of the AND code of ethics into the proposed rules for the Registered Dietitian/Licensed Nutritionist in South Dakota.
In fact, I have used this document in my practice and find it inclusive and to hold us to a high standard. Thank you.

Georgia Larson, RD, LN
Clinical Nutrition Manager
Sanford Medical Center
1305 W 18th Street
Sioux Falls, SD 57105
605-333-7130
Georgia.larson@sanfordhealth.org

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From: Helen
To: SDBMOE
Subject: In support of the adoption of the AND Code of Ethics
Date: Monday, March 09, 2015 9:15:57 AM

SDBMOE,

I would like to extend my support for the inclusion of the AND Code of Ethics to the SD Licensed Nutritionist rules along with the proposed fee schedule.

Helen Nichols, RD LN CDE

From:	Witte, Hope M.
To:	SDBMOE
Subject:	code of ethics into the proposed rules for the Registered Dietitian/Licensed Nutritionist in South Dakota
Date:	Friday, March 06, 2015 3:25:49 PM

I support the inclusion of the AND code of ethics into the proposed rules for the Registered Dietitian/Licensed Nutritionist in South Dakota. Thank you.

Hope Witte, RD, LN, CDE
301 South Chicago St
Hot Springs, SD 57747
hope.witte@yahoo.com

From:	Conti, Kibbe (IHS/ABR/RCH)
To:	SDBMOE
Subject:	Support
Date:	Friday, March 06, 2015 4:54:07 PM
Attachments:	image001.gif image002.png

"I support the inclusion of the AND code of ethics into the proposed rules for the Registered Dietitian/Licensed Nutritionist in South Dakota".

Kibbe Conti MS, RD, CDE
LCDR US Public Health Service
Nutrition Specialist
Rapid City Indian Hospital

wbw2014-logo-hd

From: Kim Hepper
To: SDBMOE
Subject: AND cod of ethics
Date: Friday, March 06, 2015 11:31:21 PM

To whom it may concern,
I support the inclusion of the AND code of ethics into the proposed rules for the Registered Dietitian/Licensed Nutritionist in South Dakota.

Thank you,
Kim Hepper, RD LN; Clinical Dietitian

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From: Stark,Lisa
To: SDBMOE
Subject: AND code of ethics
Date: Friday, March 06, 2015 3:45:17 PM

I support the inclusion of the AND code of ethics into the proposed rules for the Registered Dietitian/Licensed Nutritionist in South Dakota.

Thank you,
Lisa Stark, RD LN CDE CNSC
Sanford Health

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From: Sturdevant,Michele
To: SDBMOE
Date: Friday, March 06, 2015 5:30:31 PM

I support the inclusion of the AND code of ethics into the proposed rules for the Registered Dietitian/Licensed Nutritionist in South Dakota.

I am working to follow these standards.

Michele Sturdevant, RD,LN
Neonatal Dietian
Neonatal Intensive Care Nursery
Sanford Children's Hospital
1305 W 18th Street
Sioux Falls, SD 57105
605.328.3061
Michele.Sturdevant@SanfordHealth.org

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From: RBrand@regionalhealth.com
To: SDBMOE
Subject: March 11th SDBMOE Meeting
Date: Friday, March 06, 2015 5:10:10 PM

SDBMOE Board Members:

I support the inclusion of the AND code of ethics into the proposed rules for the Registered Dietitian/Licensed Nutritionist in South Dakota.
Thank you for assisting with setting professional, practice and ethical standards for licensed nutritionists in South Dakota.

Respectfully,

Rene M Brand, MS RD LN
Clinical Nutrition Supervisor
Rapid City Regional Hospital
353 Fairmont Blvd
Rapid City, SD 57701
605-755-8835 or cell 605-877-1277
rbrand@regionalhealth.com

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From: Shelly B
To: SDBMOE
Subject: Nutritionist ethics
Date: Saturday, March 07, 2015 6:55:41 AM

Please consider the inclusion of the Academy of Nutrition & Dietetics (A.N.D.) code of ethics into the proposed rules for the Registered Dietitian/Licensed Nutritionist in South Dakota. Thank you for your consideration on this matter.

Shelly Brandenburger, Licensed Nutritionist in SD

--

Dr. Shelly Brandenburger
1453 Sixth Street
Brookings SD 57006
(605) 692-2225
Cell: 651-0465

Henry Travers, MD, FACP

1 March 2015

South Dakota Board of Medical and Osteopathic Examiners
101 N Main Ave, Ste 301
Sioux Falls, South Dakota 57104

Ladies and Gentlemen:

Below for your consideration are my comments on the proposed rules under the following sections: 20:47:07, 20:47:08, 20:52:02, 20:63:04, 20:64:05, 20:66:02, 20:70:03, 20:78:05:09, 20:78:05:10, 20:82, 20:83.

Page 9: Nondiscrimination.

The text reads "…*should* not discriminate…" I wonder if the rule should be more directive (e.g. *must* not discriminate). The word "should" is more a guideline than a rule.

Page 9: Initiation and Discontinuation of Care

At the bottom of the page it says patients are entitled to access *appropriate* information contained within their medical record. I would submit that the patient is entitled not only to access, but also to **copy** *all* information in their medical record.

Page 10: Informed Consent/Page 13: Genetic Testing

A recent article in the *New England Journal of Medicine* about modern challenges in the area of informed consent (NEJM 2015;372(9):855) suggests that training in communication of informed consent information may be useful. This is particularly true in the area of genetic testing, an area of practice growing exponentially in complexity. The complexity is so daunting that few practitioners truly have the expertise to provide informed consent for many of these tests. The rule could be modified to indicate that the information provided by the PA should only be within the scope of specific training in genetic testing and counseling and that the services of a qualified genetics counselor be sought in appropriate circumstances.

Page 14: Reproductive Decision Making

The last sentence is far more legal than medical and asks the PA to interpret law rather than to make health care recommendations. I would reword the sentence to read: "…ensure the patient's access to all treatment options together with information where those options may be legally available."

704 Tomar Court
Sioux Falls, SD 57105
henrytravers@sio.midco.net
605-359-2750

Page 19: PAs and Research

One might encounter considerable disagreement over the premise that honesty is the most important ethical principle in research. *Integrity*, for example, may be a better ethical concept. One can be honest, but still "spin" information. PAs participating in research must be familiar with the ethical requirements of informed consent.

Page 36: Physical Therapists, Principle #2A

Saying one adheres to core values without specifying what those values are is an incomplete guide. There should be some reference to a description or list of those values.

Page 36: Physical Therapists, Principle #2D

The concept of collaborating "with patients/clients to empower them in decisions…" is conceptually oblique to the *obligation* of physical therapists to provide information and obtain informed consent from patients/clients about their health care. This principle should be reworded.

Thank you for the opportunity to review these rules and to offer comments to the Board.

Sincerely,

Henry Travers, MD, FACP

Henry Travers, MD, FACP

1 March 2015

South Dakota Board of Medical and Osteopathic Examiners
101 N Main Ave, Ste 301
Sioux Falls, South Dakota 57104

Ladies and Gentlemen:

Below for your consideration are my comments on the proposed rules under the following sections: 20:47:07, 20:47:08, 20:52:02, 20:63:04, 20:64:05, 20:66:02, 20:70:03, 20:78:05:09, 20:78:05:10, 20:82, 20:83.

Page 9: Nondiscrimination.

The text reads "…*should* not discriminate…" I wonder if the rule should be more directive (e.g. *must* not discriminate). The word "should" is more a guideline than a rule.

Page 9: Initiation and Discontinuation of Care

At the bottom of the page it says patients are entitled to access *appropriate* information contained within their medical record. I would submit that the patient is entitled not only to access, but also to **copy** *all* information in their medical record.

Page 10: Informed Consent/Page 13: Genetic Testing

A recent article in the *New England Journal of Medicine* about modern challenges in the area of informed consent (NEJM 2015;372(9):855) suggests that training in communication of informed consent information may be useful. This is particularly true in the area of genetic testing, an area of practice growing exponentially in complexity. The complexity is so daunting that few practitioners truly have the expertise to provide informed consent for many of these tests. The rule could be modified to indicate that the information provided by the PA should only be within the scope of specific training in genetic testing and counseling and that the services of a qualified genetics counselor be sought in appropriate circumstances.

Page 14: Reproductive Decision Making

The last sentence is far more legal than medical and asks the PA to interpret law rather than to make health care recommendations. I would reword the sentence to read: "…ensure the patient's access to all treatment options together with information where those options may be legally available."

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Sioux Falls, SD 57105
henrytravers@sio.midco.net
605-359-2750

Page 19: PAs and Research

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Thank you for the opportunity to review these rules and to offer comments to the Board.

Sincerely,

Henry Travers, MD, FACP

From: Tom Benzoni
To: SDBMOE
Subject: Re: Updated Public Hearing Notice for Proposed Administrative Rules
Date: Friday, February 20, 2015 8:26:30 PM

I can't make it in person.

Regarding physician assistant portion:

I question the wisdom of placing what appears to be an aspirational document into rules.

Thomas Benzoni, DO

On Feb 20, 2015 1:43 PM, "SDBMOE" <SDBMOE@state.sd.us> wrote:

> Licensees and Interested Parties,
>
> Please find attached an updated notice for the **Wednesday, March 11th at 9:00 AM CDT public hearing** for proposed administrative rules.
>
> Persons interested in presenting data, opinions, and arguments for or against the proposed rules may do so by appearing in person at the hearing or by sending them to the South Dakota Board of Medical and Osteopathic Examiners, 101 N Main Ave, Ste 301, Sioux Falls, South Dakota 57104 or by email to SDBMOE@state.sd.gov by **March 10, 2015**.
>
> Copies of the proposed rules may be obtained from the South Dakota Administrative Rules website https://rules.sd.gov/detail.aspx?Id=168 or by contacting the Board of Medical and Osteopathic Examiners.
>
> Sincerely,
>
> Board Staff from General Email
>
> South Dakota Board of Medical & Osteopathic Examiners
>
> sdbmoe@state.sd.us
>
> www.sdbmoe.gov

South Dakota Legislative Research Council

Representative Dean Wink, Chair
Senator Corey Brown, Vice Chair

Jason Hancock, Director
Sue Cichos, Deputy Director
Doug Decker, Code Counsel

February 24, 2015

Mr. Tyler Klatt
Board of Medical and Osteopathic Examiners
101 N. Main Ave., Suite 301
Sioux Falls, SD 57104

Dear Mr. Klatt:

The Board of Medical and Osteopathic Examiners has proposed the adoption and amendment of rules ARSD articles 20:47, 20:52, 20:63, 20:64, 20:66, 20:70, 20:78, 20:82, and 20:83 regarding physician and surgeons; physician assistants; athletic trainers; occupational therapist and occupational therapy assistants; physical therapist and physical therapist assistants, respiratory care practitioners; contested case hearing procedures; genetic counselors; and nutrition and dietetics. We have reviewed these rules, scheduled for hearing on March 11, 2015, and approve them for legality.

This letter is based on a preliminary review of your proposed rules. Attached are your rules edited for form and style pursuant to SDCL 1-26-6.5 and directions for submitting the final draft of the rules. If you have any questions, please don't hesitate to call me or the staff member who has reviewed your rules.

Sincerely,

Doug

Doug Decker
Code Counsel

DD:KS
Enclosures

State Capitol, 500 East Capitol, Pierre, SD 57501-5070
605/773-3251 – Fax 605/773-4576
http://legis.state.sd.us

Style + Form

ARTICLE 20:47

PHYSICIANS AND SURGEONS

Chapter

20:47:01 Definitions, repealed.

20:47:02 Operation of board, transferred.

20:47:03 Licensure.

20:47:04 Inspections.

20:47:05 Declaratory rulings, transferred.

20:47:06 Fees.

20:47:07 Physician best practices.

20:47:08 Ethics

CHAPTER 20:47:07

PHYSICIAN BEST PRACTICES

20:47:07:01. Best practices defined

20:47:07:02. Best practices for the prescription of controlled substances for the treatment of pain.

20:47:07:03. Best practices for medical records when prescribing controlled substances for the treatment of pain

20:47:07:01. Best practices defined. "Best practices" means a process or procedure established in this ~~article~~ chapter as a guideline to physicians. ~~F~~A physician's failure to comply with best practices established in this ~~article~~ chapter is not grounds ~~for cancellation,~~ to cancel ~~revocation~~ revoke or ~~suspension of~~ suspen a physician's medical license. A physician's failure to comply with best practices may be justified based on the circumstances of a

particular case or on the applicable community standards. A physician's Compliance with best practices is a defense to a proceeding to cancel ~~for cancellation~~, revoke ~~revocation~~ or suspend ~~suspension of~~ a physician's medical license that is based upon medical treatment for which best practices have been established.

Source:

General Authority: SDCL 36-4-35.

Law Implemented: SDCL 36-4-28, 36-4-29, 36-4-30.

20:47:07:02. Best practices for the prescription of controlled substances for the treatment of pain. Each ~~All~~ patient has ~~have~~ a level or risk of addiction to controlled substances prescribed for the treatment of pain, that can only be estimated initially, with the estimate modified over time as more information is obtained concerning the efficacy of the treatment and the patient's on-going or increasing risk of addiction. The best practices for the prescription of controlled substances for the treatment of pain includes: ~~follow this process and procedure~~:

(1) A medical diagnosis ~~is made~~ with an appropriate differential;

(2) A complete patient assessment, including assessment of the risk for substance use disorders, ~~is performed~~;

(3) A proposed treatment plan that includes disclosure of the level or risk of addition and alternative treatment methods, ~~is~~ discussed with the patient and written informed consent from the patient ~~is obtained~~;

(4) A written treatment agreement, signed by both the physician and the patient, ~~is established~~ that sets forth the expectations and obligations of the patient and the treating physician;

(5) An appropriate trial of opioid therapy, with or without adjunctive medications, ~~is~~

initiated. During this trial period, the efficacy of the opioid therapy is tested to determine whether the treatment goals can be met in terms of reduction of pain and restoration of function;

(6) The written treatment plan is revised as necessary based upon the results of the trial of opioid therapy and discussed with the patient. The revised written treatment plan sets forth the expectations and obligations of the patient and the treating physician, and signed by both;

(7) Regular assessments of pain and function are conducted, initially every month, and after treatment goals are being met, at least ~~a minimum of~~ every 6 months, which include:

(a) A full reassessment of the patient's pain score and level of function;

(b) Evaluation of the patient in terms of the "5 a's": analgesia, activity, adverse effects, aberrant behaviors, and affect;

(c) Review of the pain diagnosis and any comorbid conditions, including substance use disorders;

(d) Adjustment of the treatment regimen based upon the entire reassessment.

(8) If treatment goals of reduction of pain and restoration of function are not met, the physician shall adjust the opioid dose, substitute a different opioid, add an adjunctive therapy, or discontinue the use of opioids and select an alternative approach to pain management; and

(9) In no case~~s~~ should a physician continue to prescribe opioids at the same level or in the same manner, with no alternative therapies being explored, when a patient's treatment goals are not being met.

Source:

General Authority: SDCL 36-4-35.

Law Implemented: SDCL 36-4-28, 36-4-29, 36-4-30.

References: Federation of State Medical Boards Model Policy for the Use of Opioid Analgesics in the Treatment of Chronic Pain; Federation of State Medical Boards Model Policy on Data 2000 and Treatment of Opioid Addiction in the Medical Office. Copies may be obtained at http://www.fsmb.org/policy/advocacy-policy/policy-documents

20:47:07:02. Best practices for medical records when prescribing controlled substances for the treatment of pain. The best practices for medical records when a physician prescribes controlled substances for the treatment of pain includes ~~include each of~~ the following ~~listed items~~:

(1) Copies of the signed informed consent and treatment agreement required by ARSD 20:47:07:01(3), (4) and (6);

(2) The patient's medical history;

(3) The results of all physical examinations and all laboratory tests;

(4) The results of all risk assessments, including results of any screening instruments used;

(5) A description of the treatments provided, including all medications prescribed or administered, with the date of prescription or administration, the name and type of the medication; and the dosage and quantity of medication prescribed or administered. The medical records must include all prescription orders for opioid analgesics and other controlled substances, whether written or telephoned;

(6) Instructions to the patient, including discussions of risks and benefits with the patient and any significant others, and written instructions for the use of all medications;

(7) Results of ongoing assessments of patient progress or lack of progress in terms of pain management and functional improvement;

(8) Notes on evaluations by and consultations with specialists;

(9) Any other information used to support the initiation, continuation, revision, or termination of treatment and the steps taken in response to any aberrant medication use behaviors;

(10) Medical records of past hospitalizations or treatments by other providers, to the extent obtained by the physician;

(11) Authorization for release of information to other treatment providers; and

(12) Name, address and telephone number of the patient's pharmacy.

Source:

General Authority: SDCL 36-4-35.

Law Implemented: SDCL 36-4-29, 36-4-30.

References: Federation of State Medical Boards Model Policy for the Use of Opioid Analgesics in the Treatment of Chronic Pain; Federation of State Medical Boards Model Policy on Data 2000 and Treatment of Opioid Addiction in the Medical Office.

CHAPTER 20:47:08

ETHICS

20:47:08:01. Professional ethical standards and conduct.

20:47:08:02. Violation.

20:47:08:03. Ethical considerations.

chapter

20:47:08:03. Professional ethical standards and conduct. A licensee under SDCL 36-4

shall comply with the following professional ethical standards and conduct.

(1) A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights.

(2) A physician shall uphold the standards of professionalism, be honest in all professional interactions, and strive to report physicians deficient in character or competence, or engaging in fraud or deception, to appropriate entities.

(3) A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.

(4) A physician shall respect the rights of patients, colleagues, and other health professionals, and shall safeguard patient confidences and privacy within the constraints of the law.

(5) A physician shall continue to study, apply, and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.

(6) A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care.

(7) A physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health.

(8) A physician shall, while caring for a patient, regard responsibility to the patient as paramount.

(9) A physician shall support access to medical care for all people.

Source:

General Authority: SDCL 36-4-35.

Law Implemented: SDCL 36-4-11, 36-4-28, 36-4-29, 36-4-29.1, 36-4-30.

20:47:08:02. Violations. A violation of any of the ethical standards and conduct are considered unprofessional conduct as defined by SDCL 36-4-30(22).

Source:

General Authority: SDCL 36-4-35.

Law Implemented: SDCL 36-4-11, 36-4-28, 36-4-29, 36-4-29.1, 36-4-30.

20:47:08:03. Ethical considerations. The Board may utilize the annotations and opinions included in Code of Medical Ethics of the American Medical Association 2012-2013 edition as guidance in determining whether a licensee has violated professional ethical standards and conduct.

Source:

General Authority: SDCL 36-4-35.

Law Implemented: SDCL 36-4-11, 36-4-28, 36-4-29, 36-4-29.1, 36-4-30.

Reference: Code of Medical Ethics of the American Medical Association 2012-2013 edition, Annotations prepared by the southern Illinois University School of Medicine Copies may be viewed at the Board's office or obtained from American Medical Association by calling 1-800-621-8335 or website at www.amabookstore.org.

ARTICLE 20:52

~~PHYSICIAN'S~~ PHYSICIAN ASSISTANTS

Chapter

20:52:01 Physician assistant license.

20:52:02 Ethics.

CHAPTER 20:52:02

ETHICS

Section

20:52:02:01 Code of ethics.

20:52:02:02 Violations.

20:52:02:03 Ethical considerations.

20:52:02:01. Code of ethics. A licensee under SDCL chapter 36-4A shall comply with the following code of ethics.

Statement of Values of the Physician Assistant Profession

- Physician assistants hold as their primary responsibility the health, safety, welfare, and dignity of all human beings.
- Physician assistants uphold the tenets of patient autonomy, beneficence, nonmaleficence, and justice.
- Physician assistants recognize and promote the value of diversity.
- Physician assistants treat equally all persons who seek their care.

- Physician assistants hold in confidence the information shared in the course of practicing medicine.
- Physician assistants assess their personal capabilities and limitations, striving always to improve their medical practice.
- Physician assistants actively seek to expand their knowledge and skills, keeping abreast of advances in medicine.
- Physician assistants work with other members of the health care team to provide compassionate and effective care of patients.
- Physician assistants use their knowledge and experience to contribute to an improved community.
- Physician assistants respect their professional relationship with physicians.
- Physician assistants share and expand knowledge within the profession.

The PA and Patient

PA Role and Responsibilities

Physician assistant practice flows out of a unique relationship that involves the PA, the physician, and the patient. The individual patient–PA relationship is based on mutual respect and an agreement to work together regarding medical care. In addition, PAs practice medicine with physician supervision; therefore, the care that a PA provides is an extension of the care of the supervising physician. The patient–PA relationship is also a patient–PA–physician relationship.

The principal value of the physician assistant profession is to respect the health, safety, welfare, and dignity of all human beings. This concept is the foundation of the patient–PA relationship.

Physician assistants have an ethical obligation to see that each of their patients receives appropriate care. PAs should be sensitive to the beliefs and expectations of the patient. PAs should recognize that each patient is unique and has an ethical right to self-determination.

Physician assistants are professionally and ethically committed to providing nondiscriminatory care to all patients. While PAs are not expected to ignore their own personal values, scientific or ethical standards, or the law, they should not allow their personal beliefs to restrict patient access to care. A PA has an ethical duty to offer each patient the full range of information on relevant options for their health care. If personal moral, religious, or ethical beliefs prevent a PA from offering the full range of treatments available or care the patient desires, the PA has an ethical duty to refer a patient to another qualified provider. That referral should not restrict a patient's access to care. PAs are obligated to care for patients in emergency situations and to responsibly transfer patients if they cannot care for them.

Physician assistants should always act in the best interests of their patients and as advocates when necessary. PAs should actively resist policies that restrict free exchange of medical information. For example, a PA should not withhold information about treatment options simply because the option is not covered by insurance. PAs should inform patients of financial incentives to limit care, use resources in a fair and efficient way, and avoid arrangements or financial incentives that conflict with the patient's best interests.

The PA and Diversity

The physician assistant should respect the culture, values, beliefs, and expectations of the patient.

Nondiscrimination

Physician assistants should not discriminate against classes or categories of patients in the delivery of needed health care. Such classes and categories include gender, color, creed, race, religion, age, ethnic or national origin, political beliefs, nature of illness, disability, socioeconomic status, physical stature, body size, gender identity, marital status, or sexual orientation.

Initiation and Discontinuation of Care

In the absence of a preexisting patient–PA relationship, the physician assistant is under no ethical obligation to care for a person unless no other provider is available. A PA is morally bound to provide care in emergency situations and to arrange proper follow-up. PAs should keep in mind that contracts with health insurance plans might define a legal obligation to provide care to certain patients.

A physician assistant and supervising physician may discontinue their professional relationship with an established patient as long as proper procedures are followed. The PA and physician should provide the patient with adequate notice, offer to transfer records, and arrange for continuity of care if the patient has an ongoing medical condition. Discontinuation of the professional relationship should be undertaken only after a serious attempt has been made to clarify and understand the expectations and concerns of all involved parties.

If the patient decides to terminate the relationship, they are entitled to access appropriate information contained within their medical record.

Informed Consent

Physician assistants have a duty to protect and foster an individual patient's free and informed choices. The doctrine of informed consent means that a PA provides adequate information that is comprehendible to a competent patient or patient surrogate. At a minimum, this should include the nature of the medical condition, the objectives of the proposed treatment, treatment options, possible outcomes, and the risks involved. PAs should be committed to the concept of shared decision making, which involves assisting patients in making decisions that account for medical, situational, and personal factors.

In caring for adolescents, the PA should understand all of the laws and regulations in his or her jurisdiction that are related to the ability of minors to consent to or refuse health care.

Adolescents should be encouraged to involve their families in health care decision making. The PA should also understand consent laws pertaining to emancipated or mature minors. (See the section on *Confidentiality*.)

When the person giving consent is a patient's surrogate, a family member, or other legally authorized representative, the PA should take reasonable care to assure that the decisions made are consistent with the patient's best interests and personal preferences, if known. If the PA believes the surrogate's choices do not reflect the patient's wishes or best interests, the PA should work to resolve the conflict. This may require the use of additional resources, such as an ethics committee.

Confidentiality

Physician assistants should maintain confidentiality. By maintaining confidentiality, PAs respect patient privacy and help to prevent discrimination based on medical conditions. If

patients are confident that their privacy is protected, they are more likely to seek medical care and more likely to discuss their problems candidly.

In cases of adolescent patients, family support is important but should be balanced with the patient's need for confidentiality and the PA's obligation to respect their emerging autonomy.

Adolescents may not be of age to make independent decisions about their health, but providers should respect that they soon will be. To the extent they can, PAs should allow these emerging adults to participate as fully as possible in decisions about their care. It is important that PA's be familiar with and understand the laws and regulations in their jurisdictions that relate to the confidentiality rights of adolescent patients. (See the section on *Informed Consent*.)

Any communication about a patient conducted in a manner that violates confidentiality is unethical. Because written, electronic, and verbal information may be intercepted or overheard, the PA should always be aware of anyone who might be monitoring communication about a patient.

PAs should choose methods of storage and transmission of patient information that minimize the likelihood of data becoming available to unauthorized persons or organizations. Computerized record keeping and electronic data transmission present unique challenges that can make the maintenance of patient confidentiality difficult. PAs should advocate for policies and procedures that secure the confidentiality of patient information.

The Patient and the Medical Record

Physician assistants have an obligation to keep information in the patient's medical record confidential. Information should be released only with the written permission of the patient or the patient's legally authorized representative. Specific exceptions to this general rule may exist

(e.g., workers compensation, communicable disease, HIV, knife/gunshot wounds, abuse, and substance abuse). It is important that a PA be familiar with and understands the laws and regulations in his or her jurisdiction that relate to the release of information. For example, stringent legal restrictions on release of genetic test results and mental health records often exist.

Both ethically and legally, a patient has certain rights to know the information contained in his or her medical record. While the chart is legally the property of the practice or the institution, the information in the chart is the property of the patient. Most states have laws that provide patients access to their medical records. The PA should know the laws and facilitate patient access to the information.

Disclosure

A physician assistant should disclose to his or her supervising physician information about errors made in the course of caring for a patient. The supervising physician and PA should disclose the error to the patient if such information is significant to the patient's interests and well-being. Errors do not always constitute improper, negligent, or unethical behavior, but failure to disclose them may.

Care of Family Members and Co-workers

Treating oneself, co-workers, close friends, family members, or students whom the physician assistant supervises or teaches may be unethical or create conflicts of interest. For example, it might be ethically acceptable to treat one's own child for a case of otitis media but it probably is not acceptable to treat one's spouse for depression. PAs should be aware that their judgment might be less than objective in cases involving friends, family members, students, and

colleagues and that providing "curbside" care might sway the individual from establishing an ongoing relationship with a provider. If it becomes necessary to treat a family member or close associate, a formal patient-provider relationship should be established, and the PA should consider transferring the patient's care to another provider as soon as it is practical. If a close associate requests care, the PA may wish to assist by helping them find an appropriate provider.

There may be exceptions to this guideline, for example, when a PA runs an employee health center or works in occupational medicine. Even in those situations, the PA should be sure they do not provide informal treatment, but provide appropriate medical care in a formally established patient-provider relationship.

Genetic Testing

Evaluating the risk of disease and performing diagnostic genetic tests raise significant ethical concerns. Physician assistants should be informed about the benefits and risks of genetic tests.

Testing should be undertaken only after proper informed consent is obtained. If PAs order or conduct the tests, they should assure that appropriate pre- and post-test counseling is provided.

PAs should be sure that patients understands the potential consequences of undergoing genetic tests – from impact on patients themselves, possible implications for other family members, and potential use of the information by insurance companies or others who might have access to the information. Because of the potential for discrimination by insurers, employers, or others, Pas should be particularly aware of the need for confidentiality concerning genetic test results.

Reproductive Decision Making

Patients have a right to access the full range of reproductive health care services. Physician assistants have an ethical obligation to provide balanced and unbiased clinical information about reproductive health care.

When the PA's personal values conflict with providing full disclosure or providing certain services, the PA need not become involved in that aspect of the patient's care. By referring the patient to a qualified provider who is willing to discuss and facilitate all treatment options, the PA fulfills their ethical obligation to ensure the patient's access to all legal options.

End of Life

Among the ethical principles that are fundamental to providing compassionate care at the end of life, the most essential is recognizing that dying is a personal experience and part of the life cycle.

Physician Assistants should provide patients with the opportunity to plan for end of life care.

Advance directives, living wills, durable power of attorney, and organ donation should be discussed during routine patient visits.

PAs should assure terminally-ill patients that their dignity is a priority and that relief of physical and mental suffering is paramount. PAs should exhibit non-judgmental attitudes and should assure their terminally-ill patients that they will not be abandoned. To the extent possible, patient or surrogate preferences should be honored. using the most appropriate measures consistent with their choices, including alternative and non-traditional treatments. PAs should explain palliative and hospice care and facilitate patient access to those services. End of life care

should include assessment and management of psychological, social, and spiritual or religious needs.

While respecting patients' wishes for particular treatments when possible, PAs also must weigh their ethical responsibility, in consultation with supervising physicians, to withhold futile treatments and to help patients understand such medical decisions.

PAs should involve the physician in all near-death planning. The PA should only withdraw life support with the supervising physician's agreement and in accordance with the policies of the health care institution.

The PA and Individual Professionalism

Conflict of Interest

Physician assistants should place service to patients before personal material gain and should avoid undue influence on their clinical judgment. Trust can be undermined by even the appearance of improper influence. Examples of excessive or undue influence on clinical judgment can take several forms. These may include financial incentives, pharmaceutical or other industry gifts, and business arrangements involving referrals. PAs should disclose any actual or potential conflict of interest to their patients.

Acceptance of gifts, trips, hospitality, or other items is discouraged. Before accepting a gift or financial arrangement, PAs might consider the guidelines of the Royal College of Physicians, "Would I be willing to have this arrangement generally known?" or of the American College of Physicians, "What would the public or my patients think of this arrangement?"

Professional Identity

Physician assistants should not misrepresent directly or indirectly, their skills, training, professional credentials, or identity. Physician assistants should uphold the dignity of the PA profession and accept its ethical values.

Competency

Physician assistants should commit themselves to providing competent medical care and extend to each patient the full measure of their professional ability as dedicated, empathetic health care providers. PAs should also strive to maintain and increase the quality of their health care knowledge, cultural sensitivity, and cultural competence through individual study and continuing education.

Sexual Relationships

It is unethical for physician assistants to become sexually involved with patients. It also may be unethical for PAs to become sexually involved with former patients or key third parties. Key third parties are individuals who have influence over the patient. These might include spouses or partners, parents, guardians, or surrogates.

Such relationships generally are unethical because of the PA's position of authority and the inherent imbalance of knowledge, expertise, and status. Issues such as dependence, trust, transference, and inequalities of power may lead to increased vulnerability on the part of the current or former patients or key third parties.

Gender Discrimination and Sexual Harassment

It is unethical for physician assistants to engage in or condone any form of gender discrimination. Gender discrimination is defined as any behavior, action, or policy that adversely affects an individual or group of individuals due to disparate treatment, disparate impact, or the creation of a hostile or intimidating work or learning environment.

It is unethical for PAs to engage in or condone any form of sexual harassment. Sexual harassment is defined as unwelcome sexual advances, requests for sexual favors, or other verbal or physical conduct of a sexual nature when:

- Such conduct has the purpose or effect of interfering with an individual's work or academic performance or creating an intimidating, hostile or offensive work or academic environment, or
- Accepting or rejecting such conduct affects or may be perceived to affect professional decisions concerning an individual, or
- Submission to such conduct is made either explicitly or implicitly a term or condition of an individual's training or professional position.

The PA and Other Professionals

Team Practice

Physician assistants should be committed to working collegially with other members of the health care team to assure integrated, well-managed, and effective care of patients. PAs should strive to maintain a spirit of cooperation with other health care professionals, their organizations, and the general public.

Illegal and Unethical Conduct

Physician assistants should not participate in or conceal any activity that will bring discredit or dishonor to the PA profession. They should report illegal or unethical conduct by health care professionals to the appropriate authorities.

Impairment

Physician assistants have an ethical responsibility to protect patients and the public by identifying and assisting impaired colleagues. "Impaired" means being unable to practice medicine with reasonable skill and safety because of physical or mental illness, loss of motor skills, or excessive use or abuse of drugs and alcohol.

PAs should be able to recognize impairment in physician supervisors, PAs, and other health care providers and should seek assistance from appropriate resources to encourage these individuals to obtain treatment.

PA–Physician Relationship

Supervision should include ongoing communication between the physician and the physician assistant regarding patient care. The PA should consult the supervising physician whenever it will safeguard or advance the welfare of the patient. This includes seeking assistance in situations of conflict with a patient or another health care professional.

Complementary and Alternative Medicine

When a patient asks about an alternative therapy, the PA has an ethical obligation to gain a basic understanding of the alternative therapy being considered or being used and how the

treatment will affect the patient. If the treatment would harm the patient, the PA should work diligently to dissuade the patient from using it, advise other treatment, and perhaps consider transferring the patient to another provider.

The PA and the Health Care System

Workplace Actions

Physician assistants may face difficult personal decisions to withhold medical services when workplace actions (e.g., strikes, sick-outs, slowdowns, etc.) occur. The potential harm to patients should be carefully weighed against the potential improvements to working conditions and, ultimately, patient care that could result. In general, PAs should individually and collectively work to find alternatives to such actions in addressing workplace concerns.

PAs as Educators

All physician assistants have a responsibility to share knowledge and information with patients, other health professionals, students, and the public. The ethical duty to teach includes effective communication with patients so that they will have the information necessary to participate in their health care and wellness.

PAs and Research

The most important ethical principle in research is honesty. This includes assuring subjects' informed consent, following treatment protocols, and accurately reporting findings. Fraud and dishonesty in research should be reported so that the appropriate authorities can take action.

Physician assistants involved in research must be aware of potential conflicts of interest. The patient's welfare takes precedence over the desired research outcome. Any conflict of interest should be disclosed.

In scientific writing, PAs should report information honestly and accurately. Sources of funding for the research must be included in the published reports.

Plagiarism is unethical. Incorporating the words of others, both verbatim or by paraphrasing, without appropriate attribution is unethical and may have legal consequences. When submitting a document for publication, any previous publication of any portion of the document must be fully disclosed.

PAs as Expert Witnesses

The physician assistant expert witness should testify to what he or she believes to be the truth. The PA's review of medical facts should be thorough, fair, and impartial.

The PA expert witness should be fairly compensated for time spent preparing, appearing, and testifying. The PA should not accept a contingency fee based on the outcome of a case in which testimony is given or derive personal, financial, or professional favor in addition to compensation.

The PA and Society

Lawfulness

Physician assistants have the dual duty to respect the law and to work for positive change to laws that will enhance the health and well-being of the community.

Executions

Physician assistants, as health care professionals, should not participate in executions because to do so would violate the ethical principle of beneficence.

Access to Care / Resource Allocation

Physician assistants have a responsibility to use health care resources in an appropriate and efficient manner so that all patients have access to needed health care. Resource allocation should be based on societal needs and policies, not the circumstances of an individual patient–PA encounter. PAs participating in policy decisions about resource allocation should consider medical need, cost-effectiveness, efficacy, and equitable distribution of benefits and burdens in society.

Community Well Being

Physician assistants should work for the health, well-being, and the best interest of both the patient and the community. Sometimes there is a dynamic moral tension between the well-being of the community in general and the individual patient. Conflict between an individual patient's best interest and the common good is not always easily resolved. In general, PAs should be committed to upholding and enhancing community values, be aware of the needs of the community, and use the knowledge and experience acquired as professionals to contribute to an improved community.

Conclusion

The American Academy of Physician Assistants recognizes its responsibility to aid the PA profession as it strives to provide high quality, accessible health care. Physician assistants wrote these guidelines for themselves and other physician assistants. The ultimate goal is to honor patients and earn their trust while providing the best and most appropriate care possible. At the same time, PAs must understand their personal values and beliefs and recognize the ways in which those values and beliefs can impact the care they provide.

Source:

General Authority: SDCL 36-4A-42

Law implemented: SDCL 36-4A-37

Reference: American Academy of Physician Assistants Guidelines for Ethical Conduct for the Physician Assistant Profession, 2013. Copies may be obtained from https://www.aapa.org/WorkArea/DownloadAsset.aspx?id=815.

20:52:02:02. Violations. A violation of any of the ethical standards and conduct are considered unprofessional conduct as defined by SDCL 36-4A-37.

Source:

General Authority: SDCL 36-4A-42

Law implemented: SDCL 36-4A-37

20:52:02:03. Ethical considerations. The board may utilize the annotations and opinions

included in the guidelines for ethical conduct for the physician assistant profession, 2013 edition as guidance in determining whether a licensee has violated professional ethical standards and conduct.

Source:

General Authority: SDCL 36-4A-42

Law implemented: SDCL 36-4A-37

ARTICLE 20:63

ATHLETIC TRAINERS

Chapter

20:63:01 General provisions.

20:63:02 Licensure requirements.

20:63:03 Continuing education.

20:63:04 Ethics.

CHAPTER 20:63:04

ETHICS

Section

20:63:04:01 Ethics

20:63:04:02 Violations.

20:63:04:03 Ethical considerations.

20:63:04:01. Ethics. A licensee under SDCL chapter 36-29 shall comply with the following code of ethics.

Practice Standards

Standard 1: Direction

The Athletic Trainer renders service or treatment under the direction of a physician.

Standard 2: Prevention

The Athletic Trainer understands and uses preventive measures to ensure the highest quality of care for every patient.

Standard 3: Immediate Care

The Athletic Trainer provides standard immediate care procedures used in emergency situations, independent of setting.

Standard 4: Clinical Evaluation and Diagnosis

Prior to treatment, the Athletic Trainer assesses the patient's level of function. The patient's input is considered an integral part of the initial assessment. The Athletic Trainer follows standardized clinical practice in the area of diagnostic reasoning and medical decision making.

Standard 5: Treatment, Rehabilitation and Reconditioning

In development of a treatment program, the Athletic Trainer determines appropriate treatment, rehabilitation and/ or reconditioning strategies. Treatment program objectives include long- and short-term goals and an appraisal of those which the patient can realistically be expected to achieve from the program. Assessment measures to determine effectiveness of the program are incorporated into the program.

Standard 6: Program Discontinuation

The Athletic Trainer, with collaboration of the physician, recommends discontinuation of the athletic training service when the patient has received optimal benefit of the program. The Athletic Trainer, at the time of discontinuation, notes the final assessment of the patient's status.

Standard 7: Organization and Administration

All services are documented in writing by the Athletic Trainer and are part of the patient's permanent records. The Athletic Trainer accepts responsibility for recording details of the patient's health status.

Code of Professional Responsibility

Code 1: Patient Responsibility

The Athletic Trainer or applicant:

1.1 Renders quality patient care regardless of the patient's race, religion, age, sex, nationality, disability, social/economic status or any other characteristic protected by law

1.2 Protects the patient from harm, acts always in the patient's best interests and is an advocate for the patient's welfare

1.3 Takes appropriate action to protect patients from Athletic Trainers, other healthcare providers or athletic training students who are incompetent, impaired or engaged in illegal or unethical practice

1.4 Maintains the confidentiality of patient information in accordance with applicable law

1.5 Communicates clearly and truthfully with patients and other persons involved in the patient's program, including, but not limited to, appropriate discussion of assessment results, program plans and progress

1.6 Respects and safeguards his or her relationship of trust and confidence with the patient and does not exploit his or her relationship with the patient for personal or financial gain

1.7 Exercises reasonable care, skill and judgment in all professional work

Code 2: Competency

The Athletic Trainer or applicant:

2.1 Engages in lifelong, professional and continuing educational activities

2.2 Participates in continuous quality improvement activities

2.3 Complies with the most current BOC recertification policies and requirements

Code 3: Professional Responsibility

The Athletic Trainer or applicant:

3.1 Practices in accordance with the most current BOC Practice Standards

3.2 Knows and complies with applicable local, state and/or federal rules, requirements, regulations and/or laws related to the practice of athletic training

3.3 Collaborates and cooperates with other healthcare providers involved in a patient's care

3.4 Respects the expertise and responsibility of all healthcare providers involved in a patient's care

3.5 Reports any suspected or known violation of a rule, requirement, regulation or law by him/herself and/or by another Athletic Trainer that is related to the practice of athletic training, public health, patient care or education

3.6 Reports any criminal convictions (with the exception of misdemeanor traffic offenses or traffic ordinance violations that do not involve the use of alcohol or drugs) and/or professional suspension, discipline or sanction received by him/herself or by another Athletic Trainer that is related to athletic training, public health, patient care or education

3.7 Complies with all BOC exam eligibility requirements and ensures that any information provided to the BOC in connection with any certification application is accurate and truthful

3.8 Does not, without proper authority, possess, use, copy, access, distribute or discuss certification exams, score reports, answer sheets, certificates, certificant or applicant files, documents or other materials

3.9 Is candid, responsible and truthful in making any statement to the BOC, and in making any statement in connection with athletic training to the public

3.10 Complies with all confidentiality and disclosure requirements of the BOC

3.11 Does not take any action that leads, or may lead, to the conviction, plea of guilty or plea of nolo contendere (no contest) to any felony or to a misdemeanor related to public health, patient care, athletics or education; this includes, but is not limited to: rape; sexual abuse of a child or patient; actual or threatened use of a weapon of violence; the prohibited sale or distribution of controlled substance, or its possession with the intent to distribute; or the use of the position of an Athletic Trainer to improperly influence the outcome or score of an athletic contest or event or in connection with any gambling activity

3.12 Cooperates with BOC investigations into alleged illegal or unethical activities; this includes but is not limited to, providing factual and non-misleading information and responding to requests for information in a timely fashion

3.13 Does not endorse or advertise products or services with the use of, or by reference to, the BOC name without proper authorization

Code 4: Research

The Athletic Trainer or applicant who engages in research:

4.1 Conducts research according to accepted ethical research and reporting standards established by public law, institutional procedures and/or the health professions

4.2 Protects the rights and well-being of research subjects

4.3 Conducts research activities with the goal of improving practice, education and public policy relative to the health needs of diverse populations, the health workforce, the organization and administration of health systems and healthcare delivery

Code 5: Social Responsibility

The Athletic Trainer or applicant:

5.1 Uses professional skills and knowledge to positively impact the community

Code 6: Business Practices

The Athletic Trainer or applicant:

6.1 Refrains from deceptive or fraudulent business practices

6.2 Maintains adequate and customary professional liability insurance

Source:

General Authority: SDCL 36-29-17

Law Implemented: SDCL 36-29-19

Reference: Board of Certification Standards of Professional Practice, 2006. Copies may be obtained from http://www.bocatc.org/resources/standards-of-professional-practice.

20:63:04:02. Violations. A violation of any of the ethical standards and conduct is considered unprofessional conduct as defined by SDCL 36-29-18.

Source:

General Authority: SDCL 36-29-17

Law Implemented: SDCL 36-29-19

20:63:04:03. Ethical considerations. The board may utilize the annotations and opinions included in the board of certification standards of professional conduct, 2006 as guidance in determining whether a licensee has violated professional ethical standards and conduct.

Source:

General Authority: SDCL 36-29-17

Law Implemented: SDCL 36-29-19

ARTICLE 20:64

OCCUPATIONAL THERAPISTS AND OCCUPATIONAL THERAPY ASSISTANTS

Chapter

20:64:01 Definitions.

20:64:02 Licensure requirements.

20:64:03 Supervision.

20:64:04 Continuing competency.

20:64:05 Ethics

CHAPTER 20:64:05

ETHICS

Section

20:64:05:01 Ethics

20:64:05:02 Violations

20:64:05:03 Ethical considerations

chapter

20:64:05:01. Ethics. A licensee under SDCL 36-31 shall comply with the following code of ethics.

Principle 1. Occupational therapy personnel shall demonstrate a concern for the well-being and safety of the recipients of their services.

Principle 2. Occupational therapy personnel shall intentionally refrain from actions that cause harm.

Principle 3. Occupational therapy personnel shall respect the right of the individual to self-determination.

Principle 4. Occupational therapy personnel shall provide services in a fair and equitable manner.

Principle 5. Occupational therapy personnel shall comply with institutional rules, local, state, federal, and international laws and AOTA documents applicable to the profession of occupational therapy.

Principle 6. Occupational therapy personnel shall provide comprehensive, accurate, and objective information when representing the profession.

Principle 7. Occupational therapy personnel shall treat colleagues and other professionals with respect, fairness, discretion, and integrity.

Source:

General Authority: SDCL 36-31-13

Law implemented: SDCL 36-31-14

Reference: American Occupational Therapy Association Occupational Therapy Code of Ethics and Standards, 2010. Copies may be obtained from https://www.aota.org/-/media/Corporate/Files/AboutAOTA/OfficialDocs/Ethics/Code%20and%20Ethics%20Standards%202010.pdf.

20:64:05:02. Violations. A violation of any of the ethical standards and conduct is considered unprofessional conduct as defined by SDCL 36-31-14.

Source:

General Authority: SDCL 36-31-13

Law Implemented: SDCL 36-31-14

20:64:05:03. Ethical considerations. The board may utilize the American Occupational Therapy Association Occupational Therapy Code of Ethics and Standards, 2010 edition as guidance in determining whether a licensee has violated professional ethical standards and conduct.

Source:

General Authority: SDCL 36-31-13

Law Implemented: SDCL 36-31-14

ARTICLE 20:66

PHYSICAL THERAPISTS AND PHYSICAL THERAPIST ASSISTANTS

Chapter

20:66:01 Fees.

20:66:02 Ethics.

CHAPTER 20:66:02

ETHICS

Section

20:66:02:01 Code of ethics.

20:66:02:02 Violations.

20:66:02:03 Ethical considerations.

20:66:02:01. Ethics. A licensee under SDCL chapter 36-10 shall comply with the following code of ethics.

Principle #1: Physical therapists shall respect the inherent dignity and rights of all individuals.

1A. Physical therapists shall act in a respectful manner toward each person regardless of age, gender, race, nationality, religion, ethnicity, social or economic status, sexual orientation, health condition, or disability.

1B. Physical therapists shall recognize their personal biases and shall not discriminate against others in physical therapist practice, consultation, education, research, and administration.

Principle #2: Physical therapists shall be trustworthy and compassionate in addressing the rights and needs of patients/clients.

2A. Physical therapists shall adhere to the core values of the profession and shall act in the best interests of patients/clients over the interests of the physical therapist.

2B. Physical therapists shall provide physical therapy services with compassionate and caring behaviors that incorporate the individual and cultural differences of patients/clients.

2C. Physical therapists shall provide the information necessary to allow patients or their surrogates to make informed decisions about physical therapy care or participation in clinical research.

2D. Physical therapists shall collaborate with patients/clients to empower them in decisions about their health care.

2E. Physical therapists shall protect confidential patient/ client information and may disclose confidential information to appropriate authorities only when allowed or as required by law.

Principle #3: Physical therapists shall be accountable for making sound professional judgments.

3A. Physical therapists shall demonstrate independent and objective professional judgment in the patient's/clients best interest in all practice settings.

3B. Physical therapists shall demonstrate professional judgment informed by professional standards, evidence (including current literature and established best practice), practitioner experience, and patient/client values.

3C. Physical therapists shall make judgments within their scope of practice and level of expertise and shall communicate with, collaborate with, or refer to peers or other health care professionals when necessary.

3D. Physical therapists shall not engage in conflicts of interest that interfere with professional judgment.

3E. Physical therapists shall provide appropriate direction of and communication with physical therapist assistants and support personnel.

Principle #4: Physical therapists shall demonstrate integrity in their relationships with patients/clients, families, colleagues, students, research participants, other health care providers, employers, payers, and the public.

4A. Physical therapists shall provide truthful, accurate, and relevant information and shall not make misleading representations.

4B. Physical therapists shall not exploit persons over whom they have supervisory, evaluative or other authority (e.g., patients/clients, students, supervisees, research participants, or employees).

4C. Physical therapists shall discourage misconduct by health care professionals and report illegal or unethical acts to the relevant authority, when appropriate.

4D. Physical therapists shall report suspected cases of abuse involving children or vulnerable adults to the appropriate authority, subject to law.

4E. Physical therapists shall not engage in any sexual relationship with any of their patients/clients, supervisees, or students.

4F. Physical therapists shall not harass anyone verbally, physically, emotionally, or

sexually.

Principle #5: Physical therapists shall fulfill their legal and professional obligations.

5A. Physical therapists shall comply with applicable local, state, and federal laws and regulations.

5B. Physical therapists shall have primary responsibility for supervision of physical therapist assistants and support personnel.

5C. Physical therapists involved in research shall abide by accepted standards governing protection of research participants.

5D. Physical therapists shall encourage colleagues with physical, psychological, or substance-related impairments that may adversely impact their professional responsibilities to seek assistance or counsel.

5E. Physical therapists who have knowledge that a colleague is unable to perform their professional responsibilities with reasonable skill and safety shall report this information to the appropriate authority.

5F. Physical therapists shall provide notice and information about alternatives for obtaining care in the event the physical therapist terminates the provider relationship while the patient/client continues to need physical therapy services.

Principle #6: Physical therapists shall enhance their expertise through the lifelong acquisition and refinement of knowledge, skills, abilities, and professional behaviors.

6A. Physical therapists shall achieve and maintain professional competence.

6B. Physical therapists shall take responsibility for their professional development based

on critical self-assessment and reflection on changes in physical therapist practice, education, health care delivery, and technology.

6C. Physical therapists shall evaluate the strength of evidence and applicability of content presented during professional development activities before integrating the content or techniques into practice.

6D. Physical therapists shall cultivate practice environments that support professional development, lifelong learning, and excellence.

Principle #7: Physical therapists shall promote organizational behaviors and business practices that benefit patients/clients and society.

7A. Physical therapists shall promote practice environments that support autonomous and accountable professional judgments.

7B. Physical therapists shall seek remuneration as is deserved and reasonable for physical therapist services.

7C. Physical therapists shall not accept gifts or other considerations that influence or give an appearance of influencing their professional judgment.

7D. Physical therapists shall fully disclose any financial interest they have in products or services that they recommend to patients/clients.

7E. Physical therapists shall be aware of charges and shall ensure that documentation and coding for physical therapy services accurately reflect the nature and extent of the services provided.

7F. Physical therapists shall refrain from employment arrangements, or other arrangements, that prevent physical therapists from fulfilling professional obligations to

patients/ clients.

Principle #8: Physical therapists shall participate in efforts to meet the health needs of people locally, nationally, or globally.

8A. Physical therapists shall provide pro bono physical therapy services or support organizations that meet the health needs of people who are economically disadvantaged, uninsured, and underinsured.

8B. Physical therapists shall advocate reducing health disparities and health care inequities, improve access to health care services, and address the health, wellness, and preventive health care needs of people.

8C. Physical therapists shall be responsible stewards of health care resources and shall avoid overutilization or underutilization of physical therapy services.

8D. Physical therapists shall educate members of the public about the benefits of physical therapy and the unique role of the physical therapist.

Source:

General Authority: SDCL 36-10-36

Law Implemented: SDCL 36-10-39; 36-10-40

Reference: Code of Ethics of the American Physical Therapy Association, 2010. Copies may be obtained from http://www.apta.org/uploadedFiles/APTAorg/About_Us/Policies/Ethics/CodeofEthics.pdf .

20:66:02:02. Violations. A violation of any of the ethical standards and conduct is considered unprofessional conduct as defined by SDCL 36-10-40

Source:

General Authority: SDCL 36-10-36

Law Implemented: SDCL 36-10-39; 36-10-40

20:66:02:02. Ethical considerations. The board may utilize the annotations and opinions included in the Code of Ethics of the American Physical Therapy Association as guidance in determining whether a licensee has violated professional ethical standards and conduct.

Source:

General Authority: SDCL 36-10-36

Law Implemented: SDCL 36-10-39; 36-10-40

ARTICLE 20:70

RESPIRATORY CARE PRACTITIONERS

Chapter

20:70:01 Fees.

20:70:02 Continuing education.

20:70:03 Ethics/

CHAPTER 20:70:03

ETHICS

Section

20:70:03:01 Ethics.

20:70:03:02. Violations.

20:70:03:03. Ethical considerations.

chapter

20:70:03:01. Ethics. A licensee under SDCL 36-4C shall comply with the following code of ethics.

- Demonstrate behavior that reflects integrity, supports objectivity, and fosters trust in the profession and its professionals.
- Seek educational opportunities to improve and maintain their professional competence and document their participation accurately.
- Perform only those procedures or functions in which they are individually competent and which are within their scope of accepted and responsible practice.

- Respect and protect the legal and personal rights of patients, including the right to privacy, informed consent and refusal of treatment.
- Divulge no protected information regarding any patient or family unless disclosure is required for the responsible performance of duty authorized by the patient and/or family, or required by law.
- Provide care without discrimination on any basis, with respect for the rights and dignity of all individuals.
- Promote disease prevention and wellness.
- Refuse to participate in illegal or unethical acts.
- Refuse to conceal, and will report, the illegal, unethical, fraudulent, or incompetent acts of others.
- Follow sound scientific procedures and ethical principles in research.
- Comply with state or federal laws which govern and relate to their practice.
- Avoid any form of conduct that is fraudulent or creates a conflict of interest, and shall follow the principles of ethical business behavior.
- Promote health care delivery through improvement of the access, efficacy, and cost of patient care.
- Encourage and promote appropriate stewardship of resources.

Source:

General Authority: SDCL 36-4C-14

Law Implemented: SDCL 36-4C-18; 36-4C-15

Reference: Statement of Ethics and Professional Conduct of the American Association for Respiratory Care, 2012. Copies may be obtained from http://c.aarc.org/resources/position_statements/documents/AARCStatementofEthicsandProfessionalConduct.pdf.

20:70:03:02. Violations. A violation of any of the ethical standards and conduct is considered unprofessional conduct as defined by SDCL 36-4C-15.

Source:

General Authority: SDCL 36-4C-14

Law Implemented: SDCL 36-4C-18; 36-4C-15

20:70:03:03. Ethical considerations. The board may utilize the annotations and opinions included in the Statement of Ethics and Professional Conduct of the American Association for Respiratory Care as guidance in determining whether a licensee has violated professional ethical standards and conduct.

Source:

General Authority: SDCL 36-4C-14

Law Implemented: SDCL 36-4C-18; 36-4C-15

CHAPTER 20:78:05

CONTESTED CASE HEARING PROCEDURES

Section

20:78:05:01 Applicability.

20:78:05:02 Petitions for hearing.

20:78:05:03 Filing of petitions for hearing.

20:78:05:04 Scheduling of hearing.

20:78:05:05 Hearing procedure.

20:78:05:06 Final board decision.

20:78:05:07 Notice of decision.

20:78:05:08 Assessment of costs of disciplinary hearings.

20:78:05:09 Board member conflict of interest.

20:78:05:10 Board member potential conflict of interest.

20:78:05:09. Board member conflict of interest. A board member (1) IS who ~~is~~ personally related to a party involved in a contested case proceeding or disciplinary action by two degrees of consanguinity; ~~or~~ ~~who~~ (2) Has ~~has~~ a direct financial interest in a party involved in a contested case proceeding or disciplinary action through employment or by contract; ~~of~~ ~~who directly~~ (3) Directly supervises and is responsible for peer review of a party involved in a contested case proceeding or disciplinary action; or ~~whose~~ (4) Has a spouse ~~is~~ employed by or directly contracts with a party involved in a contested case proceeding or disciplinary action; may not participate in the proceeding or action concerning that party. The member shall make an oral statement of recusal on the record at the initiation of the hearing. A recused member may not participate in board discussions or decision-making

List- rewrite as a list.
A board member who:
(1)
(2)
(3)
(4)

regarding that contested case proceeding or disciplinary action.

Source:

General Authority: SDCL 36-4-35, 36-4A-42, 36-4B-35, 36-10-36, 36-10B-3, 36-29-17, 36-31-13, 36-36-12.

Law Implemented: SDCL 36-4-27, 36-4-28, 36-4-29, 36-4-30, 36-4-32, 36-4A-37, 36-4A-38, 36-4A-39, 36-4A-40, 36-4B-28, 36-4B-31, 36-4B-32, 36-4B-33, 36-10-38, 36-10-39, 39-10-40, 36-10-41, 36-10-44, 36-10-45, 36-10-46, 36-10-49, 36-10B-13, 36-10B-14, 36-29-18, 36-29-19, 36-29-20, 36-29-21, 36-29-22, 36-29-25, 36-29-26,36-29-27, 36-31-14, 36-31-15, 36-31-16, 36-31-17, 36-31-18, 36-31-21, 36-31-22, 36-36-6, 36-36-13.

20:78:05:10. Board member potential conflicts of interests. A potential conflict of interest is an indirect financial interest, or a personal relationship or another interest in a party involved in a contested case proceeding or disciplinary action that is different from that of the general public, that a reasonable person would believe might result in bias or prejudgment. A ~~B~~oard member~~s~~ shall disclose any potential conflict of interest in a contested case proceeding or disciplinary action on the record at the initiation of the hearing, or during the hearing if ~~they~~ the board member ~~become~~ becomes aware of the existence of a potential conflict of interest at that time. Upon ~~its~~ the board's own motion or the motion of a party, and considering the rule of necessity should maintenance of a quorum be an issue, the board may recuse a member with a potential conflict of interest if it determines that the potential conflict of interest raises an unacceptable risk of bias or prejudgment in the contested case proceeding or disciplinary action.

Source:

General Authority: SDCL 36-4-35, 36-4A-42, 36-4B-35, 36-10-36, 36-10B-3, 36-29-17,

36-31-13, 36-36-12.

Law Implemented: SDCL 36-4-27, 36-4-28, 36-4-29, 36-4-30, 36-4-32, 36-4A-37, 36-4A-38, 36-4A-39, 36-4A-40, 36-4B-28, 36-4B-31, 36-4B-32, 36-4B-33, 36-10-38, 36-10-39, 39-10-40, 36-10-41, 36-10-44, 36-10-45, 36-10-46, 36-10-49, 36-10B-13, 36-10B-14, 36-29-18, 36-29-19, 36-29-20, 36-29-21, 36-29-22, 36-29-25, 36-29-26, 36-29-27, 36-31-14, 36-31-15, 36-31-16, 36-31-17, 36-31-18, 36-31-21, 36-31-22, 36-36-6, 36-36-13.

ARTICLE 20:82

GENETIC COUNSELORS

Chapter

20:82:01 Definitions

20:82:02 Licensure Requirements

20:82:03 Ethics

CHAPTER 20:82:01

DEFINITIONS

Section

20:82:01:01 Definitions.

20:82:01:01. Definitions. Words defined in SDCL 36-36-1 have the same meaning when used in this ~~article~~ chapter.

Source:

General Authority: SDCL 36-36-12

Law Implemented: SDCL 36-36-1; 36-36-2; 36-36-3

CHAPTER 20:82:02

LICENSURE REQUIREMENTS

Section

20:82:02:01 Fees.

20:82:02:01. Fees. The ~~following~~ fees for licensure as a genetic counselor ~~shall be charged~~ are:

(1) An applicant applying for the initial license shall pay a fee of $200;

(2) An applicant for renewal of a license shall pay a fee of $100;

(3) An applicant for a temporary license shall pay a fee of $100.

Source:

General Authority: SDCL 36-36-12

Law Implemented: SDCL 36-36-5, 36-36-11, 36-36-9

CHAPTER 20:82:03

ETHICS

Section

20:82:03:01 Ethics.

20:82:03:02 Violations.

20:82:03:03 Ethical considerations.

20:82:03:01. Ethics. All licensees under SDCL chapter 36-36 shall comply with the following code of ethics.

Section I: Genetic Counselors Themselves

Genetic counselors value competence, integrity, veracity, dignity, and self-respect in themselves as well as in each other. Therefore, in order to be the best possible human resource to themselves, their clients, their colleagues, and society, genetic counselors strive to:

1. Seek out and acquire sufficient and relevant information required for any given situation.
2. Continue their education and training.
3. Keep abreast of current standards of practice.

4. Recognize the limits of their own knowledge, expertise, and therefore competence in any given situation.
5. Accurately represent their experience, competence and credentials, including training and academic degrees.
6. Acknowledge and disclose circumstances that may result in a real or perceived conflict of interest.
7. Avoid relationships and activities that interfere with professional judgment or objectivity.
8. Be responsible for their own physical and emotional health as it impacts on their professional performance

Section II: Genetic Counselors and Their Clients

The counselor-client relationship is based on values of care and respect for the client's autonomy, individuality, welfare, and freedom. The primary concern of genetic counselors is the interests of their clients. Therefore, genetic counselors strive to:

1. Serve those who seek services regardless of personal or external interests or biases.
2. Clarify and define their professional role(s) and relationships with clients, and provide an accurate description of their services.
3. Respect their clients' beliefs, inclinations, circumstances, feelings, family relationships and cultural traditions.
4. Enable their clients to make informed decisions, free of coercion, by providing or illuminating the necessary facts, and clarifying the alternatives and anticipated consequences.
5. Refer clients to other qualified professionals when they are unable to support the clients.
6. Maintain information received from clients as confidential, unless released by the client or

disclosure is required by law.

7. Avoid the exploitation of their clients for personal advantage, profit, or interest.

Section III: Genetic Counselors and Their Colleagues

The genetic counselors' relationships with other genetic counselors, students, and other health professionals are based on mutual respect, caring, cooperation, and support. Therefore, genetic counselors strive to:

1. Share their knowledge and provide mentorship and guidance for the professional development of other genetic counselors, students and colleagues.
2. Respect and value the knowledge, perspectives, contributions, and areas of competence of colleagues and students, and collaborate with them in providing the highest quality of service.
3. Encourage ethical behavior of colleagues.
4. Assure that individuals under their supervision undertake responsibilities that are commensurate with their knowledge, experience and training.
5. Maintain appropriate limits to avoid the potential for exploitation in their relationships with students and colleagues.

Section IV: Genetic Counselors and Society

The relationships of genetic counselors with society include interest and participation in activities that have the purpose of promoting the well-being of society and access to health care. Therefore, genetic counselors, individually or through their professional organizations, strive to:

1. Keep abreast of societal developments that may endanger the physical and psychological health of individuals.

2. Promote policies that aim to prevent discrimination.
3. Oppose the use of genetic information as the basis for discrimination.
4. Participate in activities necessary to bring about socially responsible change.
5. Serve as a source of reliable information and expert opinion for policymakers and public officials.
6. Keep the public informed and educated about the impact on society of new technological and scientific advances and the possible changes in society that may result from the application of these findings.
7. Support policies that assure ethically responsible research.
8. Adhere to laws and regulations of society. However, when such laws are in conflict with the principles of the profession, genetic counselors work toward change that will benefit the public interest.

Source:

General Authority: SDCL 36-36-12

Law Implemented: SDCL 36-36-13

Reference: Code of Ethics of the National Society of Genetic Counselors, 2006. Copies may be obtained from http://nsgc.org/p/cm/ld/fid=12.

20:82:03:02. Violations. A violation of any of the ethical standards and conduct is considered unprofessional conduct as defined by SDCL 36-36-13.

Source:

General Authority: SDCL 36-36-12

Law Implemented: SDCL 36-36-13

20:82:03:03. Ethical considerations. The board may utilize the annotations and opinions included in the code of ethics of the national society of genetic counselors, 2006 as guidance in determining whether a licensee has violated professional ethical standards and conduct.

Source:

General Authority: SDCL 36-36-12

Law Implemented: SDCL 36-36-13

ARTICLE 20:83

NUTRITION AND DIETETICS

Chapter

20:83:01 Definitions.

20:83:02 Licensure requirements.

20:83:03 Ethics.

CHAPTER 20:83:01

DEFINITIONS

Section

20:83:01:01 Definitions.

20:83:01:01. Definitions. Words defined in SDCL 36-10B-1 have the same meaning when used in this ~~article~~ chapter.

Source:

General Authority: SDCL 36-10B-3

Law Implemented: SDCL 36-10B-1

CHAPTER 20:83:02

LICENSURE REQUIREMENTS

Section

20:83:02:01 Fees for licensure or renewal.

20:83:02:01. Fees for licensure or renewal. The following fees for licensure as a licensed nutritionist shall be charged:

(1) An applicant applying for the initial license shall pay a fee of $75;

(2) An applicant for renewal of license shall pay a fee of $35;

(3) An applicant for late renewal of a license shall pay a fee of $100;

(4) An applicant for a temporary permit shall pay a fee of $50.

Source:

General Authority: 36-10B-3

Law Implemented: 36-10B-8

CHAPTER 20:83:03

ETHICS

Section

20:83:03:01 Code of ethics.

20:83:03:02 Violations.

20:83:03:03 Ethical considerations.

20:83:03:01. Code of ethics. A licensee under SDCL 36-10B shall comply with the following code of ethics.

Principles

1. The practitioner conducts himself/herself with honesty, integrity, and fairness.
2. The practitioner supports and promotes high standards of professional practice. The practitioner accepts the obligation to protect clients, the public, and the profession by

upholding the Code of Ethics for the Profession of Dietetics and by reporting perceived violations of the Code through the processes established by the American Dietetic Association (ADA) and its credentialing agency, the Commission on Dietetic Registration (CDR).

3. The practitioner considers the health, safety, and welfare of the public at all times. The practitioner will report inappropriate behavior or treatment of a client by another dietetics practitioner or other professionals.
4. The practitioner complies with all laws and regulations applicable or related to the profession or to the practitioner's ethical obligations as described in this Code.
    a. The practitioner must not be convicted of a crime under the laws of the United States, whether a felony or a misdemeanor, an essential element of which is dishonesty.
    b. The practitioner must not be disciplined by a state for conduct that would violate one or more these principles
    c. The practitioner must not commit an act of misfeasance of malfeasance that is directly related to the practice of the profession as determined by a court of competent jurisdiction, a licensing board, or an agency of a governmental body.
5. The practitioner provides professional services with objectivity and with respect for the unique needs and values of individuals.
    a. The practitioner does not, in professional practice, discriminate against others on the basis of race, ethnicity, creed, religion, disability, gender, age, gender identity, sexual orientation, national origin, economic status, or any other legally protected category.
    b. The practitioner provides services in a manner that is sensitive to cultural differences.
    c. The practitioner does not engage in sexual harassment in connection with

professional practice

6. The practitioner does not engage in false or misleading practices or communications.
    a. The practitioner does not engage in false or deceptive advertising of his or her services.
    b. The practitioner promotes or endorses specific goods or products only in a manner that is not false and misleading.
    c. The practitioner provides accurate and truthful information in communicating with the public.
7. The practitioner withdraws from professional practice when unable to fulfill his or her professional duties and responsibilities to clients and others.
    a. The practitioner withdraws from practice when he/ she has engaged in abuse of a substance such that it could affect his or her practice.
    b. The practitioner ceases practice when he or she has been adjudged by a court to be mentally incompetent.
    c. The practitioner will not engage in practice when he or she has a condition that substantially impairs his or her ability to provide effective service to others.
8. The practitioner recognizes and exercises professional judgment within the limits of his or her qualifications and collaborates with others, seeks counsel, or makes referrals as appropriate.
9. The practitioner treats clients and patients with respect and consideration.
    a. The practitioner provides sufficient information to enable clients and others to make their own informed decisions.
    b. The practitioner respects the client's right to make decisions regarding the recommended plan of care, including consent, modification, or refusal.

10. The practitioner protects confidential information and makes full disclosure about any limitations on his or her ability to guarantee full confidentiality.
11. The practitioner, in dealing with and providing services to clients and others, complies with the same principles set forth above in Principles #3-7.
12. The practitioner practices dietetics based on evidence-based principles and current information.
13. The practitioner presents reliable and substantiated information and interprets controversial information without personal bias, recognizing that legitimate differences of opinion exist.
14. The practitioner assumes a life-long responsibility and accountability for personal competence in practice, consistent with accepted professional standards, continually striving to increase professional knowledge and skills and to apply them in practice.
15. The practitioner is alert to the occurrence of a real or potential conflict of interest and takes appropriate action whenever a conflict arises.
    a. The practitioner makes full disclosure of any real or perceived conflict of interest.
    b. When a conflict of interest cannot be resolved by disclosure, the practitioner takes such other action as may be necessary to eliminate the conflict, including recusal from an office, position, or practice situation.
16. The practitioner permits the use of his or her name for the purpose of certifying that services have been rendered only if he or she has provided or supervised the provision of those services.
17. The practitioner accurately presents professional qualifications and credentials.
    a. The practitioner, in seeking, maintaining, and using credentials provided by CDR, provides accurate information and complies with all requirements imposed by CDR. The dietetics practitioner uses CDR-awarded credentials ("RD" or "Registered

Dietitian"; "DTR" or "Dietetic Technician, Registered"; "CS" or "Certified Specialist"; and "FADA" or "Fellow of the American Dietetic Association") only when the credential is current and authorized by the CDR.

b. The practitioner does not aid any other person in violating any CDR requirements, or in representing himself or herself as CDR-credentialed when he or she is not.

18. The practitioner does not invite, accept, or offer gifts, monetary incentives, or other considerations that affect or reasonably give an appearance of affecting his/her professional judgment.

Clarification of Principle:

a. Whether a gift, incentive, or other item of consideration shall be viewed to affect, or give the appearance of affecting, a dietetics practitioner's professional judgment is dependent on all factors relating to the transaction, including the amount or value of the consideration, the likelihood that the practitioner's judgment will or is intended to be affected, the position held by the practitioner, and whether the consideration is offered or generally available to persons other than the practitioner.

b. It shall not be a violation of this principle for a practitioner to accept compensation as a consultant or employee or as part of a research grant or corporate sponsorship program, provided the relationship is openly disclosed and the practitioner acts with integrity in performing the services or responsibilities.

c. This principle shall not preclude a dietetics practitioner from accepting gifts of nominal value, attendance at educational programs, meals in connection with educational exchanges of information, free samples of products, or similar items, as long as such items are not offered in exchange for or with the expectation of, and do

not result in, conduct or services that are contrary to the practitioner's professional judgment.

d. The test for appearance of impropriety is whether the conduct would create in reasonable minds a perception that the dietetics practitioner's ability to carry out professional responsibilities with integrity, impartiality, and competence is impaired.

19. The practitioner demonstrates respect for the values, rights, knowledge, and skills of colleagues and other professionals.

a. The practitioner does not engage in dishonest, misleading, or inappropriate business practices that demonstrate a disregard for the rights or interests of others.

b. The practitioner provides objective evaluations of performance for employees and coworkers, candidates for employment, students, professional association memberships, awards, or scholarships, making all reasonable efforts to avoid bias in the professional evaluation of others.

Source:

General Authority: SDCL 36-10B-3

Law Implemented: SDCL 36-10B-13

Reference: American Dietetic Association Commission on Dietetic Registration Code of Ethics for the Profession of Dietetics and Process for Consideration of Ethics Issues, 2009. Copies may be obtained from http://www.eatrightpro.org/~/media/eatrightpro%20files/career/code%20of%20ethics/coe.ashx.

20:83:03:02. Violations. A violation of any of the ethical standards is considered unprofessional conduct as defined by SDCL 36-10B-13.

Source:

General Authority: SDCL 36-10B-3

Law Implemented: SDCL 36-10B-13

20:83:03:03. Ethical considerations. The board may utilize the American Dietetic Association Commission on Dietetic Registration Code of Ethics for the Profession of Dietetics and Process for Consideration of Ethics Issues, 2009 as guidance in determining whether a licensee has violated professional ethical standards and conduct.

Source:

General Authority: SDCL 36-10B-3

Law Implemented: SDCL 36-10B-13

AMA
AMERICAN MEDICAL ASSOCIATION

JAMES L. MADARA, MD
EXECUTIVE VICE PRESIDENT, CEO

ama-assn.org
T (312) 464-5000

March 4, 2015

Mary Milroy, MD
President
South Dakota State Medical Association
2600 W. 49th Street, Suite 200
PO Box 7406
Sioux Falls, SD 57117-7406

Dear Dr. Milroy:

Per your request, the American Medical Association (AMA) has reviewed the proposed amendments to Article 20:47 of South Dakota's regulations pertaining to physicians and surgeons, and we make the following observations.

The proposed "Best practices for the prescription of controlled substances for the treatment of pain," raises several areas for concern. At a threshold level, the AMA is concerned that the proposed regulation provides overly broad, vague recommendations about how physicians are expected to treat patients with pain. The proposed regulation also provides no distinction between different types of pain – whether acute, chronic, related to a terminal illness, or other condition(s).

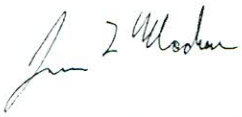
The AMA does not believe it is appropriate to establish standards of care or create specific requirements for physicians that restrict the exercise of their clinical judgment. The highly prescriptive, overly vague directions contained in the proposed regulation, however, do just that, and are not in the best interests of South Dakota's patients or the physicians who care for them.

Similarly, the proposed "Best practices for medical records when prescribing controlled substances for the treatment of pain" also lacks specificity with respect to the different needs of patients who present with different conditions. The AMA certainly supports proper documentation, but the highly prescriptive processes and procedures simply may not be appropriate or applicable in all situations and therefore should not be codified as a best practice.

The AMA has worked with federal and state policymakers in support of combating prescription drug abuse, misuse, overdose and death on many levels. We strongly support efforts to enhance education and ensure appropriate prescribing of controlled substances, including for pain. While we commend the medical board for its interest in this area, we strongly recommend that the medical board withdraw the proposed regulation for the reasons stated above

If you have any questions regarding the recommendations and comments in this letter, please contact Daniel Blaney-Koen, JD, Senior Legislative Attorney, Advocacy Resource Center, at daniel.blaney-koen@ama-assn.org or 312-464-4954.

Sincerely,



James L. Madara, MD

cc: South Dakota State Medical Association

Henry Travers, MD, FACP

1 March 2015

South Dakota Board of Medical and Osteopathic Examiners
101 N Main Ave, Ste 301
Sioux Falls, South Dakota 57104

Ladies and Gentlemen:

Below for your consideration are my comments on the proposed rules under the following sections: 20:47:07, 20:47:08, 20:52:02, 20:63:04, 20:64:05, 20:66:02, 20:70:03, 20:78:05:09, 20:78:05:10, 20:82, 20:83.

Page 9: Nondiscrimination.

The text reads "…*should* not discriminate…" I wonder if the rule should be more directive (e.g. *must* not discriminate). The word "should" is more a guideline than a rule.

Page 9: Initiation and Discontinuation of Care

At the bottom of the page it says patients are entitled to access *appropriate* information contained within their medical record. I would submit that the patient is entitled not only to access, but also to **copy** *all* information in their medical record.

Page 10: Informed Consent/Page 13: Genetic Testing

A recent article in the *New England Journal of Medicine* about modern challenges in the area of informed consent (NEJM 2015;372(9):855) suggests that training in communication of informed consent information may be useful. This is particularly true in the area of genetic testing, an area of practice growing exponentially in complexity. The complexity is so daunting that few practitioners truly have the expertise to provide informed consent for many of these tests. The rule could be modified to indicate that the information provided by the PA should only be within the scope of specific training in genetic testing and counseling and that the services of a qualified genetics counselor be sought in appropriate circumstances.

Page 14: Reproductive Decision Making

The last sentence is far more legal than medical and asks the PA to interpret law rather than to make health care recommendations. I would reword the sentence to read: "…ensure the patient's access to all treatment options together with information where those options may be legally available."

704 Tomar Court
Sioux Falls, SD 57105
henrytravers@sio.midco.net
605-359-2750

Page 19: PAs and Research

One might encounter considerable disagreement over the premise that honesty is the most important ethical principle in research. *Integrity*, for example, may be a better ethical concept. One can be honest, but still "spin" information. PAs participating in research must be familiar with the ethical requirements of informed consent.

Page 36: Physical Therapists, Principle #2A

Saying one adheres to core values without specifying what those values are is an incomplete guide. There should be some reference to a description or list of those values.

Page 36: Physical Therapists, Principle #2D

The concept of collaborating "with patients/clients to empower them in decisions…" is conceptually oblique to the *obligation* of physical therapists to provide information and obtain informed consent from patients/clients about their health care. This principle should be reworded.

Thank you for the opportunity to review these rules and to offer comments to the Board.

Sincerely,

Henry Travers, MD, FACP

SOUTH DAKOTA STATE MEDICAL ASSOCIATION

Values. Ethics. Advocacy.

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March 5, 2015

South Dakota Board Of Medical & Osteopathic Examiners
101 N Main Ave Ste 301
Sioux Falls, SD 57104-6411

RE: Proposed Rules – ARSD Ch. 20:47:07 and 20:47:08

Dear Board Members:

I am writing in my capacity as President of the South Dakota State Medical Association ("SDSMA"). SDSMA is a professional organization of more than 2,000 physicians, residents and medical students, all of whom are dedicated to protecting the health care interests of patients and advancing the effectiveness of physicians throughout South Dakota.

This is intended as SDSMA's written testimony on the proposed rules described below. SDSMA respectfully reserves the right to appear and provide additional live testimony at the March 11, 2015 rules hearing.

While SDSMA greatly appreciates the efforts of the Board and its staff to provide guidance on the complex issues described in the proposed "Best Practices" rules, SDSMA believes the proposed rules are so generalized and vague that they are much more likely to result in unintended consequences and confusion than provide useful guidance.

SDSMA's concerns, presented in the same order as the rules themselves, are as follows:

<u>Proposed ARSD 20:47:07:01 – "Best practices defined."</u>

While this proposed rule first states that failure to comply is not a grounds for disciplinary action, it goes on to provide that a physician may be called upon to "justify" a failure to comply. The proposed rule also provides that compliance with established best practices constitutes a defense to a disciplinary action.

SDSMA believes these seemingly contradictory statements of policy will lead to confusion and cause physicians to believe they are required to comply with the generalized "best practices" established in the rules even if the physician's well-reasoned medical judgment calls for a different approach.

Furthermore, SDSMA objects to proposed ARSD 20:47:07:01 and the adoption of best practices generally as being inconsistent with AMA policy concerning the adoption of health care standards (see policy H-450.935 - Health Care Standards), and in particular subpart 2 of that policy, wherein the AMA

> supports the position that any practice guidelines, parameters, best practices models, or similar set of principles or clinical recommendations, whether developed or issued by government or non-government organizations, including those that result from any comparative effectiveness research or evidence-based medicine system, do not, and should expressly state that they do not, establish standard of care or create specific requirements for physicians that restrict the exercise of their clinical judgment.

<u>Proposed ARSD 20:47:07:02 - "Best practices for the prescription of controlled substances for the treatment of pain."</u>

Proposed rule 20:47:07:02 includes several provisions which give rise to SDSMA's concern that the proposal is too generalized and vague:

1. The proposed regulation makes no distinction between different types of pain – whether acute, chronic, related to a terminal illness, or other. As the Board is aware, the best course of treatment often depends on the type of pain being experienced by the patient.

2. The proposal – in steps one through nine – suggests that these steps must be followed in the order set out in the proposed rule, both in terms of "process" and "procedure." Depending on the clinical indication, many of these "process" points make little objective or clinical sense. For example, it appears that an acute care situation (e.g., a broken arm) would require both a signed patient agreement and a trial of opioid therapy, neither of which would be indicated under the existing standard of care.

3. The following considerations and questions further demonstrate why the proposed rule should be withdrawn given its vagueness:

- For subpart 1, how many acute situations (or terminal ones) truly require a differential diagnosis?

- For subpart 2, for example, is a hospice patient's risk of substance use disorder relevant?
- For subpart 3, what form would "informed consent" take? Again, shouldn't there be different considerations depending on the diagnosis and type of pain?
- For subpart 4, while this may make sense for long-term opioid therapy for chronic pain, it likely does not make sense for acute or terminal conditions.
- For subpart 5, even for chronic pain, is this the appropriate focus? Depending on the condition, some patients may be able to have function "restored," but that may not be the goal.
- For subpart 6, this is probably fine for long-term, chronic opioid-related therapy, but not for other pain treatment scenarios.
- For subpart 7, depending on the patient, this level of oversight may not be necessary, and it may lead to some patients not being able to obtain care. Similarly, this requirement should not apply to acute or terminal conditions.

Proposed ARSD 20:47:07:03[1] – "Best practices for medical records when prescribing controlled substances for the control of pain."

The concept of maintaining accurate and complete medical records of course makes sense, but as with proposed 20:47:07:02, this proposal appears to SDSMA to be overly broad and vague. For example, "pain" may not be the primary diagnosis; "cancer", "broken bone", "fibromyalgia", or some other condition might be the primary reason for treatment. Do the same record-keeping requirements apply when there is a primary diagnosis other than "pain?"

Proposed ARSD 20:47:07:03(1) includes cross-references to proposed ARSD 20:47:07:02(4) and (6)[2]; those provisions of proposed 20:47:07:02 are problematic for the reasons described above.

The proposed rule states that each of the numbered subsections must be addressed. Does that mean that risk assessments are necessary for every condition? For chronic, long-term opioid therapy, many of the listed items might make sense, but again the proposal seems to be overbroad and as a result would interfere with the practitioner's well-reasoned professional judgment.

---

[1] The proposed rule is numbered 20:47:07:02; SDSMA assumes it was intended to be numbered 20:47:07:03.

[2] The proposed rule cross-references to 20:47:07:01, but SDSMA assumes it was intended to be a cross-reference to 20:47:07:02.

General Comments Concerning Proposed Best Practices Rules

In addition to SDSMA's substantive issues about the rules themselves, SDSMA has equally-important concerns about the concept of codifying "best practices" in administrative rules. First, as noted above, inserting generalized "best practices" into rules unduly interferes with the physician-patient relationship because the physician may not feel free to craft a treatment plan that is at odds with the codified "best practices," but is best for the patient.

Second, putting "best practices" in rule means further rule-making or legislation would be required to modify those "best practices" as medicine evolves. As a result, the advance of medicine will be slowed. If the Board elects to proceed with the adoption of "best practices" as proposed, which SDSMA opposes, SDSMA joins with the AMA in urging the Board to "set and make publicly available a regular schedule for review and update and to include the level of evidence supporting the guidelines." AMA Policy H-450.935.

Third, our research and that of the AMA indicates that since the FSMB began promoting the new guidelines in July 2013, only 10 states have adopted a version of them. SDSMA respectfully submits that this lack of adoption of the guidelines is an indication of a lack of professional consensus as to the substance of the proposed guidelines.

Finally, I have enclosed a copy of the full American Medical Association policy on the adoption of best practices and similar policy statements, as well as a letter from the AMA dated March 4, 2015 which expresses many of the same concerns about the substance of the proposed rules and the practice of incorporating best practices into administrative rule.

Proposed ARSD Ch. 20:47:08 – Ethics.

As to the proposed adoption of the AMA's model rules of ethics for physicians, SDSMA supports and applauds the Board's effort so to do.

Thank you for the opportunity to provide SDSMA's perspective on the proposed rules. For the reasons stated above, SDSMA strongly encourages the Board to reject proposed ARSD Ch. 20:47:07 in its entirety. SDSMA supports the adoption of proposed ARSD Ch. 20:47:08.

Sincerely,

Mary Milroy, MD, President
South Dakota State Medical Association

Avera
McKennan Hospital
& University Health Center

1325 S. Cliff Ave.
P.O. Box 5045
Sioux Falls, SD 57117-5045
605-322-8000

AveraMcKennan.org

March 2, 2015

South Dakota Board of Medical and Osteopathic Examiners
101 N. Main Avenue Suite 301
Sioux Falls, SD 57104

Dear SDBMOE:

I am writing this letter in response to your public hearing notice for Proposed Administrative Rules. I read with interest Chapter 20:47:07 Physician Best Practices for the Prescription of Controlled Substances for the Treatment of Pain and Best Practices for Medical Records when Prescribing Controlled Substances for the Treatment of Pain. In general, I applaud your efforts to encourage best practices and developing standardized procedures for prescribing Opioid related analgesics for pain. I do however have a couple of concerns regarding the wording of this chapter that I would like to bring to your attention.

First, I think the wording is quite broad and could create multiple challenges particularly if it is applied to non-opioid containing narcotics such as a substance like valium. Likewise with the broad generic nature of this chapter, I do not believe that it applies well at all to the inpatient prescribing of opioid and non-opioid containing analgesics and other controlled substances. Therefore, I would highly recommend that verbage be included in this chapter to make it clear that it was pertaining to the outpatient prescribing of narcotics. Additionally, the implementation of these best practices could be somewhat challenging given our current electronic medical record environment. I would hope that the folks trying to pass these best practice recommendations would be cognizant of that and allow clinics the adequate time to develop EMR templates and other workflow mechanisms to meet the requirements of these best practices.

Again, I applaud the Board of Medical and Osteopathic Examiners efforts to improve the practices around the prescribing of opioid containing analgesics for pain control and hope that you would take my comments into consideration when drafting the final recommendations.

Please do not hesitate to reach out to me should you have any questions or concerns.

Sincerely,

M. Elliott, MD

Mike Elliott, MD
Senior Vice President Medical Affairs/CMO

ME/bkd

From: Stephen G. Eckrich
To: SDBMOE
Subject: Comment on proposed rule for prescribing opioids
Date: Tuesday, February 24, 2015 5:03:03 PM

Dear SDBMOE:

As a practicing physician who prescribes opioid narcotics for the treatment of pain in the acute and post-operative setting, I am writing to oppose the proposed rule on opioid prescriptions because the rule does not differentiate between the use of opioids for the chronic treatment of pain and their use for acute and post-surgical pain. It would appear that the Board's intent was to address the use of these medications for the treatment of chronic pain, as the article referenced at the end of the rule clearly refers to chronic pain; however, there is nothing in the body of the rule which differentiates between these two, vastly different uses of narcotic pain medications. To state that in order for me to prescribe opioids post injury or post-surgery in a "best practice" manner would require that I obtain an informed consent from the patient, with an outlined treatment plan, and discussion of the alternatives, is just not realistic nor in the patient's best interest. In an acute injury scenario, it is challenge enough to impart a minimum understanding of the choices for treatment and their rationale to a patient who is already in pain, frightened, and unfamiliar with the medical system. To then add another layer of anxiety and concern over how exactly there pain will be handled is just not realistic.

If it was the Board's intent to have this rule apply only to the use of opioids to treat chronic pain, however that may be defined, then that must be clearly stated in the proposed rule. As the rule is written, it does not address these two fundamentally distinct uses of narcotics to treat pain, and should be amended to reflect that. In the absence of such an amendment, it should be rejected.

Stephen Eckrich, MD
Rapid City, SD

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From: Steven Giuseffi
To: SDBMOE; SDBMOE
Subject: Concern about SD narcotic prescription proposed rule
Date: Wednesday, February 25, 2015 6:03:28 PM

South Dakota Medical Board:

I am concerned about the proposed rule for

"Best practices for the prescription of controlled substances for the treatment of pain."

Such a rule would have broad implications for surgeons who frequently prescribe short-term opioid pain medications for acute trauma or post-operative pain management.
The requirements to specifically document opioid dependence risk, develop a written and signed opioid agreement between patient and provider, and follow mandated follow-up appointment intervals would be onerous for surgeons while not benefitting patients that receive limited narcotics for acute pain.

While these rules would appear to be appropriate for long-term chronic pain management, they are inappropriate for short-term narcotic dispersal.
I'm concerned that the above rule does not appear to distinguish between the prescription of narcotics for acute traumatic events and/or post-surgical pain versus chronic pain.
Failure to make this distinction would dramatically affect my practice and that of my colleagues in a negative way without providing patient benefit.

Please consider revising the rule to distinguish between opioid prescription for acute versus chronic pain management and apply these requirements only for long-term opioid prescription.

Sincerely,

Steven A. Giuseffi, MD
Orthopedic Surgery
Black Hills Orthopedic and Spine Center
Rapid City, SD

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From: Tom Benzoni
To: SDBMOE
Subject: Re: Updated Public Hearing Notice for Proposed Administrative Rules
Date: Friday, February 20, 2015 8:26:30 PM

I can't make it in person.

Regarding physician assistant portion:

I question the wisdom of placing what appears to be an aspirational document into rules.

Thomas Benzoni, DO

On Feb 20, 2015 1:43 PM, "SDBMOE" <SDBMOE@state.sd.us> wrote:

> Licensees and Interested Parties,
>
> Please find attached an updated notice for the **Wednesday, March 11th at 9:00 AM CDT public hearing** for proposed administrative rules.
>
> Persons interested in presenting data, opinions, and arguments for or against the proposed rules may do so by appearing in person at the hearing or by sending them to the South Dakota Board of Medical and Osteopathic Examiners, 101 N Main Ave, Ste 301, Sioux Falls, South Dakota 57104 or by email to SDBMOE@state.sd.gov by **March 10, 2015**.
>
> Copies of the proposed rules may be obtained from the South Dakota Administrative Rules website https://rules.sd.gov/detail.aspx?Id=168 or by contacting the Board of Medical and Osteopathic Examiners.
>
> Sincerely,
>
> Board Staff from General Email
>
> South Dakota Board of Medical & Osteopathic Examiners
>
> sdbmoe@state.sd.us
>
> www.sdbmoe.gov

State of South Dakota

Board of Medical and Osteopathic Examiners

Petition

Pursuant to the provisions of SDCL 1-26-15, I, Tyler Klatt of 101 N. Main Ave. Ste. 301 Sioux Falls, South Dakota, am Board staff, and I do hereby petition the South Dakota Board of Medical and Osteopathic Examiners for their decision in regard to the following:

1. It is requested that the September 21, 1994 declaratory ruling of the Board which requires compliance with Centers for Disease Control universal precautions be vacated.

2. The administrative rule which prompted this declaratory ruling was repealed December 27, 2004.

3. The petitioner requests that the declaratory ruling be vacated.

Dated at Sioux Falls, South Dakota, this 4 day of March, 2015.

Tyler Klatt

AN ACT

ENTITLED, An Act to adopt the Interstate Medical Licensure Compact.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF SOUTH DAKOTA:

Section 1. The Interstate Medical Licensure Compact is enacted into law and entered into with all other jurisdictions that legally join the compact, which is substantially as follows:

INTERSTATE MEDICAL LICENSURE COMPACT

SECTION 1: PURPOSE

In order to strengthen access to health care, and in recognition of the advances in the delivery of health care, the member states of the Interstate Medical Licensure Compact have allied in common purpose to develop a comprehensive process that complements the existing licensing and regulatory authority of state medical boards, provides a streamlined process that allows physicians to become licensed in multiple states, thereby enhancing the portability of a medical license and ensuring the safety of patients. The compact creates another pathway for licensure and does not otherwise change a state's existing Medical Practice Act. The compact also adopts the prevailing standard for licensure and affirms that the practice of medicine occurs where the patient is located at the time of the physician-patient encounter, and therefore, requires the physician to be under the jurisdiction of the state medical board where the patient is located. State medical boards that participate in the compact retain the jurisdiction to impose an adverse action against a license to practice medicine in that state issued to a physician through the procedures in the compact.

SECTION 2: DEFINITIONS

In this compact:

(a) "Bylaws" means those bylaws established by the Interstate Commission pursuant to section 11 for its governance, or for directing and controlling its actions and conduct.

(b) "Commissioner" means the voting representative appointed by each member board

pursuant to section 11.

(c) "Conviction" means a finding by a court that an individual is guilty of a criminal offense through adjudication, or entry of a plea of guilt or no contest to the charge by the offender. Evidence of an entry of a conviction of a criminal offense by the court shall be considered final for purposes of disciplinary action by a member board.

(d) "Expedited License" means a full and unrestricted medical license granted by a member state to an eligible physician through the process set forth in the compact.

(e) "Interstate Commission" means the interstate commission created pursuant to section 11.

(f) "License" means authorization by a state for a physician to engage in the practice of medicine, which would be unlawful without the authorization.

(g) "Medical Practice Act" means laws and regulations governing the practice of allopathic and osteopathic medicine within a member state.

(h) "Member Board" means a state agency in a member state that acts in the sovereign interests of the state by protecting the public through licensure, regulation, and education of physicians as directed by the state government.

(i) "Member State" means a state that has enacted the compact.

(j) "Practice of Medicine" means the clinical prevention, diagnosis, or treatment of human disease, injury, or condition requiring a physician to obtain and maintain a license in compliance with the Medical Practice Act of a member state.

(k) "Physician" means any person who:

(1) Is a graduate of a medical school accredited by the Liaison Committee on Medical Education, the Commission on Osteopathic College Accreditation, or a medical school listed in the International Medical Education Directory or its equivalent;

(2) Passed each component of the United States Medical Licensing Examination

(USMLE) or the Comprehensive Osteopathic Medical Licensing Examination (COMLEX-USA) within three attempts, or any of its predecessor examinations accepted by a state medical board as an equivalent examination for licensure purposes;

(3) Successfully completed graduate medical education approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association;

(4) Holds specialty certification or a time-unlimited specialty certificate recognized by the American Board of Medical Specialties or the American Osteopathic Association's Bureau of Osteopathic Specialists;

(5) Possesses a full and unrestricted license to engage in the practice of medicine issued by a member board;

(6) Has never been convicted, received adjudication, deferred adjudication, community supervision, or deferred disposition for any offense by a court of appropriate jurisdiction;

(7) Has never held a license authorizing the practice of medicine subjected to discipline by a licensing agency in any state, federal, or foreign jurisdiction, excluding any action related to nonpayment of fees related to a license;

(8) Has never had a controlled substance license or permit suspended or revoked by a state or the United States Drug Enforcement Administration; and

(10) Is not under active investigation by a licensing agency or law enforcement authority in any state, federal, or foreign jurisdiction.

(l) "Offense" means a felony, gross misdemeanor, or crime of moral turpitude.

(m) "Rule" means a written statement by the Interstate Commission promulgated pursuant to section 12 of the compact that is of general applicability, implements, interprets, or

prescribes a policy or provision of the Compact, or an organizational, procedural, or practice requirement of the Interstate Commission, and has the force and effect of statutory law in a member state, and includes the amendment, repeal, or suspension of an existing rule.

(n) "State" means any state, commonwealth, district, or territory of the United States.

(o) "State of Principal License" means a member state where a physician holds a license to practice medicine and which has been designated as such by the physician for purposes of registration and participation in the compact.

SECTION 3: ELIGIBILITY

(a) A physician must meet the eligibility requirements as defined in section 2(k) to receive an expedited license under the terms and provisions of the compact.

(b) A physician who does not meet the requirements of section 2(k) may obtain a license to practice medicine in a member state if the individual complies with all laws and requirements, other than the compact, relating to the issuance of a license to practice medicine in that state.

SECTION 4: DESIGNATION OF STATE OF PRINCIPAL LICENSE

(a) A physician shall designate a member state as the state of principal license for purposes of registration for expedited licensure through the compact if the physician possesses a full and unrestricted license to practice medicine in that state, and the state is:

(1) The state of primary residence for the physician; or

(2) The state where at least twenty-five percent of the practice of medicine occurs; or

(3) The location of the physician's employer; or

(4) If no state qualifies under subsection (1), subsection (2), or subsection (3), the state designated as state of residence for purpose of federal income tax.

(b) A physician may redesignate a member state as state of principal license at any time, as long

as the state meets the requirements in subsection (a).

(c) The Interstate Commission is authorized to develop rules to facilitate redesignation of another member state as the state of principal license.

SECTION 5: APPLICATION AND ISSUANCE OF EXPEDITED LICENSURE

(a) A physician seeking licensure through the compact shall file an application for an expedited license with the member board of the state selected by the physician as the state of principal license.

(b) Upon receipt of an application for an expedited license, the member board within the state selected as the state of principal license shall evaluate whether the physician is eligible for expedited licensure and issue a letter of qualification, verifying or denying the physician's eligibility, to the Interstate Commission.

(i) Static qualifications, which include verification of medical education, graduate medical education, results of any medical or licensing examination, and other qualifications as determined by the Interstate Commission through rule, shall not be subject to additional primary source verification where already primary source verified by the state of principal license.

(ii) The member board within the state selected as the state of principal license shall, in the course of verifying eligibility, perform a criminal background check of an applicant, including the use of the results of fingerprint or other biometric data checks compliant with the requirements of the Federal Bureau of Investigation, with the exception of federal employees who have suitability determination in accordance with U.S. C.F.R. §731.202.

(iii) Appeal on the determination of eligibility shall be made to the member state where the application was filed and shall be subject to the law of that state.

(c) Upon verification in subsection (b), physicians eligible for an expedited license shall complete the registration process established by the Interstate Commission to receive a license in a

member state selected pursuant to subsection (a), including the payment of any applicable fees.

(d) After receiving verification of eligibility under subsection (b) and any fees under subsection (c), a member board shall issue an expedited license to the physician. This license shall authorize the physician to practice medicine in the issuing state consistent with the Medical Practice Act and all applicable laws and regulations of the issuing member board and member state.

(e) An expedited license shall be valid for a period consistent with the licensure period in the member state and in the same manner as required for other physicians holding a full and unrestricted license within the member state.

(f) An expedited license obtained though the compact shall be terminated if a physician fails to maintain a license in the state of principal licensure for a nondisciplinary reason, without redesignation of a new state of principal licensure.

(g) The Interstate Commission is authorized to develop rules regarding the application process, including payment of any applicable fees, and the issuance of an expedited license.

SECTION 6: FEES FOR EXPEDITED LICENSURE

(a) A member state issuing an expedited license authorizing the practice of medicine in that state may impose a fee for a license issued or renewed through the compact.

(b) The Interstate Commission is authorized to develop rules regarding fees for expedited licenses.

SECTION 7: RENEWAL AND CONTINUED PARTICIPATION

(a) A physician seeking to renew an expedited license granted in a member state shall complete a renewal process with the Interstate Commission if the physician:

(1) Maintains a full and unrestricted license in a state of principal license;

(2) Has not been convicted, received adjudication, deferred adjudication, community supervision, or deferred disposition for any offense by a court of appropriate jurisdiction;

(3) Has not had a license authorizing the practice of medicine subject to discipline by a licensing agency in any state, federal, or foreign jurisdiction, excluding any action related to nonpayment of fees related to a license; and

(4) Has not had a controlled substance license or permit suspended or revoked by a state or the United States Drug Enforcement Administration.

(b) Physicians shall comply with all continuing professional development or continuing medical education requirements for renewal of a license issued by a member state.

(c) The Interstate Commission shall collect any renewal fees charged for the renewal of a license and distribute the fees to the applicable member board.

(d) Upon receipt of any renewal fees collected in subsection (c), a member board shall renew the physician's license.

(e) Physician information collected by the Interstate Commission during the renewal process will be distributed to all member boards.

(f) The Interstate Commission is authorized to develop rules to address renewal of licenses obtained through the compact.

SECTION 8: COORDINATED INFORMATION SYSTEM

(a) The Interstate Commission shall establish a database of all physicians licensed, or who have applied for licensure, under section 5.

(b) Notwithstanding any other provision of law, member boards shall report to the Interstate Commission any public action or complaints against a licensed physician who has applied or received an expedited license through the compact.

(c) Member boards shall report disciplinary or investigatory information determined as necessary and proper by rule of the Interstate Commission.

(d) Member boards may report any nonpublic complaint, disciplinary, or investigatory

information not required by subsection (c) to the Interstate Commission.

(e) Member boards shall share complaint or disciplinary information about a physician upon request of another member board.

(f) All information provided to the Interstate Commission or distributed by member boards shall be confidential, filed under seal, and used only for investigatory or disciplinary matters.

(g) The Interstate Commission is authorized to develop rules for mandated or discretionary sharing of information by member boards.

SECTION 9: JOINT INVESTIGATIONS

(a) Licensure and disciplinary records of physicians are deemed investigative.

(b) In addition to the authority granted to a member board by its respective Medical Practice Act or other applicable state law, a member board may participate with other member boards in joint investigations of physicians licensed by the member boards.

(c) A subpoena issued by a member state shall be enforceable in other member states.

(d) Member boards may share any investigative, litigation, or compliance materials in furtherance of any joint or individual investigation initiated under the compact.

(e) Any member state may investigate actual or alleged violations of the statutes authorizing the practice of medicine in any other member state in which a physician holds a license to practice medicine.

SECTION 10: DISCIPLINARY ACTIONS

(a) Any disciplinary action taken by any member board against a physician licensed through the compact shall be deemed unprofessional conduct which may be subject to discipline by other member boards, in addition to any violation of the Medical Practice Act or regulations in that state.

(b) If a license granted to a physician by the member board in the state of principal license is revoked, surrendered or relinquished in lieu of discipline, or suspended, then all licenses issued to

the physician by member boards shall automatically be placed, without further action necessary by any member board, on the same status. If the member board in the state of principal license subsequently reinstates the physician's license, a license issued to the physician by any other member board shall remain encumbered until that respective member board takes action to reinstate the license in a manner consistent with the Medical Practice Act of that state.

(c) If disciplinary action is taken against a physician by a member board not in the state of principal license, any other member board may deem the action conclusive as to matter of law and fact decided, and:

(i) Impose the same or lesser sanction(s) against the physician so long as such sanctions are consistent with the Medical Practice Act of that state; or

(ii) Pursue separate disciplinary action against the physician under its respective Medical Practice Act, regardless of the action taken in other member states.

(d) If a license granted to a physician by a member board is revoked, surrendered or relinquished in lieu of discipline, or suspended, then any license(s) issued to the physician by any other member board(s) shall be suspended, automatically and immediately without further action necessary by the other member board(s), for ninety days upon entry of the order by the disciplining board, to permit the member board(s) to investigate the basis for the action under the Medical Practice Act of that state. A member board may terminate the automatic suspension of the license it issued prior to the completion of the ninety day suspension period in a manner consistent with the Medical Practice Act of that state.

SECTION 11: INTERSTATE MEDICAL LICENSURE COMPACT COMMISSION

(a) The member states hereby create the Interstate Medical Licensure Compact Commission.

(b) The purpose of the Interstate Commission is the administration of the Interstate Medical Licensure Compact, which is a discretionary state function.

(c) The Interstate Commission shall be a body corporate and joint agency of the member states and shall have all the responsibilities, powers, and duties set forth in the compact, and such additional powers as may be conferred upon it by a subsequent concurrent action of the respective legislatures of the member states in accordance with the terms of the compact.

(d) The Interstate Commission shall consist of two voting representatives appointed by each member state who shall serve as commissioners. In states where allopathic and osteopathic physicians are regulated by separate member boards, or if the licensing and disciplinary authority is split between multiple member boards within a member state, the member state shall appoint one representative from each member board. A commissioner shall be a(n):

(1) Allopathic or osteopathic physician appointed to a member board;

(2) Executive director, executive secretary, or similar executive of a member board; or

(3) Member of the public appointed to a member board.

(e) The Interstate Commission shall meet at least once each calendar year. A portion of this meeting shall be a business meeting to address such matters as may properly come before the commission, including the election of officers. The chairperson may call additional meetings and shall call for a meeting upon the request of a majority of the member states.

(f) The bylaws may provide for meetings of the Interstate Commission to be conducted by telecommunication or electronic communication.

(g) Each commissioner participating at a meeting of the Interstate Commission is entitled to one vote. A majority of commissioners shall constitute a quorum for the transaction of business, unless a larger quorum is required by the bylaws of the Interstate Commission. A commissioner shall not delegate a vote to another commissioner. In the absence of its commissioner, a member state may delegate voting authority for a specified meeting to another person from that state who shall meet the requirements of subsection (d).

(h) The Interstate Commission shall provide public notice of all meetings and all meetings shall be open to the public. The Interstate Commission may close a meeting, in full or in portion, where it determines by a two-thirds vote of the commissioners present that an open meeting would be likely to:

(1) Relate solely to the internal personnel practices and procedures of the Interstate Commission;

(2) Discuss matters specifically exempted from disclosure by federal statute;

(3) Discuss trade secrets, commercial, or financial information that is privileged or confidential;

(4) Involve accusing a person of a crime, or formally censuring a person;

(5) Discuss information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy;

(6) Discuss investigative records compiled for law enforcement purposes; or

(7) Specifically relate to the participation in a civil action or other legal proceeding.

(i) The Interstate Commission shall keep minutes which shall fully describe all matters discussed in a meeting and shall provide a full and accurate summary of actions taken, including record of any roll call votes.

(j) The Interstate Commission shall make its information and official records, to the extent not otherwise designated in the compact or by its rules, available to the public for inspection.

(k) The Interstate Commission shall establish an executive committee, which shall include officers, members, and others as determined by the bylaws. The executive committee shall have the power to act on behalf of the Interstate Commission, with the exception of rulemaking, during periods when the Interstate Commission is not in session. When acting on behalf of the Interstate Commission, the executive committee shall oversee the administration of the compact including

enforcement and compliance with the provisions of the compact, its bylaws and rules, and other such duties as necessary.

(l) The Interstate Commission may establish other committees for governance and administration of the compact.

SECTION 12: POWERS AND DUTIES OF THE INTERSTATE COMMISSION

The Interstate Commission shall have the duty and power to:

(a) Oversee and maintain the administration of the compact;

(b) Promulgate rules which shall be binding to the extent and in the manner provided for in the compact;

(c) Issue, upon the request of a member state or member board, advisory opinions concerning the meaning or interpretation of the compact, its bylaws, rules, and actions;

(d) Enforce compliance with compact provisions, the rules promulgated by the Interstate Commission, and the bylaws, using all necessary and proper means, including but not limited to the use of judicial process;

(e) Establish and appoint committees including, but not limited to, an executive committee as required by section 11, which shall have the power to act on behalf of the Interstate Commission in carrying out its powers and duties;

(f) Pay, or provide for the payment of the expenses related to the establishment, organization, and ongoing activities of the Interstate Commission;

(g) Establish and maintain one or more offices;

(h) Borrow, accept, hire, or contract for services of personnel;

(i) Purchase and maintain insurance and bonds;

(j) Employ an executive director who shall have such powers to employ, select or appoint employees, agents, or consultants, and to determine their qualifications, define their

duties, and fix their compensation;

(k) Establish personnel policies and programs relating to conflicts of interest, rates of compensation, and qualifications of personnel;

(l) Accept donations and grants of money, equipment, supplies, materials and services, and to receive, utilize, and dispose of it in a manner consistent with the conflict of interest policies established by the Interstate Commission;

(m) Lease, purchase, accept contributions or donations of, or otherwise to own, hold, improve or use, any property, real, personal, or mixed;

(n) Sell, convey, mortgage, pledge, lease, exchange, abandon, or otherwise dispose of any property, real, personal, or mixed;

(o) Establish a budget and make expenditures;

(p) Adopt a seal and bylaws governing the management and operation of the Interstate Commission;

(q) Report annually to the Legislatures and Governors of the member states concerning the activities of the Interstate Commission during the preceding year. Such reports shall also include reports of financial audits and any recommendations that may have been adopted by the Interstate Commission;

(r) Coordinate education, training, and public awareness regarding the compact, its implementation, and its operation;

(s) Maintain records in accordance with the bylaws;

(t) Seek and obtain trademarks, copyrights, and patents; and

(u) Perform such functions as may be necessary or appropriate to achieve the purposes of the compact.

SECTION 13: FINANCE POWERS

(a) The Interstate Commission may levy on and collect an annual assessment from each member state to cover the cost of the operations and activities of the Interstate Commission and its staff. The total assessment must be sufficient to cover the annual budget approved each year for which revenue is not provided by other sources. The aggregate annual assessment amount shall be allocated upon a formula to be determined by the Interstate Commission, which shall promulgate a rule binding upon all member states.

(b) The Interstate Commission shall not incur obligations of any kind prior to securing the funds adequate to meet the same.

(c) The Interstate Commission shall not pledge the credit of any of the member states, except by, and with the authority of, the member state.

(d) The Interstate Commission shall be subject to a yearly financial audit conducted by a certified or licensed public accountant and the report of the audit shall be included in the annual report of the Interstate Commission.

SECTION 14: ORGANIZATION AND OPERATION

OF THE INTERSTATE COMMISSION

(a) The Interstate Commission shall, by a majority of commissioners present and voting, adopt bylaws to govern its conduct as may be necessary or appropriate to carry out the purposes of the compact within twelve months of the first Interstate Commission meeting.

(b) The Interstate Commission shall elect or appoint annually from among its commissioners a chairperson, a vice-chairperson, and a treasurer, each of whom shall have such authority and duties as may be specified in the bylaws. The chairperson, or in the chairperson's absence or disability, the vice-chairperson, shall preside at all meetings of the Interstate Commission.

(c) Officers selected in subsection (b) shall serve without remuneration from the Interstate Commission.

(d) The officers and employees of the Interstate Commission shall be immune from suit and liability, either personally or in their official capacity, for a claim for damage to or loss of property or personal injury or other civil liability caused or arising out of, or relating to, an actual or alleged act, error, or omission that occurred, or that such person had a reasonable basis for believing occurred, within the scope of Interstate Commission employment, duties, or responsibilities; provided that such person shall not be protected from suit or liability for damage, loss, injury, or liability caused by the intentional or willful and wanton misconduct of such person.

(1) The liability of the executive director and employees of the Interstate Commission or representatives of the Interstate Commission, acting within the scope of such person's employment or duties for acts, errors, or omissions occurring within such person's state, may not exceed the limits of liability set forth under the constitution and laws of that state for state officials, employees, and agents. The Interstate Commission is considered to be an instrumentality of the states for the purposes of any such action. Nothing in this subsection shall be construed to protect such person from suit or liability for damage, loss, injury, or liability caused by the intentional or willful and wanton misconduct of such person.

(2) The Interstate Commission shall defend the executive director, its employees, and subject to the approval of the attorney general or other appropriate legal counsel of the member state represented by an Interstate Commission representative, shall defend such Interstate Commission representative in any civil action seeking to impose liability arising out of an actual or alleged act, error or omission that occurred within the scope of Interstate Commission employment, duties or responsibilities, or that the defendant had a reasonable basis for believing occurred within the scope of Interstate Commission employment, duties, or responsibilities, provided that the actual or alleged act, error, or

omission did not result from intentional or willful and wanton misconduct on the part of such person.

(3) To the extent not covered by the state involved, member state, or the Interstate Commission, the representatives or employees of the Interstate Commission shall be held harmless in the amount of a settlement or judgment, including attorney's fees and costs, obtained against such persons arising out of an actual or alleged act, error, or omission that occurred within the scope of Interstate Commission employment, duties, or responsibilities, or that such persons had a reasonable basis for believing occurred within the scope of Interstate Commission employment, duties, or responsibilities, provided that the actual or alleged act, error, or omission did not result from intentional or willful and wanton misconduct on the part of such persons.

SECTION 15: RULE-MAKING FUNCTIONS OF THE INTERSTATE COMMISSION

(a) The Interstate Commission shall promulgate reasonable rules in order to effectively and efficiently achieve the purposes of the compact. Notwithstanding the foregoing, in the event the Interstate Commission exercises its rule-making authority in a manner that is beyond the scope of the purposes of the compact, or the powers granted hereunder, then such an action by the Interstate Commission shall be invalid and have no force or effect.

(b) Rules deemed appropriate for the operations of the Interstate Commission shall be made pursuant to a rule-making process that substantially conforms to the Model State Administrative Procedure Act of 2010, and subsequent amendments thereto.

(c) Not later than thirty days after a rule is promulgated, any person may file a petition for judicial review of the rule in the United States District Court for the District of Columbia or the federal district where the Interstate Commission has its principal offices, provided that the filing of such a petition shall not stay or otherwise prevent the rule from becoming effective unless the court

finds that the petitioner has a substantial likelihood of success. The court shall give deference to the actions of the Interstate Commission consistent with applicable law and shall not find the rule to be unlawful if the rule represents a reasonable exercise of the authority granted to the Interstate Commission.

SECTION 16: OVERSIGHT OF INTERSTATE COMPACT

(a) The executive, legislative, and judicial branches of state government in each member state shall enforce the compact and shall take all actions necessary and appropriate to effectuate the compact's purposes and intent. The provisions of the compact and the rules promulgated hereunder shall have standing as statutory law but shall not override existing state authority to regulate the practice of medicine.

(b) All courts shall take judicial notice of the compact and the rules in any judicial or administrative proceeding in a member state pertaining to the subject matter of the compact which may affect the powers, responsibilities or actions of the Interstate Commission.

(c) The Interstate Commission shall be entitled to receive all service of process in any such proceeding, and shall have standing to intervene in the proceeding for all purposes. Failure to provide service of process to the Interstate Commission shall render a judgment or order void as to the Interstate Commission, the compact, or promulgated rules.

SECTION 17: ENFORCEMENT OF INTERSTATE COMPACT

(a) The Interstate Commission, in the reasonable exercise of its discretion, shall enforce the provisions and rules of the compact.

(b) The Interstate Commission may, by majority vote of the commissioners, initiate legal action in the United States District Court for the District of Columbia, or, at the discretion of the Interstate Commission, in the federal district where the Interstate Commission has its principal offices, to enforce compliance with the provisions of the compact, and its promulgated rules and bylaws,

against a member state in default. The relief sought may include both injunctive relief and damages. In the event judicial enforcement is necessary, the prevailing party shall be awarded all costs of such litigation including reasonable attorney's fees.

(c) The remedies herein shall not be the exclusive remedies of the Interstate Commission. The Interstate Commission may avail itself of any other remedies available under state law or the regulation of a profession.

SECTION 18: DEFAULT PROCEDURES

(a) The grounds for default include, but are not limited to, failure of a member state to perform such obligations or responsibilities imposed upon it by the compact, or the rules and bylaws of the Interstate Commission promulgated under the compact.

(b) If the Interstate Commission determines that a member state has defaulted in the performance of its obligations or responsibilities under the compact, or the bylaws or promulgated rules, the Interstate Commission shall:

(1) Provide written notice to the defaulting state and other member states, of the nature of the default, the means of curing the default, and any action taken by the Interstate Commission. The Interstate Commission shall specify the conditions by which the defaulting state must cure its default; and

(2) Provide remedial training and specific technical assistance regarding the default.

(c) If the defaulting state fails to cure the default, the defaulting state shall be terminated from the compact upon an affirmative vote of a majority of the commissioners and all rights, privileges, and benefits conferred by the compact shall terminate on the effective date of termination. A cure of the default does not relieve the offending state of obligations or liabilities incurred during the period of the default.

(d) Termination of membership in the compact shall be imposed only after all other means of

securing compliance have been exhausted. Notice of intent to terminate shall be given by the Interstate Commission to the Governor, the majority and minority leaders of the defaulting state's Legislature, and each of the member states.

(e) The Interstate Commission shall establish rules and procedures to address licenses and physicians that are materially impacted by the termination of a member state, or the withdrawal of a member state.

(f) The member state which has been terminated is responsible for all dues, obligations, and liabilities incurred through the effective date of termination including obligations, the performance of which extends beyond the effective date of termination.

(g) The Interstate Commission shall not bear any costs relating to any state that has been found to be in default or which has been terminated from the compact, unless otherwise mutually agreed upon in writing between the Interstate Commission and the defaulting state.

(h) The defaulting state may appeal the action of the Interstate Commission by petitioning the United States District Court for the District of Columbia or the federal district where the Interstate Commission has its principal offices. The prevailing party shall be awarded all costs of such litigation including reasonable attorney's fees.

SECTION 19: DISPUTE RESOLUTION

(a) The Interstate Commission shall attempt, upon the request of a member state, to resolve disputes which are subject to the compact and which may arise among member states or member boards.

(b) The Interstate Commission shall promulgate rules providing for both mediation and binding dispute resolution as appropriate.

SECTION 20: MEMBER STATES, EFFECTIVE DATE AND AMENDMENT

(a) Any state is eligible to become a member state of the compact.

(b) The compact shall become effective and binding upon legislative enactment of the compact into law by no less than seven states. Thereafter, it shall become effective and binding on a state upon enactment of the compact into law by that state.

(c) The Governors of nonmember states, or their designees, shall be invited to participate in the activities of the Interstate Commission on a nonvoting basis prior to adoption of the compact by all states.

(d) The Interstate Commission may propose amendments to the compact for enactment by the member states. No amendment shall become effective and binding upon the Interstate Commission and the member states unless and until it is enacted into law by unanimous consent of the member states.

SECTION 21: WITHDRAWAL

(a) Once effective, the compact shall continue in force and remain binding upon each and every member state; provided that a member state may withdraw from the compact by specifically repealing the statute which enacted the compact into law.

(b) Withdrawal from the compact shall be by the enactment of a statute repealing the same, but shall not take effect until one year after the effective date of such statute and until written notice of the withdrawal has been given by the withdrawing state to the Governor of each other member state.

(c) The withdrawing state shall immediately notify the chairperson of the Interstate Commission in writing upon the introduction of legislation repealing the compact in the withdrawing state.

(d) The Interstate Commission shall notify the other member states of the withdrawing state's intent to withdraw within sixty days of its receipt of notice provided under subsection (c).

(e) The withdrawing state is responsible for all dues, obligations and liabilities incurred through the effective date of withdrawal, including obligations, the performance of which extend beyond the effective date of withdrawal.

(f) Reinstatement following withdrawal of a member state shall occur upon the withdrawing state reenacting the compact or upon such later date as determined by the Interstate Commission.

(g) The Interstate Commission is authorized to develop rules to address the impact of the withdrawal of a member state on licenses granted in other member states to physicians who designated the withdrawing member state as the state of principal license.

SECTION 22: DISSOLUTION

(a) The compact shall dissolve effective upon the date of the withdrawal or default of the member state which reduces the membership in the compact to one member state.

(b) Upon the dissolution of the compact, the compact becomes null and void and shall be of no further force or effect, and the business and affairs of the Interstate Commission shall be concluded and surplus funds shall be distributed in accordance with the bylaws.

SECTION 23: SEVERABILITY AND CONSTRUCTION

(a) The provisions of the compact shall be severable, and if any phrase, clause, sentence, or provision is deemed unenforceable, the remaining provisions of the compact shall be enforceable.

(b) The provisions of the compact shall be liberally construed to effectuate its purposes.

(c) Nothing in the compact shall be construed to prohibit the applicability of other interstate compacts to which the states are members.

SECTION 24: BINDING EFFECT OF COMPACT AND OTHER LAWS

(a) Nothing herein prevents the enforcement of any other law of a member state that is not inconsistent with the compact.

(b) All laws in a member state in conflict with the compact are superseded to the extent of the conflict.

(c) All lawful actions of the Interstate Commission, including all rules and bylaws promulgated by the commission, are binding upon the member states.

(d) All agreements between the Interstate Commission and the member states are binding in accordance with their terms.

(e) In the event any provision of the compact exceeds the constitutional limits imposed on the Legislature of any member state, such provision shall be ineffective to the extent of the conflict with the constitutional provision in question in that member state.

Section 2. No state general funds shall be used to support the Interstate Medical Licensure Compact enacted by this bill.

An Act to adopt the Interstate Medical Licensure Compact.

==========

I certify that the attached Act originated in the

SENATE as Bill No. 63

_____
Secretary of the Senate

==========

_____
President of the Senate

Attest:

_____
Secretary of the Senate

_____
Speaker of the House

Attest:

_____
Chief Clerk

Senate Bill No. _63_
File No. ____
Chapter No. _____

==========

Received at this Executive Office this _____ day of _____ ,

20____ at _____ M.

By _____
for the Governor

==========

The attached Act is hereby approved this _____ day of _____ , A.D., 20___

_____
Governor

==========

STATE OF SOUTH DAKOTA,
ss.
Office of the Secretary of State

Filed _____ , 20___
at _____ o'clock __ M.

_____
Secretary of State

By _____
Asst. Secretary of State

15SC090405

SOUTH DAKOTA
CONSULTANT CONTRACT/LETTER OF AGREEMENT
FOR CONSULTANT SERVICES
BETWEEN

SD Department of Health
SD Board of Nursing and Board of Medical and Osteopathic Examiners
Health Professionals and Assistance Program
4305 South Louise Avenue Suite 201
Sioux Falls, SD 57106
Referred to as "State"

Midwest Health Management Services, LLC
3130 West 57th Street Suite 111
Sioux Falls, SD 57108
Referred to as "Consultant"

State and Consultant hereby enter into a contract for Consultant Services.

I. CONSULTANT

A. The term of this contract shall begin May 1, 2014 and end May 31, 2015 with the option to renew for seven (7) additional one (1) year extensions at the State's discretion and by mutual agreement. State will not pay for any services provided by Consultant unless this contract is signed by all parties BEFORE CONSULTANT BEGINS TO PROVIDE SERVICES.

B. Consultant is not a full or part-time employee of State or any agency of the state of South Dakota.

C. Consultant, as an independent contractor, is solely responsible for the withholding and payment of applicable income and Social Security taxes due and owing from money received under this contract.

D. Consultant will not use equipment, supplies or facilities owned by the state of South Dakota.

E. Consultant will not purchase capital assets or equipment using State funds.

F. Consultant agrees to:

1. The scope of work for the contracted Health Professionals Assistance Program is separated into the areas of program administration and case management. A program director with overall responsibility for the program, case managers, a medical director and necessary support staff will be required to manage all aspects of the program for all areas of the state. Contractors must have experience in the area of mental health services and substance use disorders. The Program Director must be a Master's level prepared Licensed Professional Counselor and a licensed chemical dependency counselor. Case managers must be licensed chemical dependency counselors and master's prepared in mental health or related field as licensed professional counselors. The program will assure that the number of case managers will be sufficient to support a caseload that meets the needs of the participating licensing boards. Licensed professionals will

have priority for program admission. The medical director must be a licensed physician.

2. Program Administration:

Overall responsibility for implementation of the SD Health Professionals Assistance Program (SDHPAP) in accordance with SDCL 36-2A including:

a. Coordination of the SDHPAP evaluation committee(s) throughout the state as needed for admission and monitoring of program applicants and participants. The evaluation committee structure and duties are defined in SDCL 36-2A.

b. Coordination of the SDHPAP service committee meetings on an annual basis or as often as necessary to transact its business. Provide an annual report of program activities to the service committee. The responsibilities of the program service committee are defined in SDCL 36-2A.

c. Establish and maintain an electronic system of management of program participant information, compliance monitoring and drug testing. Participating licensing boards will have access to all information on board mandated participants.

d. Develop and implement a mental health monitoring component of the SDHPAP in conjunction with the program service committee within 8 weeks of the contract implementation.

e. Consult with a medical director for the program that is a licensed physician, preferably a board certified physician in the areas of addiction medicine and psychiatry.

f. Develop and maintain updated criteria for approval of substance use disorder/mental health services to which program participants may be referred within the state of SD and for specialized services in other states.

g. Coordinate clinical services and resources with providers for access as needed by program participants.

h. Assure that appropriate levels of confidentiality are maintained for the program as defined in SDCL-36-2A as well as all other applicable state and federal standards.

i. Recommend the development and review of policies and procedures for the SDHPAP program for approval by the program service committee on an ongoing basis in accordance with local and national standards of practice for the treatment of substance use and mental health disorders.

j. Provide educational seminars for healthcare providers and facilities to promote understanding and access to the SDHPAP.

k. Serve a public spokesperson for the SDHPAP.

l. Provide a liaison to each of the health care licensing boards participating in the SDHPAP for the purpose of information sharing and management of board referred program participants.

m. Supervise all personnel involved in the program implementation.

n. Provide utilization reports to the licensing boards for the purpose of financial management.

3. Case Management Services:

Case management services are provided by staff in conjunction with the evaluation committee. The case management services include all aspects of program participation to enhance the wellness of the program participants and maintain public safety requirements. Functions include the following activities:

a. Implementation of participation agreements, making indicated changes according to need.

b. Facilitate the management of referral to clinical services as the need arises

c. Facilitate and manage the delivery of support groups for participants.

d. Coordinate all aspects of compliance monitoring as it relates to the individual treatment program. Examples of compliance monitoring include but are not limited to: completing quarterly meetings, random drug screens, support group attendance, referrals for treatment and continuing care, practice restrictions, work site reports, and the filing of any other necessary reports.

e. Maintain participant records in accordance with established policy.

f. Maintain confidentiality of program participants.

G. INSURANCE: Consultant agrees, at its sole cost and expense, to maintain the following insurance:

1. Commercial General Liability Insurance:
Consultant shall maintain occurrence based commercial general liability insurance or equivalent form with a limit of not less than $1,000,000 each occurrence. If such insurance contains a general aggregate limit it shall apply separately to this contract or be no less than two times the occurrence limit.

2. Professional Liability Insurance:
Consultant shall procure and maintain professional liability insurance with a limit of not less than one million dollars.

3. Business Automobile Liability Insurance:
Consultant shall maintain business automobile liability insurance or equivalent form with a limit of not less than $1,000,000 each accident. Such insurance shall include coverage for owned, hired and non-owned vehicles.

4. Worker's Compensation Insurance:
Consultant shall procure and maintain workers' compensation and employers' liability insurance as required by South Dakota law.

5. Certificates of Insurance:
Before beginning work under this Contract, Consultant shall furnish State with properly executed Certificates of Insurance which shall clearly evidence all insurance required in this Contract. In the event of a substantial change in insurance, issuance of a new policy, cancellation or nonrenewal of the policy, Consultant agrees to provide immediate notice to the State and provide a new certificate of insurance showing continuous coverage in the amounts required. Consultant shall furnish copies of insurance policies if requested by State.

H. Consultant agrees to indemnify and hold the State of South Dakota, its officers, agents and employees, harmless from and against any and all actions, suits, damages, liability or other proceedings that may arise as a result of performing services hereunder. This section does not require Consultant to be responsible for or defend against claims or damages arising solely from acts or omissions of the State, its officers, agents or employees.

I. This contract does not require Consultant to engage in a function or activity involving the use or disclosure of State's Protected Health Information (PHI), as defined in the Health Insurance Portability and Accountability Act (HIPAA), 45 CFR § 160.103.

II. STATE

A. State will pay, upon State's satisfaction that services have been completed, up to $400,000.00 with Board of Nursing and Board of Medical and Osteopathic Examiners each paying $200,000.00.

B. State will not pay the Consultant expenses as a separate item.

C. TOTAL CONTRACT AMOUNT (Not to Exceed) $400,000.00. Payment will be made upon receipt of itemized invoices, and consistent with SDCL Ch. 5-26.

D. State will not be held liable for reimbursement of amounts shown on an itemized billing if not received within 30 calendar days from the close of the month being reported.

E. State agrees to:

1. Except for such discretion as is provided, to give full and complete discretion in the conduct for the duties and responsibilities set for in state law and SD Administrative Law.

2. Provide access to disciplinary records as necessary for Board referral of participants in the SDHPAP program.

3. Pay monthly for services rendered.

III. OTHER PROVISIONS

A. CHOICE OF LAW AND FORUM. The terms and conditions of this contract are subject to and will be construed under the laws of the State of South Dakota. The parties further agree that any dispute arising from the terms and conditions of this contract, which cannot be resolved by mutual agreement, will be tried in the Sixth Judicial Circuit Court, Hughes County, South Dakota.

B. INTEGRATION. This contract is a complete version of the entire agreement between the parties with respect to the subject matter within this contract and supersedes all prior or contemporaneous written or oral understandings, agreements and communications between them with respect to such subject matter. This contract may be modified or amended only by a writing signed by both parties.

C. TERMINATION: This contract may be terminated by either party hereto upon thirty (30) days written notice, and may be terminated by State for cause at any time, with or without notice.

D. NOTICE: Any notice or other communication required under this contract shall be in writing and sent to the address set forth above. Notices shall be given by and to the State Contact Person on behalf of State, and by and to the Consultant Contact Person on behalf of Consultant, or such authorized designees as either party may from time to time designate in writing. Notices or communications to or between the parties shall be deemed to have been delivered when mailed by first class mail, provided that notice of default or termination shall be sent by registered or certified mail, or, if personally delivered, when received by such party.

E. CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY, AND VOLUNTARY EXCLUSION: Consultant agrees that neither Consultant, nor any of Consultant's principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in transactions by any Federal department or agency. Consultant will provide immediate written notice to the Department of Health, Division of Administration (600 East Capitol Avenue, Pierre, SD 57501 (605) 773-3361), if Consultant, or any of Consultant's principals, becomes debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in transactions involving Federal funding. Consultant further agrees that if this contract involves federal funds or federally mandated compliance, then Consultant is in compliance with all applicable regulations pursuant to Executive Order 12549, including Debarment and Suspension and Participants' Responsibilities, 29 C.F.R. § 98.510 (1990).

F. FUNDING TERMINATION: This contract depends upon the continued availability of appropriated funds and expenditure authority from Congress, the Legislature or the Executive Branch for this purpose. This contract will be terminated for cause by State if Congress, the Legislature or Executive Branch fails to appropriate funds, terminates funding or does not grant expenditure authority. Funding termination is not a default by State nor does it give rise to a claim against State.

G. NONASSIGNMENT/SUBCONTRACTING: Consultant shall not assign this contract, or any portion thereof, without the prior written consent of State. Consultant's assignment or attempted assignment of this contract, or any portion thereof, without State's prior written consent constitutes a material breach of contract. The Consultant may not use subcontractors to perform the services described herein without the express prior written consent of State. Consultant will include provisions in its subcontracts requiring its subcontractors to comply with the applicable provisions of this Agreement, to indemnify the State, and to provide insurance coverage in a manner consistent with this Agreement. Consultant will cause its subcontractors, agents, and employees to comply with applicable federal, state and local laws, regulations, ordinances, guidelines, permits and requirements and will adopt such review and inspection procedures as are necessary to assure such compliance.

H. FEDERAL AND STATE LAWS: Consultant agrees that it will comply with all federal and state laws, rules and regulations as they may apply to the provision of services pursuant to this contract, including the Americans with Disabilities Act (ADA) of 1990, 42 U.S.C. §§ 12101-12213, and any amendment thereto, Section 306 of the Clean Air Act, and Section 508 of the Clean Water Act. Both parties further agree to provide services covered by this contract without regard to race, color, national origin, sex, age or disability as prohibited by state or federal law.

I. OWNERSHIP: All reports, recommendations, documents, drawings, plans, specifications, technical data and information, copyrights, patents, licenses, or other products produced as a result of the services rendered under this contract, excluding medical records kept in the normal course of Consultant's business, will become the sole property of State. State hereby grants Consultant the unrestricted right to retain copies of and use these materials and the information contained therein in the normal course of Consultant's business for any lawful purpose. Either the originals, or reproducible copies satisfactory to State, of all technical data, evaluations, reports and other work product of Consultant shall be delivered to State upon completion or termination of services under this contract.

J. REPORTING OF PERSONAL INJURIES AND/OR PROPERTY DAMAGE: Consultant agrees to report promptly to State any event encountered in the course of performance of this contract which results in injury to the person or property of third parties, or which may otherwise subject Consultant or State to liability. Reporting to State under this section does not satisfy Consultant's obligation to report any event to law enforcement or other entities as required by law.

K. SEVERABILITY: In the event that any term or provision of this contract shall violate any applicable law, such provision does not invalidate any other provision hereof.

L. AUDIT REQUIREMENTS:
(EXPENDING $750,000 OR MORE)
A nonprofit subrecipient, (as well as profit hospitals) (Consultant), expending $750,000 or more in one year in Federal awards, must have an annual audit made in accordance with 2 CFR Chapter I, Chapter II, Part 200, et al. Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards.

All audits must be conducted by an auditor approved by the Auditor General to perform the audit. Approval may be obtained by forwarding a copy of the audit engagement letter to the Department of Legislative Audit, 427 South Chapelle, c/o 500 East Capitol, Pierre, SD 57501-5070. On continuing engagements, the Auditor General's approval should be obtained annually. The auditor must follow the Auditor General's guidelines when conducting the audit. The draft audit report must be submitted to the Auditor General for approval prior to issuing the final report. The auditor must file the requested copies of the final audit report with the Auditor General. Audits shall be completed and filed with granting agencies by the end of the ninth month following the end of the fiscal year being audited or 30 days after receipt of the auditor's report, whichever is earlier. If it appears that a required audit cannot be completed by the end of the ninth month following your fiscal year, you must request an extension from the federal agency for which the majority of federal expenditures relates.

Failure to complete audit(s) as required will result in the disallowance of audit costs as direct or indirect charges to programs. Additionally, a percentage of awards may be withheld, overhead costs may be disallowed, and/or awards may be suspended, until the audit is completed satisfactorily.

M. PERSONNEL: Neither the Consultant nor any employee or agent thereof will hold him or herself out as or claim to be an officer or employee of State and will not make any claim, demand or application to or for any right or privilege applicable to an officer or employee of State including, but not limited to, workers' compensation, health, life, malpractice insurance, and retirement membership or credit.

N. FORCE MAJEURE: Neither Consultant nor State shall be liable to the other for any delay in, or failure of performance of, any covenant or promise contained in this contract, nor shall any delay or failure constitute default or give rise to any liability for damages if, and only to the extent that, such delay or failure is caused by "force majeure". As used in this contract, "force majeure" means acts of God, acts of the public enemy, acts of the State and any governmental entity in its sovereign capacity, fires, floods, epidemics, quarantine restrictions, strikes or other labor disputes, freight embargoes, or unusually severe weather.

O. CONTRACT ORIGINAL AND COPIES: An original of this contract will be retained by the State Auditor's Office. A photocopy will be on file with the South Dakota Department of Health and a second original will be sent to Consultant.

P. RECORD RETENTION/EXAMINATION: Consultant agrees to maintain all records that are pertinent to this contract and retain them for a period of three years following final payment against the contract. State agrees to assume responsibility for these items after that time period. These records shall be subject at all reasonable times for inspection, review or audit by State, other personnel duly authorized by State, and federal officials so authorized by law.

Q. DRUG FREE WORK PLACE: Consultant agrees to encourage all its employees to refrain from using illegal drugs which may affect an employee's ability to perform the essential functions required under the terms and conditions of this contract. State reserves the right to terminate this contract if Consultant, or any of its employees or agents, is convicted of using illegal drugs. Consultant further agrees that if this contract involves federal funds or federally mandated compliance, then Consultant is in compliance with the requirements of the "Drug-Free Workplace Act" (Public Law 100-690 Title V, Subtitle D, 41 U.S.C. §§ 701 et seq.).

R. LOBBYING: Consultant agrees to not use any of the funds received pursuant to this contract for lobbying purposes. Consultant further agrees that if this contract involves federal funds or federally mandated compliance, the Consultant is in compliance with all applicable regulations pursuant to Section 319 of Public Law 101-121, Guidance for New Restrictions on Lobbying, including Certification and Disclosure, 29 C.F.R. § 93.110 (1990)

S. RECYCLING. State strongly encourages Consultant to establish a recycling program to help preserve our natural resources and reduce the need for additional landfill space.

The parties signify their agreement by signing below.

Maria Eining April 30 2014
Maria Eining
Midwest Health Management Services LLC
Date

Gloria Damgaard April 30, 2014
Gloria Damgaard
Executive Secretary
SD Board of Nursing
Date

Joan Adam 5/5/14
Joan Adam, Director
Division of Administration
Department of Health
Date

Margaret Hansen April 30, 2014
Margaret Hansen
Executive Secretary
SD Board of Medical & Osteopathic Examiners
Date

5/6/14
Kari J. Williams
Administrator, Financial Management
Department of Health
Date

State Contact Person: Susan Sporrer Phone: 605- 773-3361

Consultant Contact Person: Gloria Damgaard Phone: 605-362-2760

The following shall be completed by the Consultant:

Nonprofit _____ Profit _____
Consultant fiscal year beginning _____ and ending _____

The following shall be completed by the State:

MSA Account code 5 2 0 4 _____

Fund Source Name:	Fund Source Name:	Fund Source Name:
CFDA No:	CFDA No:	CFDA No:
Program: SD Boards of Nursing and Medical & Osteopathic Examiners	Program: SD Board of	Program: SD Board of
CO: 6503-Other	CO: 6503-Other	CO: 6503-Other

SDCL 1-24A-1 states that a copy of all consulting contracts shall be filed by the agency with the State Auditor within five days after such contract is entered into and finally approved by the contracting parties. For further information about consulting contracts, see the State Auditor's policy handbook.

04-28-14-OK
GOA042314

SOUTH DAKOTA DEPARTMENT OF HEALTH

600 East Capitol Avenue | Pierre, SD 57501 P605.773.3361 F605.773.5683

Division of Administration

FAX TRANSMISSION

TO: Maria Eining

FROM: Colleen Kozel (773-3923)

DATE:

TELEPHONE NUMBER:

FAX NUMBER:

TOTAL PAGES: 8 (INCLUDING COVER PAGE)

MESSAGE/INSTRUCTIONS:

Confidentiality Note: The information contained with this facsimile transmission is intended only for the individual(s) named on this cover page. If you have received this fax in error, please destroy this information. Use or disclosure of this information by any individual(s) not listed on this cover page is strictly prohibited. South Dakota Department of Health

SD Health Professionals Assistance Program*

Operated By

Midwest Health Management Services, LLC

Financial Report and Program Update
5/1/14 to 3/6/15

Page

2- 3	Profit & Loss by Class
3	Utilization & Cost per Participant per Board
4	Future Operations- Strategic Planning

March 11, 2015

Midwest Health Management Services, LLC
Profit & Loss by Class
May 1, 2014 through March 6, 2015

	SD HPAP Budget	SDHPAP	MWHMS	TOTAL
Ordinary Income/Expense	**5/1/14-5/31/15**			
Income				
Capitation Fees		0.00	0.49	0.49
MWHMS			19,676.53	19,676.53
SDHPAP		322,824.62	0.00	322,824.62
SDHPAP Contract	**400,000**			
SD Board of Medicine	**190,000**	151,412.31		
SD Board of Nursing	**190,000**	151,412.31		
SD Board of Pharmacy	**10,000**	10,000.00		
SD Board of Dentistry	**10,000**	10,000.00		
Total Income	**400,000**	322,824.62	19,677.02	342,501.64
Gross Profit		322,824.62	19,677.02	342,501.61
Expense				
Payroll Taxes		0.00	-154.89	-154.89
Mileage		0.00	1,332.80	1,332.80
Retirement Plan		0.00	206.76	206.76
Education/Conferences	**4,000**	475.00	380.00	855.00
Education/FSPHP	**500**	500.00	0.00	500.00
Postage	**1,000**	551.10	0.00	551.10
Office Equipment		1,520.67	0.00	1,520.67
Advertising and Promotion	**2,000**	356.53	450.37	806.90
Bank Service Charges		1.42	-5.00	-3.58
Computer/ Internet Expenses		0.00	324.26	324.26
Continuing Education		0.00	75.00	75.00
Depreciation Expense		0.00	1,945.23	1,945.23
Dues and Subscriptions		0.00	50.00	50.00
Insurance Expense	**54,715**	33,172.15	0.00	33,172.15
Interest Expense		0.00	174.07	174.07
Meals and Entertainment	**2,500**	735.29	520.14	1,255.43
Office Supplies	**7,000**	1,964.32	157.48	2,121.80
Payroll Expenses	**293,370**	182,667.23	5,000.00	187,667.23
Professional Fees		1,943.01	400.00	2,343.01
Rent Expense	**26,000**	19,602.12	600.00	20,202.12
Repairs and Maintenance		0.00	47.70	47.70
Telephone Expense	**4,000**	3,275.29	0.00	3,275.29
Travel Expense	**5,500**	114.48	324.51	438.99
Total Expense	**400,585**	246,878.61	11,828.43	258,707.04
Net Ordinary Income		75,946.01	7,848.59	83,794.60
Net Income		**75,946.01**	**7,848.59**	83,794.60

Midwest Health Management Services, LLC
Profit & Loss by Class
May 1, 2014 through March 6, 2015

2014-15 Budget created by estimate of historical operating costs under previous contract- until business is established we have been conservative in all expense areas

Additional details regarding above noted categories:

- Insurance includes professional liability, general liability, workers comp as required by HPAP contract, **health & dental**
- **Payroll includes FICA taxes and federal unemployment**
- Professional Fees= legal fees, monthly accounting fees
- Rent amount varies includes triple- net (real estate taxes, building insurance, maintenance, garbage)
- Bank service charge-interest on first month HPAP operating expenses prior to contract payment
- Program is operating under budget in payroll, continuing to be cautious with staffing hours

Utilization & Cost per Participant per Board:

SD Licensing Board	Number of Individuals with Active Licenses	Based on avg. national expense for PHPs ($28/eligible lic.. per FSPHP)	SD Expense per participating licensing board	Average monthly participation btwn 5/1/14-3/6/15 by licensing board	**Expense per participant per board** (based on monthly average utilization from 5/1/14-3/6/15)
Medical and Osteopathic	8,750**	$245,000	$190,000	14	$13,572

- Above data does not include a full fiscal year. It is anticipated that as program utilization continues to increase cost per participant will continue to decrease.
- We anticipate cost to operate HPAP to remain steady at 400,000.00 for FY 2015**; allocation for expenses is to be determined by the Program Service Committee (SDCL 36-2A**).
- HPAP is not a self-sustaining business. Investment in the program is investment in the recovery and wellbeing of South Dakota's health care professionals. MWHMS is committed to providing quality services in the most cost effective manner possible and appreciates the participating boards' recognition that adequate funding is essential to SD HPAP's success**.** As of May 1, 2014, the SD Department of Health, the SD Board of Nursing, and the SD Board of Medical and Osteopathic Examiners entered into a contract for consultant services with Midwest Health Management Services, LLC (MWHMS) for operation of the SD Health Professionals Assistance Program. Contract is from 5/1/14 to 5/31/15 with option to renew for seven one year extensions at the State's discretion and by mutual agreement.
- MWHMS seeks to support operation of HPAP in part through economy of scale. We are building relationships to establish additional potential contracts, as well as providing monitored recovery services on a pay for fee basis for individuals not covered by contractual services; our goal in part is to bring services to other populations, and in doing so will help to offset overhead costs for HPAP.

Midwest Health Management Services, LLC
Profit & Loss by Class
May 1, 2014 through March 6, 2015

Strategic Planning for current and future operations:

Scope of HPAP services defined by statute- SD CL 36-2 A: 36-2A-1. Definitions. "Health professionals assistance program," **a confidential program designed to monitor the treatment and continuing care** of any regulated health professional who may be unable to practice with reasonable skill and safety, if the professional's **mental health issues or substance use disorder i**s not appropriately managed; **Source:** SL 1996, ch 227, § 1; SL 2013, ch 171, § 1.

Operations:

**Key*: Black- Developed; Blue – In Progress; Green- Early Development Stages

A. Addressing Substance Use Concerns
B. Addressing Mental Health
C. Addressing Abuse and Neglect Complaint Referrals from Licensing Board
D. Voluntary Self-Pay/Monitored Recovery to HPAP
E. True Monitored Recovery
F. Addressing Stress Management Related to Malpractice Claims
G. Linking with Resources for Continuum of Services
H. Marketing

A. Addressing Substance Use Concerns:

1. Diagnostic Rule-out
2. Clarify Treatment Goals
3. Recovery Monitoring and Management (as defined by the Participation Agreement and PA Addendums)

B. Addressing Mental Health Concerns:

1. Full Diagnostic Rule-out
2. Clarify Treatment Goals
3. Recovery Monitoring and Management (as defined by the Participation Agreement and PA Addendums)

C. Addressing Abuse and Neglect Complaint Referrals from Licensing Board:

1. Full Diagnostic Rule- Out (looking to rule out or identify treatment needs related to presence of a substance use disorder or mental health issue that may have contributed to complaint)
2. Clarify Treatment Goals
3. Recovery Monitoring and Management (as defined by the Participation Agreement and PA Addendum)

D. Voluntary Self Pay/ Monitored Recovery leading to HPAP:

1. Full Diagnostic Rule-Out
2. Clarify Treatment Goals
3. Recovery Monitoring and Management (as defined by the Participation Agreement and PA Addendum)
    a. Non- Successful Completion
        i. Board notification (Clarify)
        ii. Notify worksite if appropriate
        iii. Refer to alternative services if appropriate
    b. Successful Participation
    c. Support reinstatement request, convert to HPAP track if applicable

Midwest Health Management Services, LLC
Profit & Loss by Class
May 1, 2014 through March 6, 2015

E. True Monitored Recovery (Employee Groups/ Professionals other than those licensed under BMOE/BON/BOP/BOD):*This is Midwest Health Management Services/ not HPAP**

1. Full Diagnostic Rule-Out
2. Clarify Treatment Goals
3. Recovery Monitoring and Management (as defined by the Participation Agreement and PA Addendum)
    a. Non- Successful Completion
        i. Notify worksite if appropriate
        ii. Refer to alternative services if appropriate
    b. Successful Completion
        i. (How will we know?- time of stable recovery as evidenced by decrease illness symptoms, and/or decrease in impact of illness as evidenced by improvement in demonstrated effective coping (relationship skills, emotion regulation), resolution of financial, legal, employment concerns.

F. Addressing Stress Management Related to Malpractice Claims:

Of the 46 other state Physician Health Programs, 5 offer services to address Malpractice Litigation (Maryland, Massachusetts, New Jersey, Colorado, and Tennessee). Physician Health Programs are monitoring programs, not treatment, each program that addressed Malpractice Litigation offers consultation, but not formal services

SD HPAP Proposed Services (will need to be approved by the HPAP Program Service Committee and would likely need legal consultation)

1. Offer initial consultation with Dr. Uthe
2. Refer for continued supportive services if appropriate
3. During consultation, screen for MH or SUD- if co-occurring, refer for services /HPAP Monitoring as indicated
4. **Sanford, Avera, and the Medical Association all have resources available- have info available on hand to collaborate when indicated-**
5. Work with HPAP approved providers to provide continued supportive services/ screening if appropriate
6. ***HPAP cannot treat-**outside scope defined by statute**, so if additional supportive services are requested, we propose providing an educational support group (benefit- if under HPAP- not medical, so no records kept/ and not subject to subpoena, would not have the same legal protection if under MWHMS)

G. Linking with Resources for Continuum of Service:

- **Medical Association**
    - Financial
    - Family/ Medical Marriage
    - Stress Management
    - Wellness

- **Medical School & Residency Program**
    - **Schools: (information on HPAP, prevention skills, healthy coping and protective skills)**
        - **USD School of Medicine- Residents (Craig Uthe, MD)**

Midwest Health Management Services, LLC
Profit & Loss by Class
May 1, 2014 through March 6, 2015

- **USD School of Medicine- Medical Students (Craig Uthe, MD, Maria Eining)**
- **Augustana School of Nursing- Nursing Students (Janell Christensen)**
- **SDSU (Nursing and Pharmacy Students)**

- **Community Treatment Programs and Services**

- **Sanford**
  - EAP
  - Sanford Nursing Leadership

- **Avera**
  - EAP
  - LIGHT Program
  - Nursing Grand Rounds When a Nurse Diverts- Case Presentation, Prevention & Rehabilitative Considerations
  - Avera Physician Academy

- **Regional**
  - EAP
  - Diversion Committee

- **SDAHO**

Marketing Strategy (how do we increase engagement):

1. Web-Page
2. Brochures
3. Outreach Speaking
4. Networking/Conferences

December 4, 2014 Minutes

South Dakota Board of Medical & Osteopathic Examiners – Public Board Meeting

Board Members Present:	Kevin Bjordahl, MD; Walter Carlson, MD; David Erickson, MD; Laurie Landeen, MD; Brent Lindbloom, DO; Jeffrey Murray, MD
Board Members Absent:	Ms. Deb Bowman; Mary Carpenter, MD
Board Staff Present:	Margaret Hansen, PA-C; Mr. Tyler Klatt; Ms. Jane Phalen
Counsel Present:	Steven Blair, Board counsel William Golden, Staff counsel

Dr. Walter Carlson, Vice President of the Board, called the public meeting to order at 9:00 am. Roll was called, a quorum was established.

A motion to approve the agenda was ratified by the Board (Erickson/unanimous).

A motion to approve the minutes from the September 11, 2014, meeting was ratified by the Board (Lindbloom/unanimous).

A motion to approve the new licenses, permits, registrations and certificates issued since the September 11, 2014, Board meeting was ratified by the Board (Murray/unanimous).

The financial report was presented by Ms. Hansen: 1) monthly reports and statistics; 2) update from the Secretary of Health for the upcoming legislative session; 3) developing educational information for the Board members in the form of “frequently asked questions”. The Board accepted the financial report for information.

Maria Eining, Director of Midwest Health Management Services (MHMS), presented the financial report to the Board. MHMS is the contracted administrating agency for the South Dakota Health Professionals Assistance Program (HPAP). Discussion was held regarding physicians who are experiencing the medical malpractice process, and that HPAP could be a resource for them. Dr. Carlson requested that Ms. Eining appear at the next Board meeting to discuss the steps that are underway in contacting new stakeholders for support of HPAP.

Preliminary discussion was held regarding the possibility of changing the annual renewal of South Dakota medical licenses to a bi-annual basis. It was decided that more information and discussion would be necessary.

Mr. Tyler Klatt presented the reports from recent advisory committee meetings: 1) Athletic Training – undergoing red tape review of statute and rules; 2) Occupational Therapy – discussed guidelines for re-entry to the field of OT; 3) Physical Therapy – working on proposed rules for continuing education requirements and discussion on jurisprudence exam. Mr. Klatt presented some draft language and explained that this was in the preliminary stage; 4) Respiratory Care – auditing for continuing education. A motion to approve the reports was ratified by the Board (Bjordahl/unanimous).

Mr. Klatt explained that at the Board directed him to re-write proposed ethics rules for Genetic Counselors, Licensed Nutritionists/Dietitians, and Occupational Therapists. Mr. Klatt presented the revised rules. A motion to approve the revised ethics rules and proceed to public hearing for Genetic

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Counselors, Licensed Nutritionists/Dietitians and Occupational Therapists was ratified by the Board (Landeen/unanimous).

At the last Board meeting Dr. Carpenter brought the 1994 Declaratory Ruling for Universal Precautions to the attention of the Board. This declaratory ruling appears in the administrative rules for all professions regulated by the Board. The staff was directed to research the history of this ruling and report to the Board. Mr. Klatt reported that the Department of Health vacated the declaratory ruling on universal precautions in 2004. He then presented the staff's recommendation to petition the Board to vacate the universal precautions rule at the March 2015 meeting.

Mr. Klatt presented the proposed rule ARSD 20:47:07: Physician Best Practices. A motion to approve ARSD 20:47:07, and authorize the staff to proceed to public hearing was ratified by the Board (Murray/unanimous).

Mr. Klatt presented the proposed rule ARSD 20:78:05: Board Member Conflict of Interest. A motion to approved ARSD 20:78:05 and authorize the staff to proceed to public hearing was ratified by the Board (Lindbloom/unanimous).

Ms. Hansen presented the executive director report on the following topics: 1) Monthly statistical reports; 2) The article on the Health Professionals Assistance Program (HPAP) in South Dakota Medicine; 3) Rules, guidelines and updates for the coming legislative session.

Dr. Carlson requested that the staff prepare information in the form of "Frequently Asked Questions" for review at Board meetings.

Public Hearings: Board members assigned to a case do not deliberate or vote in that case (ARSD 27:78:05:05)

In August, 2014, Jessica A. Thurman, PA, who was represented by counsel David Kroon, agreed to sign a Consent Agreement with Reprimand. At the September 11, 2014 Board meeting, she appeared with her attorney to ask that the reprimand she agreed to be amended to a letter of concern. The parties were unable to stipulate to the facts; therefore, the Board continued the case to December 4, 2014, and asked the parties to reach an agreement if possible. No agreement or stipulation to the facts was reached. Ms. Thurman and her attorney appeared at this Board meeting. A motion to enter into executive session at 11:15 am pursuant to SDCL 1-25-2 (2) & (3) was ratified by the Board (Landeen/unanimous). The public meeting resumed at 11:23 am. The Board directed the parties to come to an agreement or proceed to contested case hearing before an administrative law judge. The parties agreed to amend the Consent Agreement with Reprimand to a Consent Agreement with a Letter of Concern which is a public Board action and reported to the national practitioner data bank and other entities to which the board is required to report licensure action. A motion to approve the amended agreement was ratified by the Board (Landeen/unanimous). The assigned Board member, Dr. Carlson, did not participate in the deliberation or vote. Dr. Bjordahl addressed the Board members and directed that his statements be entered into the record. He expressed his concern about the evidentiary issues in this case. He recommended that in the future, contested cases be conducted first in the presence of an administrative judge who could examine the evidence, and then prepare findings of fact and conclusions of law based upon the evidence for final consideration by the Board. He further recommended that if a party entered into an agreement and then wanted to change the terms of the agreement that the matter must first go to a contested case hearing in the presence of an administrative judge.

ARSD 20:78:03:07. Application withdrawn during investigation. ***An applicant may withdraw an application after an investigation has been initiated by the executive secretary. An application***

withdrawn after investigation has been initiated shall be reported as "withdrawn under investigation" in the board's permanent license files and in any national databases to which the board is required to report licensure action.

Paramedic Elizabeth M. Daggett appeared at the meeting. While she was under investigation, she chose not to submit a renewal application for her paramedic license. Her license was suspended by statute due to non-renewal on July 15, 2014. A motion to approve the Withdrawal under Investigation was ratified by the Board (Erickson/unanimous).

A motion to entered into executive session at 12:40 pursuant to SDCL 1-25-2(3) was ratified by the Board (Murray/unanimous).

The public meeting resumed at 1:00.

Confidential Physician Hearings (Closed Session pursuant to SDCL 36-4-31.5 unless privilege is waived by physician): Board members assigned to a case do not deliberate or vote in that case (ARSD 27:78:05:05)

The physicians did not waive privilege so the Board entered a closed session pursuant to SDCL 36-4-31.5 *Evidence in cancellation, revocation, suspension, or limitation proceedings 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 Examiners considering cancellation, revocation, suspension, or limitation of a license, resident license, or certificate 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 the physician's staff privileges was based. The prohibition relating to discovery of evidence does not apply to any person or the person's counsel in the defense of an action against the person's access to the materials covered under this section.* ***Source:*** *SL 1985, ch 297, § 21; SL 2009, ch 178, § 13; SL 2013, ch 172, § 14.*

In the matter of applicant Dr. Kerry A. Blackham, a motion to amend the Findings of Fact and Conclusions of Law to mirror the restrictions imposed on his medical license in Utah, and issue a restricted South Dakota medical license with Dr. Blackham's agreement to participate in SD HPAP and comply with all Utah requirements was ratified by the Board (Landeen/unanimous). All primary source verifications must first be received and be satisfactory before issuance of the South Dakota medical license. The assigned Board member, Ms. Bowman, was absent from this Board meeting.

In the matter of Dr. Winn Harrison Gregory, a motion to approve the Stipulation and Agreement which mirrors the conditions imposed by the Oregon Board of Medicine was ratified by the Board (Erickson/unanimous). The assigned Board member, Ms. Bowman, was absent from this Board meeting.

In the matter of Dr. Scharazard Gray, a motion to approve the Stipulation and Agreement to mirror the conditions imposed by the North Dakota Board of Medicine was ratified by the Board (Carlson/unanimous). The assigned Board member, Ms. Bowman, was absent from this Board meeting.

In the matter of Dr. Roger Carter, a motion to accept the Voluntary Surrender of his South Dakota medical License # 1729 was ratified by the Board (Bjordahl/unanimous). The assigned Board member, Dr. Landeen, did not participate in the deliberation or vote.

The Board reviewed the complaint and investigation docket and the competency docket for information purposes.

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Discussion was held regarding the next Board meeting; to change from the scheduled two days to one day and have that one day meeting longer if necessary. A motion to change the scheduled two (2) day March Board meeting to a one (1) day Board meeting on Wednesday, March 11, 2015, was ratified by the Board (Landeen/unanimous).

There being no further business, the meeting adjourned at 3:10 pm.

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EXECUTIVE SUMMARY FINANCIAL REPORT

TO: THE BOARD OF MEDICAL AND OSTEOPATHIC EXMINERS
FROM: MARGARET B HANSEN
DATE: MARCH 2, 2015

1. The Board has three different locations of cash on hand (page 2)

- Petty Cash
- Local Checking
- State Treasury Fund

		FY15	FY14	FY13
		02/28/2015	*06/30/2014*	*06/30/2013*
Total Cash		3,076,194	2,656,838	2,303,882

2. Revenue (page 3)

- Total revenue for licensing, services, and other sources by line detail on the report.

		FY15	FY14	FY13
		02/28/2015	*06/30/2014*	*06/30/2013*
Total Revenue		1,069,610.35	1,256,516.60	1,246,698.72

3. Income Statement – review of expense variances (Pages 5 -6)

		FY15	FY15	FY14	FY14
		Budgeted	*02/28/2015*	Budgeted	*06/30/2014*
3-A	5102090 – Unemployment Insurance	42	57	42	99
3-B	5203280 - Other Public Out-of-state • HPAP billing is now being processed here which was previously processed through Other Contractual Services	100	171	100	150
3-C	5203300 - Lodging Out-Of-State • Hotel expenses for out of state meetings or training attended	500	1,250	500	3,653
3-D	5204160 - Workshop Registration Fees • Training classes for staff and meeting attendance fees	2,000	2,291	2,000	3,280
3-E	5204180 - State Computer Services • BIT maintenance expenses	9,359	10,326	9,359	15,734
3-F	5204530 - Telecommunication Services • Board Member Laptop wireless • Background Reports e.g. NPDB	3,000	6,543	3,000	15,418
3-G	5205320 - Duplication – Private • Printed pages from leased printers	300	5,890	300	1142
3-H	5205350 – Postage • Postage fees on all items mailed	11,000	11,622	11,000	11,557

4. Income Statement - Net Income - (page 6)

Shows earnings measured by taking total revenue and minus expenses.

	FY15	FY15	FY14	FY14	FY13	FY13
	Budgeted	*02/28/2015*	Budgeted	*06/30/2014*	Budgeted	*06/30/2013*
Net Income	174,257	468,799	210,382	332,259	209,394	494,300

5. Other Contractual Services Breakdown by service description (page 7)

	FY15	FY14	FY13
	02/28/2015	06/30/2014	06/30/2013
Total Other Contractual Services	16,379	60,868	52,060

6. Conference Room, Suite 215, budget analysis (page 8)

- Review of some of the variances

		As of
	Budgeted	*02/28/2015*
Total Conference Room Expenses	150,250.00	142,015.69

SDBMOE Financial Report

03/02/2051

for
07/01/14 - 02/28/2015

Page	Report Name
2	Balance Sheet (Cash Only)
3	Revenue Summary
5	Income Statement
7	Other Contractual Services
8	Board Conference Room, Suite 215 Budget Analysis

SDBMOE
Balance Sheet (Cash Only)

Date Range: July 1, 2014 - February 28, 2015

		FY15	FY14	FY13	FY12	FY11	FY10
		02/28/2015	*06/30/2014*	*06/30/2013*	*06/30/2012*	*06/30/2011*	*06/30/2010*
	Cash						
	Petty Cash	100	100	100	100	100	100
	Local Checking	2,230	3,598	2,930	4,223	4,712	4,313
	State Treasury Fund	3,073,864	2,653,139	2,300,852	1,810,978	1,370,641	1,149,460
1	**Total Cash**	**3,076,194**	**2,656,838**	**2,303,882**	**1,815,301**	**1,375,452**	**1,153,873**

SDBMOE
Revenue by Item Summary

Date Range: July 1, 2014 - February 28, 2015

Type	07/01/14 - 02/28/15 Amount	07/01/13 - 04/30/14 Amount	07/01/12 - 06/31/13 Amount
Licenses			
Athletic Trainer Application	$ 2,300.00	$ 3,000.00	$ 3,300.00
Athletic Trainer Reinstatement	$ -	$ -	$ 50.00
Athletic Trainer Renewal	$ 1,550.00	$ 9,500.00	$ 8,850.00
Advanced EMT for Instate Graduate	$ 950.00	$ 850.00	$ 700.00
Advanced EMT for out of state Graduate	$ 150.00	$ 225.00	
Advanced EMT Renewal	$ 225.00	$ 800.00	$ 450.00
Advanced EMT Reinstatement	$ 50.00	$ -	$ -
ALS-I 85 Application for Instate Graduate	$ -	$ -	$ 200.00
ALS-I 85 Application for Out of State Graduate	$ 150.00	$ 75.00	$ 150.00
ALS-I 85 Renewal	$ 1,400.00	$ 3,625.00	$ 4,875.00
ALS-I 99 Application for Instate Graduate	$ -	$ -	$ -
ALS-I 99 Application for Out of State graduate	$ -	$ -	$ -
ALS-I 99 Renewal	$ 50.00	$ 225.00	$ 275.00
ALS-I 99 Reinstatement	$ -	$ -	$ 50.00
ALS-I85 Reinstatement	$ 100.00	$ 450.00	$ 350.00
ALS-Paramedic Application for Instate graduate	$ 750.00	$ 1,850.00	$ 2,100.00
ALS-Paramedic Application for Out of State Graduate	$ 2,775.00	$ 5,250.00	$ 2,475.00
ALS-Paramedic Renewal	$ 4,825.00	$ 11,100.00	$ 11,475.00
ALS-Paramedic Reinstatement	$ 350.00	$ 600.00	$ 500.00
Genetic Counselor Temporary Application	$ -	$ 200.00	$ 100.00
Genetic Counselor Application	$ 2,000.00	$ 1,600.00	$ 1,200.00
Genetic Counselor Renewal	$ 100.00	$ 1,900.00	$ 800.00
Licensed Nutritionist Application	$ 980.00	$ 1,750.00	$ 2,240.00
Licensed Nutritionist Renewal	$ 420.00	$ 10,395.00	$ 10,290.00
Temporary License Nutritionist Application	$ 50.00	$ 250.00	$ 650.00
Licensed Nutritionist Reinstatement	$ 300.00	$ -	$ 100.00
Locum Tenens Application	$ 1,950.00	$ 2,550.00	$ 4,000.00
MD/DO Application	$ 35,800.00	$ 74,600.00	$ 76,800.00
MD/DO Reinstatement	$ 3,800.00	$ 6,600.00	$ 6,200.00
MD/DO-Renewals	$ 738,000.00	$ 729,400.00	$ 700,200.00
Medical Assistant Application	$ 490.00	$ 1,000.00	$ 900.00
Medical Assistant Renewal	$ 20.00	$ 2,720.00	$ 15.00
Medical Assistant Reinstatement	$ 40.00	$ 300.00	$ 30.00
Medical Corp Application	$ 550.00	$ 550.00	$ 300.00
Medical Corp Reinstatement	$ 700.00	$ 1,000.00	$ 650.00
Medical Corp Renewal	$ 15,900.00	$ 15,900.00	$ 17,100.00
Occupational Therapist Application	$ 1,200.00	$ 1,950.00	$ 2,200.00
Occupational Therapist Reinstatement	$ 25.00	$ 50.00	$ 75.00
Occupational Therapy Assistant Application	$ 700.00	$ 850.00	$ 1,050.00
Occupational Therapist Renewal	$ 21,100.00	$ 22,000.00	$ 22,000.00
Occupational Therapy Assistant Reinstatement	$ -	$ -	$ 50.00
Occupational Therapy Assistant Renewal	$ 7,200.00	$ 7,150.00	$ 7,100.00
Occupational Therapist Limited Permit	$ 25.00	$ 125.00	$ 50.00
Occupational Therapy Assistant Limited License	$ -	$ 75.00	$ 50.00
Physical Therapist Application	$ 3,180.00	$ 3,900.00	$ 4,630.00
Physical Therapist Renewal	$ 44,500.00	$ 43,900.00	$ 42,650.00
Physical Therapist Reinstatement	$ 350.00	$ 150.00	$ 100.00
Physical Therapist Assistant Application	$ 1,140.00	$ 1,980.00	$ 1,800.00
Physical Therapist Assistant Renewal	$ 11,800.00	$ 12,050.00	$ 11,550.00
Physical Therapist Assistant Reinstatement	$ -	$ 50.00	$ 50.00
Physician Assistant Corporation Application	$ -	$ -	$ -
Physician Assistant Corporation Renewal	$ 200.00	$ 200.00	$ 100.00
Physician Assistant Corporation Reinstatement	$ -	$ -	$ -
Physician Assistant Application	$ 2,475.00	$ 4,425.00	$ 4,275.00
Physician Assistant Temporary Permit	$ -	$ 50.00	$ 150.00
Physician Assistant Reinstatement	$ -	$ 125.00	$ 200.00
Physician Assistant Renewal	$ -	$ 52,900.00	$ 50,500.00
Resident Certificate Application		$ -	$ 650.00
Resident License Application	$ 350.00	$ 3,800.00	$ 6,650.00
Resident License Renewal	$ 1,200.00	$ 3,650.00	$ -
Respiratory Care Practitioner Application	$ 825.00	$ 3,225.00	$ 3,375.00
Respiratory Care Temporary Application	$ 520.00	$ 520.00	$ 520.00
Respiratory Care Practitioner Renewal	$ 26,940.00	$ 60.00	$ 27,540.00
Respiratory Care Practitioner Reinstatement	$ 95.00	$ 95.00	$ 95.00
NSF Check Board Fine		$ -	$ -
USMLE Testing		$ 3,150.00	$ -
Other Income		$ -	$ -

SDBMOE
Revenue by Item Summary

Date Range: July 1, 2014 - February 28, 2015

		07/01/14 - 02/28/15 Amount	07/01/13 - 04/30/14 Amount	07/01/12 - 06/31/13 Amount
Total Licenses		**$ 940,550.00**	**$ 1,054,695.00**	**$ 1,044,785.00**
Other				
Interest Income		$ 24,236.35	$ 30,177.73	$ 37,093.72
Fines & Penalties		$ -	$ -	$ -
Total Services		**$ 24,236.35**	**$ 30,177.73**	**$ 37,093.72**
Services				
Information Request		$ -	$ 30.00	$ 90.00
Online Verifications		$ 80,484.00	$ 118,256.00	$ 119,495.00
Written Verifications		$ 23,790.00	$ 47,940.00	$ 42,810.00
Duplicate License Card		$ 550.00	$ 1,020.00	$ 1,325.00
Candian Service Fee (Skype Fee Charge)		$ -	$ (2.13)	$ -
Mailing List			$ 4,400.00	$ 1,100.00
Total Services		**$ 104,824.00**	**$ 171,643.87**	**$ 164,820.00**
Total	**2.**	**$ 1,069,610.35**	**$ 1,256,516.60**	**$ 1,246,698.72**

SDBMOE
Income Statement

Date Range: July 1, 2014 to February 28, 2015

		FY15 Budgeted	FY15 *02/28/2015*	% of Budget FY15	FY14 Budgeted	FY14 *06/30/2014*	% of Budget FY14	FY13 Budgeted	FY13 *06/30/2013*
Ordinary Income/Expense									
Income									
	License Fee Revenue	1,010,000	940,550	93%	1,012,000	1,054,695	104%	985,500	1,044,785
	Fines and Penalties	0	0	0%	0	0	0%	0	0
	Sales and Service Revenue	150,750	104,824	70%	152,000	171,644	113%	135,500	164,820
Total Income		**1,160,750**	**1,045,374**	**90%**	**1,164,000**	**1,226,339**	**105%**	**1,121,000**	**1,209,605**
Gross Profit		**1,160,750**	**1,045,374**	90%	**1,164,000**	**1,226,339**	105%	**1,121,000**	**1,209,605**
07/01/13 - 02/28/14									
	5101000 - Employee Salaries	288,154	230,702	80%	277,412	308,612	111%	266,986	267,036
	5101030 - Board & Community Member Fees	3,275	1,200	37%	3,154	2,520	80%	3,037	2,640
	5102010 - OASI	26,392	16,670	63%	24,207	22,796	94%	21,959	19,952
	5102020 - Retirement	16,133	13,595	84%	16,133	18,472	114%	16,133	16,022
	5102060 - Health Insurance	60,790	44,906	74%	50,963	70,193	138%	44,323	51,857
	5102080 - Worker's Compensation	889	185	21%	889	216	24%	889	322
3-A	5102090 - Unemployment Insurance	42	104	247%	42	99	235%	42	200
	5201030 - Board Member Per Diem			0%		0	0%	275	0
	5203010 - Auto - State owned - Instate								1,653
	5203030 - Auto - Private - Low Rate		181			423			241
	5203030 - Auto - Private - High Rate	2,000	278	14%	2,000	1,412	71%	2,000	530
	5203040 - Air-State owned-Instate	16,000	2,083	13%	16,000	8,473	53%	16,000	11,858
	5203060 - Air-Commercial Carrier Instate		2,882			582			
	5203070 - Air Travel - Charter Flights	30,000		0%	30,000	3,750	13%	30,000	
	5203100 - Lodging In-State	2,000		0%	2,000	697	35%	2,000	747
	5203120 - Incidentals-Travel Instate	50	32	64%	50	56	112%	50	
	5203130 - Nonemployee Travel		342			8,827			
	5203140 - Taxable Meals		18			20			119
	5203150 - Non-taxable meals In-state	600		0%	600	353	59%	600	319
	5203260 - Air-Commercial Out-of-state	1,100	471	43%	1,100	1,795	163%	1,100	
3-B	5203280 - Other Public Out-of-state	100	171	171%	100	150	150%	100	
3-C	5203300 - Lodging Out-Of-State	500	1,250	250%	500	3,653	731%	500	
	5203320 - Incidentals - Out of State		25			50			
	5203350 - Out of State Meals		255			436			
	5204010 - Subscriptions	1,000	90	9%	1,000	270	27%	1,000	87
	5204020 - Membership Dues	6,000	5,336	89%	6,000	4,171	70%	6,000	4,728
	5204030 - Legal Document Fees					10			
	5204050 - Computer Consultant					70,980			46,410
	5204080 - Legal Counsel	198,000	32,154	16%	198,000	37,188	19%	198,000	105,488
	5204090 - Management Consultant		110,833			22,655			
	5204100 - Consultant Fees--Medical	13,500	250	2%	13,500	1,750	13%	13,500	1,875
	5204130 - Other Consulting	0	9,692		0	8,820		0	9,210

SDBMOE
Income Statement

Date Range: July 1, 2014 to February 28, 2015

		FY15 Budgeted	FY15 *02/28/2015*	% of Budget FY15	FY14 Budgeted	FY14 *06/30/2014*	% of Budget FY14	FY13 Budgeted	FY13 *06/30/2013*
3-D	5204160 - Workshop Registration Fees	2,000	2,291	115%	2,000	3,280	164%	2,000	948
3-E	5204180 - State Computer Services	9,359	10,326	110%	9,359	15,734	168%	6,503	15,420
	5204181 - BIT Development Costs		155			12			77
	5204190 - Private Computer Services								
	5204200 - Central Services	3,531	2,892	82%	3,531	3,709	105%	3,531	5,095
	5204202 - Property Management		271			317			23
	5204203 - Purchasing Central Services		376			488			46
	5204204 - Records Management		88			131			77
	5204207 - Human Resource Services		2,260			3,454			3,304
	5204220 - Equipment Maintenance		772			35,201			11,442
	5204230 - Janitorial					0			
	5204250 - Cable TV (Office Internet)		555			695			792
	5204320 - Audit Services - Private	5,500			5,500	0		5,500	
	5204350 - Advertising - Magazines					2,750			2,750
	5204360 - Advertising Newspapers	500	1,128		500	207		500	
	5204400 - Advertising Internet	500	294	0%	500	0	0%	500	
	5204460 - Equipment Rental	2,000	560	28%	2,000	1,040	52%	2,000	2,256
	5204490 - Rents - Other					791			
	5204510 - Rents - Lease	83,000	54,705	66%	62,000	51,160	83%	62,000	61,980
3-F	5204530 - Telecommunication Services	3,000	6,543	218%	3,000	15,418	514%	3,000	15,191
	5204550 - Garbage and Sewer		863			1,610			1,017
	5204580 - Truck-Drayage & Freight		1,222			857			1,505
	5204590 - Professional Liability Insurance	20,000		0%	20,000	2,400	12%	20,000	1,504
	5204620 - Taxes and License Fees					995			
	5204730 - Maintenance Contract	1,000		0%	1,000	0	0%	1,000	0
	5204740 - Bank Charges	24,192		0%	24,192	78	0%	24,192	78
	5204960 - Other Contractual Services	151,986	16,379	11%	172,986	50,800	29%	172,986	52,060
	5205020 - Office Supplies	10,000	1,841	18%	10,000	1,912	19%	10,000	6,201
	5205290 - Flags		209						
	5205040 - Educational & Instructional Sup					275			16
	5205310 - State-Printing					0			
3-G	5205320 - Duplication - Private	300	5,890	1963%	300	1,142	381%	300	7,074
	5205340 - Supp. Public & Ref Material		185						178
3-H	5205350 - Postage	11,000	11,622	106%	11,000	11,557	105%	11,000	16,005
	5205390 - Food Stuffs	100		0%	100	280	280%	100	120
	5207121 - Building Improvement & Remodel					800			
	5207451 - Office Furniture & Fixtures		1,194			37,742			
	5207495 - Telephone Equipment	10,000	76	1%	10,000	13,138	131%	10,000	282
	5207531 - Household Appliances					875			
	5207675 - Audio Visual Equipment		4,217			61,152			
	5207791 - Police and Security Equipment					0			3,335
	5207901 - Computer Hardware (BIT)					3,468			881
	5207905 - Computer systems	6,000			6,000	0		6,000	
	5207960 - Computer Software					0			1,078
	5207961 - Computer Software (BIT)	1,000			1,000	1,089		1,000	
	5207980 - Depreciation Expense - Computer					0			
	5207965 - Software State Contract					0			
	5208080 - Prior Year Revenue Refund					0			0
	5208210 - Interest on Late Vendor Payment		196			275			371
Total Expense		**1,011,493**	**600,811**	**59%**	**988,618**	**924,257**	**93%**	**966,606**	**752,398**
Net Ordinary Income		**149,257**	**444,563**	**298%**	**175,382**	**302,082**	**172%**	**154,394**	**457,207**
Other Income/Expense									
Other Income									
	4491000 - Interest Income	25,000	24,236	97%	35,000	30,178	86%	55,000	37,094
Total Other Income		**25,000**	**24,236**	**97%**	**35,000**	**30,178**	**86%**	**55,000**	**37,094**
Net Other Income		**25,000**	**24,236**	**97%**	**35,000**	**30,178**	**86%**	**55,000**	**37,094**
Net Income	**4**	**174,257**	**468,799**	**269%**	**210,382**	**332,259**	**158%**	**209,394**	**494,300**

SDBMOE
Other Contractual Services

Date Range: July 1, 2014 - February 28, 2018

	Description	FY15 02/28/2015	FY14 06/30/2014	FY13 06/30/2013
	Other Contractual Services			
	Health Practitioners Assistance - HPAP	$ -	$ 28,295	$ 7,405
	SDBON - CNP, CNM Co-regulation	$ -	$ -	$ -
	Investigator Contractor	$ -	$ -	$ -
	Investigations Expenses	$ 4,625	$ 1,521	$ 4,408
	Temporary Employment Services	$ -	$ -	$ 896
	Other State Verifications	$ -	$ -	$ -
	Shredding	$ -	$ -	$ 78
	Goods and Services	$ -	$ -	$ -
	Background Reports	$ -	$ -	$ 6,085
	BD member Expenses	$ 345	$ 172	$ -
	Board Meeting Audio	$ -	$ -	$ 535
	Other	$ 11,409	$ 30,881	$ 32,654
5.	**Total Other Contractual Services**	**$ 16,379**	**$ 60,868**	**$ 52,060**

SDBMOE
Board Conference Room (Suite 215) Budget Analysis

		Budgeted	As of 02/28/2015	% of Budget
	Itemized Expenses:			
	Project Management/ Consulting (Budget)	$ 4,500.00	$ 2,000.00	44%
	Technology Equipment and Service Agreement	$ 84,750.00	$ 96,036.00	113%
	Appliances	$ 1,500.00	$ 1,675.00	112%
	Furniture	$ 25,000.00	$ 38,936.12	156%
	Art and Room Décor	$ 2,500.00	$ 208.57	8%
	IT Network and Internet (BIT and AVI - e.g. Wiring)	$ 15,000.00	$ -	0%
	Communication - Marketing	$ 2,000.00	$ -	0%
	Contingency Fund - Zoning Compliance Cost (2nd Door)	$ 15,000.00	$ 3,160.00	21%
6.	**Total**	$ 150,250.00	$ 142,015.69	95%

* BIT bills on a monthly basis for all services provided - not able to determine this exactly
* Still have coffee pot and coffee cup expenses
* Flag expenses and the microphone expenses have been added to the total

New Licenses issued from December 1, 2014 through February 28, 2015

Advanced EMT: 7

Athletic Trainer: 7

Dietitian/Nutritionist: 3

EMT Student Status: 40

EMT I/85: 1

Genetic Counselors: 4

Genetic Counselor Temporary: 0

Medical Assistants: 17

Medical Corporations: 4

Medical License (MD/DO): 61*(3 licenses issued by waiver: Back Ki Hong, MD (page 9); Natasha Adelle Telesford, MD (page 9); Massimo Asolati, MD (page 10)*

Nutritionist Temporary Permit: 0

Occupational Therapists: 14

Occupational Therapist Temporary Permit: 1

Occupational Therapy Assistants: 3

Occupational Therapy Assistants Temporary Permit: 0

Paramedics: 16

Physical Therapist Assistants: 7

Physical Therapists: 9

Physician Assistants: 8

Physician Assistant Temporary: 0

Physician Locum Tenens (60-Day Certificates): 13

Resident License: 2

Respiratory Care Practitioners: 5

Respiratory Care Practitioners Temporary Permit: 2

Total: 224

Advanced EMT License Total 7

License Number	Name	Address	Specialty	Issue Date
1905	Sara Lee Booth	PO Box 101, Hill City, SD 57745-0101		12/29/2014
1915	Slade Shannon Swedlund	PO Box 578, Hill City, SD 57745		2/12/2015
1904	Cesareo Davis Meza	184 Top O Hill Court, Hill City, SD 57745		12/23/2014
1903	Lori Elayne Balciunas	616 Clay Street, Custer, SD 57730		12/23/2014
1901	Brooke Marie Mabey	3512 Westview Drive, Spearfish, SD 57783		12/18/2014
1912	Julie Ann Martin	19122 Mockingbird Lane, Belle Fourche, SD 57717		2/10/2015
1918	Vince Paul Devlin	208 East 8th , Dell Rapids, SD 57022		2/24/2015

Athletic Trainer License Total 7

License Number	Name	Address	Specialty	Issue Date
0480	Katie Dee Willmott	1024 Delaware Avenue, Platt, SD 57369		2/9/2015
0474	Matthew Michael Stern	16212 S 120th Street, Springfield, NE 68059		12/2/2014
0479	Paige Katharina Mehling	180 S Circle Drive, Huron, SD 57350		1/5/2015
0476	Katie Marie Kimmich	908 S Thompson Ave., Sioux Falls, SD 57103		12/17/2014
0478	Mary Elizabeth Johnson	601 E. 69th Street Apt 227, Sioux Falls, SD 57108		1/5/2015
0477	Marcus Lee Moberg	71308 310th Street, Clinton, MN 56225		12/22/2014
0475	Michael Lee Smith	1101 W 22nd Street Unit 284, Sioux Falls, SD 57105		12/8/2014

Dietician/Nutritionist License Total 3

License Number	Name	Address	Specialty	Issue Date
0507	Patricia Ann Price	1009 Southland Lane, Apt 302, Brookings, SD 57006		12/17/2014
0509	Megan Nicole Olesen	1327 W 23rd Avenue Apt. 320, Mitchell, SD 57301		1/23/2015
0508	Jessica Ann VanOverschelde	2607 McLeod Drive East, West Fargo, ND 58078		12/24/2014

EMT Student Status Total 40

License Number	Name	Address	Specialty	Issue Date
3597	Lea Ann Krog-Tatro	2008 Colorado Drive, Sturgis, SD 57785		12/29/2014
3605	Denise Michelle Brown	48133 188th Street, Brandt, SD 57218		1/16/2015
3600	Lisa Renee Lundberg	812 Golf View Drive, Clear Lake, SD 57226		1/9/2015
3616	Jacob Steven Sandgren	34818 Oasis Road, Lindstrom, MN 55045		2/18/2015
3620	Kelli Melissa Grimlie	106 9th Ave North, Clear Lake, SD 57226		2/19/2015
3606	Billie Jo Gauger	18350 SD Hwy 15, Clear Lake, SD 57226		1/20/2015
3596	Melissa Jean Swedlund	1948 Davenport, Sturgis, SD 57785		12/29/2014
3603	Lisa Lynn Pederson	103 9th Ave N, Clear Lake, SD 57726		1/15/2015
3610	Jeffrey John Hauck	420 29th Street NW, Watertown, SD 57201		2/5/2015
3615	Michael Lawrence Sackmann	708 1st St NW, Watertown, SD 57201		2/12/2015
3609	Ayla Jene Dixon	116 17th Avenue, brookings, SD 57006		2/4/2015
3613	Taner Robert Reister	1200 2nd Ave SW #17, Watertown, SD 57201		2/10/2015
3612	Morgan Nicole Bartz	12020 463rd Avenue, Sisseton, SD 57262		2/6/2015
3627	Paul Scott Nelson	300 1st Ave NE Apt 130, Watertown, SD 57201		2/25/2015
3629	Theodore John Bueltel	3909 200th Ave, Minneota, MN 56264		2/25/2015
3618	Joe John Denison	19726 455th Ave, Arlington, SD 57212		2/18/2015
3595	Katie Adele O'Bryan	2007 Colorado Drive, Sturgis, SD 57785		12/29/2014
3604	Brenda Lee Schake	705 8TH ST. W., CLEAR LAKE, SD 57226		1/15/2015
3601	Erik Jon Eversman	713 5th Ave S., Clear Lake, SD 57226		1/13/2015
3598	Darin Michael Sinner	1825 Tanbury Lane, Brookings, SD 57006		1/5/2015
3623	Alexa Lynn Wallace	1019 Garfield Ave, Sheldon, IA 51201		2/23/2015

3602	Joni Adele Kanable	415 3rd Street West, Clear Lake, SD 57226		1/15/2015
3625	Matthew Carroll Gruchow	4521 E Ashbury Place, Apt. 102, Sioux Falls, SD 57110		2/24/2015
3608	Konard Otto Hauffe	1026 6th Ave, Brookings, SD 57006		1/28/2015
3624	Gage Tyler Whitted	45073 164th Street, Watertown, SD 57201		2/23/2015
3617	Tiffany Ann Davis	505 8th St., Springfield, SD 57062		2/18/2015
3626	Morgan Jaysen Bendt	46245 174th Street, Watertown, SD 57201		2/25/2015
3611	Nathan Ryan Becker	1951 42nd Street SW, Watertown, SD 57201		2/6/2015
3614	Trevor John Allen	405 E 13th NE Apt 201, Watertown, SD 57201		2/11/2015
3621	Rita Faye Sattler	820 E 12th Ave, Webster, SD 57274		2/20/2015
3622	Candyce Sue Michlitsch	620 E 2nd Street, Webster, SD 57274		2/20/2015
3594	Afton Elizabeth Leichtnam	5334 Williams St. , Rapid City, SD 57703		12/29/2014
3607	Sheila Joy Monnier	19061 479th Avenue, Brandt, SD 57218		1/20/2015
3599	Rachel Rene Sirignano	2128 Elm Ave, Rapid City, SD 57701		1/6/2015
3591	Samantha Jo Bartels	1921 Ellen Street Apt 5, Sturgis, SD 57785		12/5/2014
3592	Kaleb A Zook	1905 Heather Court, Sturgis, SD 57785		12/9/2014
3592	Kaleb A Zook	1905 Heather Court, Sturgis, SD 57785		12/9/2014
3593	Kingsley Arden Swanson	3820 jackson Blvd., Rapid City, SD 57702		12/15/2014
3619	Rachel Marie Wintle	5430 Bay Meadows Rd., Omaha, NE 68127		2/18/2015
3628	Meagan Elizabeth Einrem	311 8th Street, Springfield, SD 57078		2/25/2015

EMT-I/85 License Total 1

License Number	Name	Address	Specialty	Issue Date
1913	Clarence Duane Gilstad	214 Center Avenue South, Ashley, ND 58413		2/12/2015

Genetic Counselor License Total 4

License Number	Name	Address	Specialty	Issue Date
0035	Nicole Marie Mattila	3043 Wedge Court, Green Bay, WI 54313		12/23/2014
0034	Kristen Marie Rauch	29526 Lyndon Street, Livonia, MI 48154		12/15/2014
0033	Andrea Elizabeth Ramirez	3046 South Fork Drive, Corpus Christi, TX 78414		12/8/2014
0036	Rawan Isam Awwad	1015 Henrietta Street, Birmingham, MI 48009		2/9/2015

Medical Assistant Registration Total 17

License Number	Name	Address	Specialty	Issue Date
1162	Justin William Hagedorn	6145 Sunrise Lake Drive, Fort Worth, TX 76179		12/15/2014
1159	Jada Marie Keenan	4704 W. St. James Drive #12, Sioux Falls, SD 57106		12/8/2014
1163	Loni Skye Johnson	3841 N Gemini Drive, Sioux Falls, SD 57107		12/22/2014
1167	Mary Margaret Benson	7705 W Boulder Creek Place #11, Sioux Falls, SD 57106		1/29/2015
1170	Ashley Marie Barrie	405 4th St. SE, Watertown, SD 57201		2/24/2015
1172	Wendy Jane Rogers	20779 Monte Carlo Road, Lead, SD 57754		2/26/2015
1171	Ashleigh JeAnne Schmidt	24447 475th Avenue, Dell Rapids, SD 57022		2/25/2015
1161	Kristina Jade Huber	525 Morgan Lane #13, Tea, SD 57064		12/20/2014
1165	Kammi Jo Flemming	8709 E. Fiddlewood Drive, Sioux Falls, SD 57110		1/2/2015
1166	Nicole Ann Eichacker	44157 248th Street, Salem, SD 57058		1/21/2015
1164	Mindy Marie Ruble	3001 Hale Street, Sioux City, IA 51103		12/23/2014
1157	Danielle Kristin Kuehl	42 Stewart Avenue, Sioux City, IA 51105		12/5/2014
1156	Joan Holter	404 S Main Street, Hills, MN 56138		12/3/2014
1160	Mary Lisa Feiner	639 Streeter Drive Apt. 205, North Sioux City, SD 57049		12/8/2014
1158	Jenna Rae Walsh	16 Terra Alta Court, Sioux City, IA 51104		12/5/2014
1169	Priscilla Stanisljevic	2940 E Minnesota Street Apt #304, Rapid City, SD 57703		2/9/2015
1168	Courtney Kae Lorraine Linke	416 N Broadway, Watertown, SD 57201		2/9/2015

Medical Corporation Registration Total 4

License Number	Name	Address	Specialty	Issue Date
0572	Robert J Sage, MD, PC	2820 Mt. Rushmore Road, Rapid City, SD 57701	Dermatology	12/11/2014
0573	Nauman Nisar, P.C.	425 Bay Hill Circle, Dakota Dunes, SD 57049	Pathology	12/29/2014
574	Cosmetic and Plastic Surgery Specialists, P.C.	201 South Lloyd Street, Suite W230, Aberdeen, SD 57401	Plastic Surgery	1/29/2015
0575	Surgical Solutions, PLLC	904 Quincy Street, Rapid City, SD 57701	Surgery (General)	2/23/2015

Medical License (MD/DO) Total 61

License Number	Name	Address	Specialty	Issue Date
9417	Timothy Sebastian Fisher, MD	570 Aptos Creek Rd, PO Box 302 Aptos, CA 95003	Radiology	1/26/2015
9421	Kara Lee Underwood, MD	5125 Martin Road, Duluth, MN 55811	Family Medicine/General Practice	1/28/2015
9441	Kristin Jones Tarbet, MD	2800 3rd St , Rapid City, SD 57701-7374	Ophthalmology	2/19/2015
9388	Jena Auerbach, DO	7519 N 14th Avenue, Phoenix, AZ 85021	Pathology	12/9/2014
9415	Walter Lee Chesshir, MD	1833 Windermere Way, Brookings, SD 57006	Family Medicine/General Practice	1/21/2015
9390	Gregory Antoni Szych, DO	140 Torrey Pines Dr., Jackson, TN 38305	Gastroenterology	12/15/2014
9420	Robert Wayne King, MD	19939 State Hwy 49, Lawton, OK 73507	Emergency Medicine	1/27/2015
9427	Back Ki Hong, MD: Waiver	808 Cole Street, San Francisco, CA 94117	Anesthesiology	2/4/2015
9408	Ji Yoon Yoon, MD	301 Las Colinas Blvd. West Apt #358, Irving, TX 75039	Pathology	1/6/2015
9407	Wei Tian, MD	716 Orleans Drive, Southlake , TX 76092	Pathology	1/6/2015
9422	Natasha Adelle Telesford, MD: Waiver	451 Prospect Street, South Orange, NJ 07079	Internal Medicine (General)	1/29/2015
9411	Elizabeth Mary Tucker, DO	300 South Byron Boulevard, Chamberlain, SD 57325	Surgery (General)	1/14/2015
9397	Adebola Olufemi Adesanya, MD	1801 Cottonwood Valley Circle South, Irving, TX 75038	Anesthesiology	12/18/2014
9444	Sanjiv Vinayak Prabhu, MD	3843 W. Fitch Avenue, Lincolnwood, IL 60712-1011	Pathology	2/25/2015
9418	Melissa Maniscalco Bowers, DO	13443 Sienna Meadows Lane, Rapid City, SD 57702	Pediatrics (General)	1/27/2015
9404	Justin Nilsson Duke, MD	337 Richmar Drive, Birmingham, AL 35213	Orthopedic Surgery	12/30/2014
9426	Douglas Ryan Porter, MD	336 22nd Ave North, Nashville, TN 37203	Neurology	2/3/2015
9419	Daniel Edward Laurie, MD	1 City Drive, Ste. 570, St Louis, MO 63141	Internal Medicine (General)	1/27/2015

9443	Richard Lee Davis, MD	8707 GA Hwy 17, Bowersville, GA 30516	Orthopedic Surgery	2/20/2015
9430	Timothy Blake Ebbitt, MD	1221 Nicollet Mall, Ste. 600 Minneapolis, MN 55403	Radiology	2/10/2015
9495	Norma Therese Walks, MD	1601 Kniss Avenue, Luverne, MN 56156	Surgery (General)	12/17/2014
9442	Goutham Kolli, MD	6511 S Santa Rosa Pl, Sioux Falls, SD 57108	Internal Medicine (General)	2/20/2015
9400	Barbara Jane Blasko, MD	3671 Genista Place, Fallbrook, CA 92028	Emergency Medicine	12/19/2014
9406	Lisa Ella Thompson, MD	181 Malcolm X Blvd., Unit 2 New York, NY 10026	Emergency Medicine	12/30/2014
9386	Garrett Thomas Desman, MD	214 N 11th Street #6L, Brooklyn, NY 11211	Pathology	12/4/2014
9412	Massimo Asolati, MD: Waiver	1170 E. Amherst Avenue, Englewood, CO 80113	Surgery (General)	1/16/2015
9402	Alicia Velean Lee, MD	3116 Robert Drive, Richardson, TX 75082	Family Medicine/General Practice	12/19/2014
9436	Alon Jerome Vainer, MD	540 Telford Place, Atlanta, GA 30342	Nephrology	2/12/2015
9391	Russell Michael Bruney, MD	6505 N Stone Ridge Drive, Quincy, IL 62305	Radiology	12/16/2014
9437	Sorin Vainer, MD	687 Royer Place, Atlanta, GA 30342	Nephrology	2/12/2015
9434	Aaron Clementi Baker, MD	914 High Meadow Lane SW, Rochester, MN 55902	Vascular Surgery	2/11/2015
9431	Animesh Rathore, MD	3137 Avalon Cove Court NW, Rochester, MN 55901	Vascular Surgery	2/10/2015
9433	Syed Mohiuddin Peeran, MD	101 Civic Center Drive, Apt. 218, Rochester, MN 55906	Vascular Surgery	2/10/2015
9385	Inam Ur Rahman, MD	50 South Beretania Street, Suite C210 A1, Honolulu, HI 96813	Internal Medicine (General)	12/2/2014
9394	Aaron Gregory Potnick, MD	420 Woodhaven Place, West Sacramento, CA 95605	Radiology	12/16/2014
9387	Sita Paudel, MD	1308 Plum Tree Trail, Apt D, Hoover, AL 35226	Pediatrics Subspecialties	12/5/2014
9424	Greg Anthony Vigna, MD	994 Calle Abierta, Santa Barbara, CA 93111	Physical Med. & Rehab.	1/30/2015
9399	Dennis Jackson Rinehart, MD	10666 First Timberlane Drive, Northfield, MN 55057	Radiology	12/18/2014
9428	Glenn Andrew Tuckman, MD	6416 Shamel Drive, Indianapolis, IN 46278	Radiology	2/9/2015

9425	Kenneth Lee Gibbs, MD	9250 S. Tropical Trail, Merrit Island, FL 32952	Cardiology	2/2/2015
9429	Stephanie Kay Dahl, MD	517 Arrowwood Drive, Horace, ND 58047	Obstetrics and Gynecology	2/9/2015
9423	David Bruce Bettis, MD	502 Old Saybrook Drive, Boise, ID 83706	Pediatrics Subspecialties	1/29/2015
9409	Michael H. Song, MD	343 Elm Street, Suite 202, Reno, NV 89503	Neurological Surgery	1/13/2015
9496	James Thomas Barber, DO	2207 Eaglesmoor Lane, Enola, PA 17025	Obstetrics and Gynecology	12/17/2014
9445	Kiran Poudel, MD	3150 Ashton Brooke Drive, Apt #2, Beavercreek, OH 45431	Internal Medicine (General)	2/26/2015
9393	Jeffrey David Kleinman, MD	34640 Lakeview Drive, Solon, OH 44139	Radiology	12/16/2014
9410	Venkata Satish Iduru, MD	638 Knipp Road, Houston, TX 77024	Gastroenterology	1/13/2015
9389	Jehanzeb Khan, MD	217 Evergreen Garden Drive, Elizabethtown, KY 42701	Radiology	12/15/2014
9405	William Brendan Hayes, MD	4617 Briarhaven Road, Fort Worth, TX 76109	Anesthesiology	12/30/2014
9413	Osmund Ugochukwu Agbo, MD	17722 Rough River Court, Humble, TX 77346	Internal Medicine (General)	1/16/2015
9398	Mark Nelson Beard, MD	48052 260th Street, Brandon, SD 57005	Family Medicine/General Practice	12/18/2014
9435	Salah Georges Keyrouz, MD	2350 Maybrook Lane, Saint Louis, MO 63122	Neurology	2/12/2015
9401	Jo Anne Burkhalter, MD	1218 560th Street, Cherokee, IA 51012	Dermatology	12/19/2014
9438	Brooke Denise Renard, MD	213 North James Street, Silverton, OR 97381	Obstetrics and Gynecology	2/13/2015
9392	Aaron Douglas Dykstra, MD	7220 S Highway 16, Rapid City, SD 57702	Orthopedic Surgery	12/16/2014
9403	Emmett Terrance McEleney, MD	7220 S Highway 16, Rapid City, SD 57702	Orthopedic Surgery	12/19/2014
9416	William John Mohr, MD	640 Jackson Street, Mail Stop 11105C St Paul, MN 55101	Surgery (General)	1/21/2015
9414	Faisal Abdulah Khasawneh, MD	1 Cityplace Drive, Suite 570 St. Louis, MO 63141	Internal Medicine (General)	1/21/2015
9440	Christopher Richard Sidden, MD	3620 Pelham Road, #149 Greenville, SC 29615	Radiology	2/18/2015
9439	Valerie Anne Jones, MD	2668 Bayonne Street, Sullivan's Island, SC 29482	Physical Med. & Rehab.	2/18/2015

9432	John Athanasios Kazianis, MD	1 Cityplace Drive, Ste. 570 Saint Louis, MO 63141	Internal Medicine (General)	2/10/2015

Occupational Therapist License Total 14

License Number	Name	Address	Specialty	Issue Date
0945	Jamie Marie Lien	2410 Sunrise Ridge Circle #207, Brookings, SD 57006		2/5/2015
0944	Erin Michelle Schnabel	25 Edgewater Lane, Dakota Dunes, SD 57049		2/4/2015
0954	Ashley Kay Hoyme	180 30th Avenue, Hills, MN 56138		2/24/2015
0943	Kaylee Elizabeth Williamson	2612 Sunrise Court, Brandon, SD 57005		1/29/2015
0955	Kayla Mary Grutz	3500 Court Street, Sioux City, IA 51104		2/27/2015
0939	Erika Lorene Cornella	5117 Winterset Drive, Rapid City, SD 57702		12/23/2014
0949	Jill Emily Jacobs	100 Little Rock Ave, Marshall, MN 56258		2/9/2015
0950	Amanda Louise Rolfes	1724 S 1st Street, Aberdeen, SD 57401		2/12/2015
0947	Veronica Voss Iverson	8515 Nemo Road, Rapid City, SD 57702		2/5/2015
0951	Nikki Lynn Novak	2014 Beach Drive, Fort Pierre, SD 57532		2/12/2015
0953	Carrie Elizabeth Menke	109 N Dakota Street, Vermillion, SD 57069		2/18/2015
0952	Sara Ann Kaltenbach	2904 Sunrise Court, Brandon, SD 57005		2/12/2015
0946	Blane Terrance Sharkey	336 N 14th Street, Spearfish, SD 57783		2/5/2015
0948	Rachel Ann Blake	46362 295th St., Centerville, SD 57014		2/9/2015

Occupational Therapist Temporary Permit Total 1

License Number	Name	Address	Specialty	Issue Date
942	Kaylee Elizabeth Williamson	2612 Sunrise Court, Brandon, SD 57005		1/28/2015

Occupational Therapy Assistant License Total 3

License Number	Name	Address	Specialty	Issue Date
325A	Whitney Rose German	7601 W Legacy Street, Sioux Falls, SD 57106		2/9/2015
326A	Ashley Faye Muller	839 6th SW, Pipestone, MN 56164		2/12/2015
324A	Jacklyn Adair Taffe	423 West 3rd Street, PO Box 386 Graceville, MN 56240		12/17/2014

Paramedic License Total 16

License Number	Name	Address	Specialty	Issue Date
1919	Randy Webert	PO Box 1060, Yankton, SD 57078-1060		2/26/2015
1906	Kevin Ray Schlosser	4704 W. Antelope Drive, Sioux Falls, SD 57107		1/5/2015
1908	Daniel Simon Ell	3703 Nickerson Avenue, Bismarck, ND 58503		1/20/2015
1917	Nathan Dale Holthusen	402 N Spruce Street, Ogallala, NE 69153		2/18/2015
1902	Brock Jeffrey Soderberg	503 Oak Street, Wakefield, NE 68784		12/22/2014
1909	Matthew Ryan Callahan	1212 Lincoln Street, Vermillion, SD 57069		1/20/2015
1916	Riley Bro Beckstead	820 W 58th Street, Casper, WY 82601		2/18/2015
1896	Tate Olowan Locust	Po Box 165, Pine Ridge, SD 57770		12/3/2014
1900	Sarah Elizabeth Stewart	1010 Alta Vista Drive, Rapid City, SD 57701		12/15/2014
1899	Holli Ann Stirling	46704 265th St, Sioux Falls, SD 57107		12/11/2014
1907	Bridget Joanna McCormick	15710 County Road 32, Ovid, CO 80744		1/16/2015
1898	Kelly Allen Dollinger	4613 Hitchcock Drive, Bismarck, ND 58503		12/10/2014
1911	Brittany Nicole Oliver	310 N Derby Lane #103, North Sioux City, SD 57049		2/6/2015
1897	Stephen Alan McElmurry	1421 Ridgewood Drive, Fergus Falls, MN 56537		12/5/2014
1910	Burton Paul Hayden	1103 Rocking T Drive, Gillette, WY 82718		1/22/2015
1914	Lance Truels Iversen	PO Box 441, Murdo, SD 57559		2/12/2015

Physical Therapist Assistant Certificate Total 7

License Number	Name	Address	Specialty	Issue Date
0418	Katie Elizabeth Zach	2215 Glenwood Ave, Papillion, NE 68046		2/24/2015
0417	April Elaine Soderquist	48444 292nd Street, Hudson, SD 57034		2/3/2015
0416	Isaac Thomas Bigelow	408 N. Oak Ridge Road, Brandon, SD 57005		1/22/2015
0414	Dillon Lee Jensen	1251 HWY 20, Jackson, NE 68743		12/5/2014
0415	Sally Teresa Vickery	2514 Canterbury Road, Sergeant Bluff, IA 51054		1/8/2015
0420	Elia Mya Lexine	106 North 20th St., Fort Pierce, FL 34950		2/26/2015
0419	April Suzanne Harper	637 Kensington Ave., Salt Lake City, UT 84105		2/25/2015

Physical Therapist License Total 9

License Number	Name	Address	Specialty	Issue Date
1804	Patricia Kaydi Cassidy	623 Dakota Drive, Rapid City, SD 57702		1/29/2015
1807	Jenna Rae McNeely	3738 Gardner Barclay Road, Farmdale, OH 44417		2/4/2015
1806	Mark Allen Kaufman	3615 Adams Road, Oak Brook, IL 60523		2/2/2015
1805	Brandon Michael Ness	2008 Parkway Drive, Manhatten, KS 66502		2/2/2015
1802	Toni Marie Lais	755 Dugdale Avenue, Worthington, MN 56187		1/16/2015
1799	Erin Marie DeRoos	PO Box 322, Crofton, NE 68730		12/16/2014
1801	Megan Anne Snoozy	831 Brookside Drive, Jefferson, SD 57038		1/1/2015
1800	Kelley Lanette London	213 Woodburn Drive, Hampton, VA 23664		12/17/2014
1803	Rochelle Briones De Jesus	616 Banner Avenue, Basement Brooklyn, NY 11235		1/21/2015

Physician Assistant License Total 8

License Number	Name	Address	Specialty	Issue Date
0965	Holly Jo Savenko	506 NW 1st Street, Linton, ND 58552		12/11/2014
0969	Michael Scot Fleck	819 Durant Place NE #8, Atlanta, GA 30308		1/20/2015
0968	Deborah Michelle Adams	2333 Pulmosa Drive, Grimesland, NC 27837		1/5/2015
0967	James William Kearns	814 Spring Run Road, Winterville, NC 28590		1/5/2015
0970	Susan Carol Zwiaska	6437 Seminole Lane, Rapid City, SD 57702		1/28/2015
0971	Abby Marie Gietzen	350 28th Ave SE, Watertown, SD 57201		2/17/2015
0972	Jason Ryan Hennessey	19813 Emiline Street, Gretna, NE 68028		2/25/2015
0966	Angharad Supe Lyon	69 Foothill Blvd., Pocatello, ID 83204		12/16/2014

Physician Locum Tenens Total 13

License Number	Name	Address	Specialty	Issue Date
1471	Back Ki Hong, MD	808 Cole Street, San Francisco, CA 94117	Anesthesiology	12/5/2014
1478	Shaunak Vijay Rana, MD	4071 Gresham Street, San Diego, CA 92109	Nephrology	2/9/2015
1473	Justin Nilsson Duke, MD	337 Richmar Drive, Birmingham, AL 35213	Orthopedic Surgery	1/1/2015
1474	John Joseph Loffarelli, DO	18857 N 71st Lane, Glendale, AZ 85308	Internal Medicine (General)	12/19/2014
1469	Greg Anthony Vigna, MD	994 Calle Abierta, Santa Barbara, CA 93111	Physical Med. & Rehab.	12/5/2014
1467	Kenneth Lee Gibbs, MD	9250 S. Tropical Trail, Merrit Island, FL 32952	Cardiology	12/7/2014
1465	James Thomas Barber, DO	2207 Eaglesmoor Lane, Enola, PA 17025	Obstetrics and Gynecology	1/22/2015
1475	Kiran Poudel, MD	3150 Ashton Brooke Drive, Apt #2, Beavercreek, OH 45431	Internal Medicine (General)	12/28/2014
1468	Eugene Walper Lowe, MD	1733 Wycliffe Street, Bedford, VA 24523	Surgery (General)	12/22/2014
1472	Ronald Joseph Ruszkowski, MD	210 William Way, Williamsburg, VA 23185	Hematology & Oncology	12/20/2014
1476	Kip Cardell Newell, DO	2223 S 117th Circle, Omaha, NE 68144	Other Specialties	1/1/2015
1477	Osmund Ugochukwu Agbo, MD	17722 Rough River Court, Humble, TX 77346	Internal Medicine (General)	1/8/2015
1470	Salah Georges Keyrouz, MD	2350 Maybrook Lane, Saint Louis, MO 63122	Neurology	12/28/2014

Resident License Total 2

License Number	Name	Address	Specialty	Issue Date
0216	Rachael Joan Schultz	2601 S Nicollet Street, Sioux City, IA 55106	Family Medicine/General Practice	1/22/2015
0217	Sunnah Hope Widger Maki Doesken	2501 Pierce Street, Sioux City, IA 55104	Family Medicine/General Practice	2/19/2015

Respiratory Care Practitioner License Total 5

License Number	Name	Address	Specialty	Issue Date
1027	Kim Tutt	2520 Tower Road, Room 208 Rapid City, SD 57701		1/8/2015
1032	John Christian Olsen	2321 Huntland Hills Road, Cookeville, TN 38506		2/18/2015
1031	Michael Anthony Hernandez	35027 Ave C, Yucaipa, CA 92399		2/10/2015
1029	Sylest Sierra Ford	3901 Hartwell Road, Fayetteville, NC 28304		1/27/2015
1030	Barbara Elaine Randol	8500 E Willow Ridge Place, Sioux Falls, SD 57110		2/6/2015

Respiratory Care Practitioner Temporary Permit Total 2

License Number	Name	Address	Specialty	Issue Date
1028	Hannah Marie Stromseth	2720 South Summit Avenue, Sioux Falls, SD 57105		1/16/2015
1026	Tana Marie Lockner	2847 Nugget Gulch Drive, Rapid City, SD 57702		12/3/2014

Q1_15 Advisory Meetings

Advanced Life Support committee met on January 15, 2015

1. Discussed the challenges of supervision and licensing related to crossing state lines to pick up and/or transport patients.
2. The difficulty of finding medical directors was discussed.
3. Examples of state-wide standard protocols for licensees and state-wide or regional medical directors were discussed

Athletic Trainer committee met on February 18, 2015

1. Final review of recommended changes to the administrative rules

Dietetics and Nutrition committee met on February 9, 2015

1. Discussed the recommended changes to the therapeutic diet rule
2. Reviewed the recommended continuing education rule

Genetic Counselor committee met on February 20, 2015

1. Final review of the recommended changes to the statute.
2. Discussed a draft continuing education rule

Occupational Therapy committee met on February 12, 2015

1. Final review of recommended changes to the administrative rules
2. Reviewed a question from a licensee regarding a continuing education course

Physical Therapy committee met on February 19, 2015

1. The committee discussed models for continuing education rules
    a. More research is being done related to what courses count, how many credits to require, etc.
2. The committee reviewed possible revisions to the statute

Physician Assistant committee met on February 5, 2015

1. Reviewed questions related to physician assistants supervising estheticians
2. The committee discussed what types of changes required modification to the practice agreement

Respiratory Therapy committee met on February 26, 2015

1. The committee continued working on continuing education rules related to what types of courses will count
2. The committee discussed the auditing of licensees and anticipate to begin the audit process in the coming months
3. Concern was expressed that licensees may have a medical director who is not employed where the licensee works. Statute does not prohibit this.

Daniel M. Wagner Ed.D., ATC

Address
43548 SD Hwy 38
Salem, SD, 57058
Home (605) 425-2082
Cell (605) 999-1394
email: dnwagner@dwu.edu

Education:

Ed.D.	The University of South Dakota Educational Administration: Adult and Higher Education Dissertation: *Athletic Training Education Program Directors' Perceptions of the Entry-Level Preparation for the Certified Athletic Trainer*	8/2002
M.S.	Indiana State University, Terre Haute, IN Emphasis. Athletic Training	1994
B.S.	South Dakota State University, Brookings, SD Major: Athletic Training	1992

Continuing Education:

National Athletic Trainers Symposium	1997-99, 2002, 2008-2011, 2013-14
Functional Movement Systems	2013
ImPACT Concussion Seminars	2009, 2011, 2012
District V Athletic Training Seminar	1995-00, 2002-04, 2006-07, 2009, 2010, 2011, 14
SD ATC Rep for District V Athletic Training Student Leadership Council	2008-2013
Professional Educators Conference in Athletic Training	1999, 2001, 2005, 2007, 2009, 2011, 2013
Sanford Sports Medicine Symposium	2009-10, 2012
South Dakota Athletic Trainers Association Annual Meeting	2000-2004, 2006-2009, 2011-13
Journal of Athletic Training Manuscript Reviewer	2004-2013
CNOS Sports Medicine Symposium	2010
When the Feet Strike the Ground, Everything Changes-*Practical Biomechanical Assessment*	2004

Work Experience:

Dakota Wesleyan University 2001-present

*Athletic Training Education Program Director
-CAATE accredited through 2015
* Professor of Athletic Training
* Undergraduate Courses Instructed
-Pathology and Evaluation of Athletic Injuries I and II,

Therapeutic Modalities, Therapeutic Exercise, Research and Administration of Athletic Training, Research Methods in Health and Sciences I and II, Evaluation and Prescription of Health and Fitness Programs, Methods of Free Weight Training, Exercise Physiology, Biomechanics/Kinesiology

* Graduate Courses Instructed
  -Foundations of Higher Education, Teaching and Learning in the College Classroom

*Chair, Division of Natural Science 2003-2006

*Committee Assignments
- -Rank and Tenure 2012-present
- -Graduate Studies 2012-Present
- -Assessment 2009-2012
- -Faculty Relations 2006-2009
- -President Director Council 2003-2006
- -Educational Policies and Curriculum 2003-2005
- -Bush Grant Assessment Committee 2004-2006

*Assistant Athletic Trainer/ 2001-present
Athletic Training Education Preceptor
-Primary responsibilities have been with wrestling, baseball and rehabilitation.

Mount Marty College 8/1997-2001
*Assistant Professor of Athletic Training
*Head Athletic Trainer for MMC Athletics
*Athletic Training Education Program Director

Yankton Medical Clinic 8/1994-8/1997
*Mount Marty College
-Athletic Trainer for all sports
-Adjunct Faculty for Athletic Training and Exercise Physiology courses
*Yankton High School
-Athletic Trainer for all sports
*Physical Therapy Department
- Design and instruct patients with rehabilitation exercise protocols

Indiana State University 1993-94
*Graduate Assistant Athletic Trainer for ISU Baseball
* Clinical Instructor for Athletic Training major

South Dakota State University 1992-93
*Graduate Assistant Athletic Trainer
-Coordinator of SDSU Rehabilitation Facility:
-Clinical instructor for Athletic Training major

Scholarly Presentations:

Avera Queen of Peace General Medical Staff 10/2012
Current Practices in Concussion Management
McCook Central/Montrose School Districts 4/2012
Mid Central Education Coopertive 6/2012
Consultation for Concussion Policies

Avera Salem and St Joseph Medical Staff	11/2010
Current Practices in Concussion Management	
Avera Queen of Peace Administration and Staff	4/ 2010
Concussion Management: ImPact Software	
Mid States Education Cooperative Summer Workshop	7/2010
Current Trends in Sports Medicine	
Mid States Education Cooperative Fall Workshop	8/2007
Plyometrics to Prevent Injury	

Scholarly works in Progress:

Current studies underway "Static Postural Measurements and the Relationship to Dynamic Pelvic Control" and "Critical Thinking Development in Undergraduate Athletic Training Students"

Professional Organizations and Endorsements :

National Athletic Trainers Association (Certified)
South Dakota Athletic Trainers Association
Licensed South Dakota Athletic Trainer
American Safety and Health Institute CPR Pro

Justin Thurman

Email: jtthurman@hotmail.com Phone 605 490-1839

20701 Jefferson Court, Sturgis, SD 57785

Education

1995-1999 : The University of South Dakota

Bachelor of Science - Biology

2000-2002: The University of South Dakota

Physician Assistant Studies

Publications

Jones, QA, Thurman, JT, Huela, M, & Cafruny, WA. 2000. Placental and fetal infections with lactate dehydrogenase-elevating virus. 19th Annual Meeting of the American Society for Virology, presented at Fort Collins, CO. July 8-12.

Academic Scholarships/Awards

2002	Dr. Robert Hayes Memorial Scholarship
2001	L.B. Wheeler Scholarship
2001	Gateways Leadership Scholarship 2001
1999	E. Raymond Outstanding Senior Award
1998-1999	EPSCoR Research Grant
1998	USD Unsung Leader Award
1998	Mortar Board Honor Society
1997	D.J. Lorenz Scholarship

Work Experience

1989-1997 - Laborer - Framing and roofing houses

1996-1997 - Nurse Aide - Good Samaritan Nursing Home

1998 - Physical Therapy Aide - State hospital in Yankton, SD

1999 - Research Assistant - USD School of Medicine

2000 - Admissions Counselor - The University of South Dakota

Post - Graduate Work Experience

2002-2005 - Physician Assistant - West River Dermatology : Rapid city, SD

2005- present: Physician Assistant - Fort Meade VA Hospital: Fort Meade, SD

Current Duties:

Primarily work in orthopedics including first assist in the operating room, evaluation of patients as outpatients, inpatients and emergency department, shares one in four call rotation for the surgery department.

Administrative Duties:

Lead Physician Assistant at the Black Hills VA Healthcare System (2014- current)

Physician Assistant Ad-Hoc representative to the Executive Committee of the Medical Staff

Pain Management Collaborative Committee

Medical Records Committiee

Professional Standards Board

VA Black Hills Awards:

2 Heart of Gold Awards

3 Team Awards

Employee of the Month

Professional Membership:

2002-present: Fellow, American Academy of Physician Assistants (AAPA)

2002-present: Fellow, South Dakota Academy of Physician Assistants (SDAPA)

Professional Service Involvement:

2004-2012: SDAPA Director at Large

2008-2012: SDAPA Public Relations Chair

2012-2014: SDAPA President

2014-2015: SDAPA Immediate Past President

2014 - present: SDAPA Legislative Affairs Committee Member

2012 - present: PA representative on the SD Prescription Drug Monitoring Program (PDMP)

2003 - present : Served as a preceptor for The University of South Dakota Physician Assistant Program, South Dakota State University Nurse Practitioner Program, The University of South Dakota Medical School, clinical setting preceptor for the South Dakota State University Pharmacy Program, as well as serving in a mentorship/internship capacity for several high school seniors from Sturgis-Brown High School that express an interest in medicine.

I am a lifelong resident of South Dakota, raised in Sioux Falls and relocating to the Black Hills after graduation. I have been married to my wife Carrie for 11 years, and we have a 7 year old daughter (Avery) and a 5 year old son (Jace). We have lived in Boulder Canyon near Sturgis since 2003. As a family, we enjoy camping by summer and snow skiing by winter. I also enjoy hunting and golfing and spending time in the Black Hills. I coach tee ball with my kids and assist with soccer and basketball.

WF WOODS FULLER
SHULTZ & SMITH P.C.

March 10, 2015

David C. Kroon
David.Kroon@woodsfuller.com
Extension 674

VIA E-MAIL & U.S. MAIL

William.Golden@state.sd.us

Mr. William Golden
Assistant Attorney General
South Dakota Attorney General's Office
317 N. Main Ave.
Sioux Falls, SD 57104

Re: In the Matter of David R. Starner – No. 14-056

Dear Bill:

Enclosed you will find Respondent's Objections to Findings of Fact and Conclusions of Law in the above-referenced matter.

As we discussed via e-mail correspondence on March 6, 2015, the enclosed written argument is submitted in lieu of an appearance at tomorrow's hearing.

Please let me know if you have any questions. Thank you.

Very truly yours,

WOODS, FULLER, SHULTZ & SMITH P.C.

David C. Kroon

Enclosure
cc: David Starner (w/enc.)

THE BOARD OF MEDICAL AND
OSTEOPATHIC EXAMINERS OF THE
STATE OF SOUTH DAKOTA

IN THE MATTER OF DAVID R. STARNER EMT/PARAMEDIC Respondent.	)))))))	NO. 14-056 RESPONDENT'S OBJECTIONS TO FINDINGS OF FACT AND CONCLUSIONS OF LAW

David R. Starner respectfully submits Respondent's Objections to Findings of Fact and Conclusions of Law. The Hearing Examiner recommended that David Starner's application for reinstatement of his license be denied.

Argument

1. Starner's termination from the Aberdeen Fire Department does not constitute unprofessional conduct.

The Board asserted that Starner's termination from Aberdeen Fire Department during his initial probationary period constituted "unprofessional" conduct as defined by SDCL § 36-4-30's "catch-all" provision. The Hearing Examiner found that Starner's "termination was for a series of documented events during his probationary period" and "failure to follow applicable protocols" (Findings of Fact Paragraph 9). However, the Hearing Examiner failed to identify the specific events or protocol which Starner allegedly failed to follow.

Engaging in "unprofessional" conduct is grounds for denial of the issuance or license renewal of any advanced life support personnel, including paramedics. SDCL §§ 36-4B-31, 36-4-30(22). SDCL § 36-4-30(22) does not describe a specific type of

conduct, but rather is a catch-all provision providing that "unprofessional or dishonorable conduct" includes:

> 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.

SDCL § 36-4-30(22). The South Dakota Supreme Court has held that, due to the difficulty of cataloguing all types of unprofessional misconduct, this catch-all provision is constitutional. *In re Setliff*, 645 N.W.2d 601, 606 (S.D. 2002). But to avoid vagueness concerns, conduct considered under the catch-all provision "'should not be given an overly broad connotation, it must relate to conduct which indicates an unfitness to practice medicine.'" *Id.* (quoting *Chastek v. Anderson*, 416 N.E.2d 247, 250 (Ill. 1981)).

As applied in the licensing and revocation cases 'unprofessional conduct' has been construed to include serious offense, such as intentional violations of law or recognized professional standards. We submit that as a matter of law, there is insufficient evidence to conclude that Starner's alleged failure to follow non-specific protocol was "unprofessional" within the meaning of South Dakota law.

2. Starner's failure to make disclosures for a paramedic certification in Minnesota does not constitute unprofessional conduct.

SDCL § 36-4-30 (16) provides that "unprofessional or dishonorable conduct" includes:

> 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.

The Hearing Examiner found that Starner's entering into a consent agreement established Starner failed to make the required disclosures on the application (Finding of Fact 9). The Hearing Examiner did not specifically state this constitutes a violation of SDCL § 36-4-30; however, he did cite this statute in his decision (Conclusion of Law 4).

First, we submit that the "board" referenced in SDCL § 36-4-30 (15) applies to a false statement made to the South Dakota Board of Examiners and does not contemplate statements made to other state licensing agencies.

Second, Starner testified that he did not believe that he was required to disclose the South Dakota Consent Agreement with Reprimand to the Minnesota Board of Examiners because the Minnesota application question did not include the word "reprimand." Whether Starner's interpretation was correct or not, he testified he did not intend to provide false information, and had spoken to Minnesota Board representatives about the matter.

Starner also testified that he was diagnosed with a learning disability at an early age. Starner testified this disability has adversely impacted his reading comprehension and affects activities such as completing professional applications. The Hearing Examiner noted this testimony (Finding of Fact Paragraph 10), but concluded its effect was unknown.

As a matter of law, there is insufficient evidence that Starner provided incorrect or incomplete information in order to obtain a license "by fraud or deception."

3. Starner's failure to disclose allegations of sexual misconduct memoranda does not constitute unprofessional conduct.

The Hearing Examiner noted allegations of sexual misconduct against Starner (Findings of Fact Paragraphs 4 and 8). However, it is important to note that there was no evidence presented at the hearing to suggest there was any factual basis to these allegations. Nevertheless, in the Conclusions of Law, the Hearing Examiner cited SDCL § 36-4-30(20), thereby suggesting the unsubstantiated allegations constitute "engaging in gross or immoral sexual harassment or sexual contact."

Starner was not attempting to avoid scrutiny or otherwise obtain a license by failing to disclose information. Rather, this is due in part, to the learning disability to which he testified, and also his belief that these matters did not rise to the level of a "complaint" necessitating disclosure.

Conclusion

Starner has already paid a heavy price for any mistakes he may have made. He has effectively been suspended for a significant period of time. Starner is a good and passionate paramedic. Starner submits that as a matter of law, the findings of fact do not support a sufficient basis under SDCL § 36-4-30 to support the denial of his application for a license.

Dated this 10th day of March, 2015.

WOODS, FULLER, SHULTZ & SMITH P.C.

By _____

David C. Kroon
300 South Phillips Avenue, Suite 300
Post Office Box 5027
Sioux Falls, South Dakota 57117-5027
(605)336-3890
Attorneys for David Starner

Certificate of Service

I hereby certify that on the 10th day of March, 2015, I served the foregoing Respondent's Objections to Findings of Fact and Conclusions of Law by emailing and depositing of a copy of it in the U.S. mail, first-class postage pre-paid and addressed to the following:

Mr. William Golden
Assistant Attorney General
South Dakota Attorney General's Office
317 N. Main Ave.
Sioux Falls, SD 57104
William.Golden@state.sd.us

_____
One of the Attorneys for Starner

{01856363.1}

Hansen, Margaret

From: Golden, William
Sent: Tuesday, March 10, 2015 4:24 PM
To: Hansen, Margaret
Subject: Fwd: In the Matter of David R. Starner - No. 14-056
Attachments: image003.jpg; ATT00001.htm; Bill Golden ltr 2015, 3-10 (01856802x9FB59).pdf; ATT00002.htm; Respondent's Objections to Findings of Fact and Conclusions of Law (01856857x9FB59).pdf; ATT00003.htm

Sent from my iPhone

Begin forwarded message:

From: "Kirstin J. Lange" <Kirstin.Lange@woodsfuller.com>
Date: March 10, 2015 at 4:22:35 PM CDT
To: "William.Golden@state.sd.us" <William.Golden@state.sd.us>
Cc: "David C. Kroon" <David.Kroon@woodsfuller.com>
Subject: In the Matter of David R. Starner - No. 14-056

Mr. Golden,

The attachments are sent on behalf of David Kroon. If you have any questions, please feel free to contact Dave at 336-3890 or David.Kroon@woodsfuller.com.

Thank you.

THE BOARD OF MEDICAL AND
OSTEOPATHIC EXAMINERS OF THE
STATE OF SOUTH DAKOTA

IN THE MATTER OF DAVID R. STARNER EMT/PARAMEDIC Respondent.	)))))))	NO. 14-056 PETITION FOR BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

COMES NOW, the Executive Secretary of the South Dakota Board of Medical and Osteopathic Examiners ("Secretary") and files this Petition pursuant to SDCL 36-4B-31, SDCL 1-26 and South Dakota's Administrative Rules (ARSD) 20:78:04 and 05. Respondent, David R. Starner, was again placed under investigation in September 2013 due to his involuntary termination by the Aberdeen Fire Department. He voluntarily surrendered his paramedic license while under investigation in October 2013. Mr. Starner has now applied for reinstatement of his South Dakota paramedic license. Respondent's address as reported to the Board is 14158 130th St., Hoffman, MN 56339.

After investigation, a recommendation was made pursuant to ARSD 20:78:04:04 for the BMOE to deny his application for reinstatement. Respondent has contested this recommendation. The Secretary, pursuant to ARSD 20:78:04 and ARSD ch. 20:78:05, therefore files this Petition for a contested case hearing.

A. TIME, PLACE AND NATURE OF HEARING

Hearing. A contested case hearing on this licensure action shall be heard by a Hearing Examiner pursuant to ARSD 20:78:05:04. The hearing shall begin at 1:30 pm on Friday, August 8, 2014, in the BMOE Conference Room, 101 North Main Avenue, Suite 215, Sioux Falls, South Dakota 57104.

Answer. Respondent may file an Answer within twenty (20) days of the date he is served with this Petition. An Answer, if filed, should specifically admit, deny, or otherwise answer all allegations contained in sections C and D of this Petition. The Answer and any other pleading must be filed with the Board at the following address: BMOE, 101 North Main Avenue, Suite 301, Sioux Falls, South Dakota 57104.

Presiding Officer. The Hearing Examiner will preside over the hearing and make a recommended decision consisting of proposed Findings of Fact, Conclusions of Law, and an Order, to the Board. ARSD 20:78:05:06. The Board will read the record, transcript of the contested case proceeding, and all exhibits, and make its decision thereon at a BMOE meeting following the contested case hearing. The Board may request that the parties appear to present oral argument and objections to the Hearing Examiner's recommended decision. ARSD 20:78:05:06.

Hearing Procedures. The procedural rules governing the conduct of the hearing are found at SDCL chs. 36-4 and 1-26, and ARSD chs. 20:78:05. The contested case proceeding is an adversarial proceeding. At the hearing, you have the right to be present, to appear personally, and/or to be represented by legal counsel at your own expense. You will be allowed the opportunity to

respond to the allegations of the Petition, to produce evidence on your behalf, to present witnesses, to cross-examine witnesses, and to examine and respond to any documents introduced at hearing. These and other due process rights will be forfeited if they are not exercised at the hearing.

The hearing is open to the public.

Any decision of the BMOE based on the contested case proceeding may be appealed to the circuit court and the State Supreme Court as provided by law.

Pre-hearing Conferences and Continuances. Any party may request a pre-hearing conference to discuss evidentiary issues related to hearing, or may request a continuance, by filing a motion for a prehearing conference with the BMOE at the address above.

Prosecution. Counsel for the Secretary is responsible for representing the public interest (the State) in this proceeding. Counsel for the Secretary is: William H. Golden, Assistant Attorney General, South Dakota Attorney General's Office, 101 North Main Avenue, Suite 301, Sioux Falls, South Dakota 57104. Copies of all pleadings filed in this matter must be provided to Counsel for the Secretary at this address.

Communications. You may not contact Board members in any manner, including by phone, letter, in person, or by e-mail about this Petition. BMOE members may only receive information about the case when all parties have notice and an opportunity to participate, such as at the hearing or in pleadings

you file with the BMOE office and serve upon all parties in this case. *See* SDCL 1-26-26.

B. LEGAL AUTHORITY AND JURISDICTION

Jurisdiction. The BMOE has jurisdiction in this matter pursuant to SDCL 36-4B.

Legal Authority. If any of the allegations against you are founded, the BMOE has authority to take disciplinary action against you under SDCL 36-4B-31 and 36-4-30, and ARSD 20:78:04 and 05.

Default. If you fail to appear at the hearing, the Board may enter a default decision or proceed with the hearing and render a decision in your absence, in accordance with SDCL 1-26.

C. SECTIONS OF STATUTES AND RULES INVOLVED

Count I

Respondent is subject to discipline under SDCL 36-4B-31 and 36-4-30 (15) (22). Mr. Starner submitted his 2013 paramedic renewal application on June 17, 2013, and he failed to disclose that he received disciplinary actions for violations of work rules and regulations.

Count II

Respondent is subject to discipline under SDCL 36-4B-31 and 36-4-30 (15) (22). Mr. Starner was involuntarily terminated from the Aberdeen Fire Department for unprofessional conduct.

D. FACTUAL CIRCUMSTANCES

1. Mr. Starner submitted an initial application for a South Dakota Paramedic License and was issued the license in December 2012.
2. Mr. Starner was placed under investigation in March of 2013 for failing to disclose on his initial licensure application that he had been accused of sexual assault, and that he was the respondent of a restraining order.
3. In June of 2013, Mr. Starner received a reprimand from the BMOE for failure to disclose the above referenced information on his initial application.
4. In August 2013, BMOE staff received a copy of a letter that was sent to Mr. Starner from the Aberdeen Fire Department notifying him that he had been terminated due to his failure to successfully complete his probationary period.
5. The BMOE staff obtained Mr. Starner's personnel file from the City of Aberdeen which reported the following events:
    a. 1/17/13 - Issued a Coaching & Counseling statement for having issues following orders and showing attitude toward FTO's, particularly in treatment of patients in following procedure and protocols.
    b. 3/28/13 - Violation of work rules on numerous occasions for not wearing the appropriate PPE equipment, such as gloves.
    c. 6/14/13 - Violation of work rules and regulations was issued because he was not aware how to get to an address during an

emergency call and this led to a delayed arrival time. It was noted that Mr. Starner spent a great deal of time switching the siren tones versus knowing the correct route to take.

d. 7/16/13 - Violation of work rules and regulations was issued for failure to follow medical protocols and failure to meet Aberdeen Fire Rescue standards of care. Mr. Starner failed to follow physician approved medical protocols for a patient having chest pain.

e. 8/19/13 – A notice of termination was delivered to Mr. Starner for failure to successfully complete probationary period.

6. BMOE staff reviewed Mr. Starner's 2013 renewal application, which he submitted in June 2013, and discovered that he had failed to disclose that he had received any warnings or coaching for violations of work rules and regulations.

7. In September of 2013, Mr. Starner was again placed under investigation due to the involuntary termination and employment issues in his personnel file.

8. On September 24, 2013, Mr. Starner submitted a written response describing his termination from the Aberdeen Fire Department. Mr. Starner said:

a. He was terminated for failing to pass his PHTLS course; however, he said that he could prove he did pass the course.

b. He was treated differently from other staff and treated unfairly.

c. He followed protocols and procedures.

d. Aberdeen Fire Department defamed his character through libel and slander.

9. On October 21, 2013, Mr. Starner was informed that the BMOE member of the investigative review panel recommended the revocation of his SD paramedic license. Mr. Starner then requested that his paramedic license for the State of South Dakota be surrendered on October 24, 2013.

10. Mr. Starner was advised by BMOE staff that his request to withdraw his license while under investigation would result in a public board action and would be published on the Board's website and reported to the national data banks and all other entities deemed appropriate by the Board in compliance with state and federal laws.

11. The staff also informed Mr. Starner that his withdrawal while under investigation would be placed on the agenda of the next meeting of the BMOE.

12. Mr. Starner confirmed his receipt and understanding of this information.

13. The Board accepted and approved Mr. Starner's withdrawal while under investigation at the November 2013 BMOE meeting.

14. On March 27, 2014, Mr. Starner submitted an application for the reinstatement and renewal of his SD paramedic license.

15. It is hereby requested that Mr. Starner application be denied for unprofessional conduct in this matter.

E. SETTLEMENT

This matter may be resolved by settlement agreement. The procedural rules governing the Board's settlement process are found at ARSD 20:78:04:04. If you are interested in pursuing settlement of this matter, please contact William Golden, Assistant Attorney General, at (605) 201-8588.

Signed pursuant to Article 20:78:05:02: Margaret B Hansen Date: 7/17/2014

Margaret B. Hansen
Executive Director
South Dakota Board of Medical
and Osteopathic Examiners

Copies to: William Golden
Assistant Attorney General
South Dakota Attorney General's Office
317 N. Main
Sioux Falls, SD 57104

David Kroon
Woods, Fuller, Schultz & Smith
PO Box 5027
Sioux Falls, SD 57117-5027

SOUTH DAKOTA BOARD OF MEDICAL
AND OSTEOPATHIC EXAMINERS

IN THE MATTER OF THE SOUTH DAKOTA BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS, APPLICATION FOR LICENSE, RE: DAVID STARNER.	)	FINDINGS OF FACT and CONCLUSIONS OF LAW

This matter came on for hearing on the 26th day of September, 2014, at approximately 9:30 a.m. This case centers around the application for reinstatement of David Starner's paramedic license. The South Dakota Board of Medical and Osteopathic Examiners, ("Board"), appeared through Attorney William Golden of the Attorney General's Office. David Starner was present along with his attorney, David C. Kroon, of WOODS, FULLER, SHULTZ & SMITH P.C. At the time of hearing, testimony from the several witnesses was heard, evidence was presented in the form of the exhibits received, and the parties also made argument on the case. Additionally, the parties submitted briefs on the matter. From this, the undersigning hearing examiner makes the following findings of fact and conclusions of law.

FINDINGS OF FACT

1. David Starner has a long, but checkered work history in the EMS field. He has letters commending him for his performance, and as detailed below, he has noteworthy shortcomings. He is significantly credentialed, and has a broad base of experience.

2. Mr. Starner was licensed in South Dakota as a paramedic in December, 2012, and he made a renewal application on or around June 17, 2013. However, later in 2013, Starner surrendered his license. Then, he made application to have his license reinstated in March, 2014.

3. The Board initially commenced an investigation after receiving a notification of a complaint against Mr. Starner. The complaint related to his performance in Lisbon, ND where he had been performing paramedic duties. The allegations against him included a minor narcotics control incident that resulted in a reprimand, some difficulty accepting protocols, and accepting

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direction from superiors, and also some problems getting along with others. Mr. Starner failed to make the corresponding, required disclosure on his 2012 application. After he submitted an explanation, he was granted a license.

4. Board Staff investigator Ted Huss next became aware of a rape allegation and a related protection order against Mr. Starner. Huss received this complaint in March, 2013. Mr. Starner failed to disclose this required information on his 2012 application for licensure. This matter became the subject of earlier Board action that resulted in a reprimand and consent agreement. However, Huss also found that on the 2013 renewal application there were things that he believed should have been disclosed. Mr. Starner was notified through Investigator Huss of the ongoing investigation.

5. In June, 2013, Mr. Starner was granted a renewal of his license.

6. In August, 2013, Investigator Huss received information about the termination of Mr. Starner's job at the Aberdeen Fire Department. The reason for Mr. Starner's termination was for a series of documented events during his probationary period. (exhibit 7) These included several incidents of Starner's failure to follow applicable protocols.

7. Thereafter, during the course of the investigation, Investigator Huss made a recommendation to Board staff that Mr. Starner's existing license be revoked. Huss informed Starner of this as well. (exhibit 11) In response, Mr. Starner contacted Investigator Huss indicating that he wanted to surrender, or withdraw, his license. (exhibit 12) That withdrawal was formalized by the Board on or about November 13, 2013. (exhibit 13)

8. At some point, the Board investigators received two independent reports alleging that Mr. Starner had committed some sexual harassment. The dates of the allegations and the substance of the same was poorly substantiated at hearing. However, Mr. Starner had no knowledge that the sexual harassment complaints had been made.

9. In October, 2013, Mr. Starner made application for certificate, (license), in Minnesota. However, a consent agreement entered into in Minnesota contains a finding that Mr. Starner failed to make required disclosures on the application.

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He made no disclosure of the reprimand that had been previously issued by SDBMOE. (exhibit 16)

10. Mr. Starner has a learning disability, and this was disclosed during his testimony in this matter. The fact that he has a learning disability was not disclosed on his application(s). The extent of this disability and its potential impact on Mr. Starner's ability to perform EMS duties is unknown. During cross-examination by Mr. Golden, Starner had apparent difficulty understanding and answering the relatively straight-forward questions posed. (see transcript pages 89 - 92)

11. Mr. Starner has difficulty recognizing his short-comings in performance and in interpersonal relationships, and accepting them as such. When these are called to his attention his reaction is surprise or shock. This is evidenced by his reaction to, (1) the minor reprimand from Lisbon, ND over the accounting for narcotics as well as some reported difficulty with following protocols, (2) the termination from the Aberdeen Fire Department due to several different issues including following a relevant protocol, and (3) the allegations of the female petitioner in the protection order matter along with the related criminal investigation for rape or sexual assault. (see transcript pg 89 - 92) Mr. Starner expressed his surprise or shock for each of the three.

12. Mr. Starner is unable to satisfactorily complete the South Dakota application for licensure.

From this, the following conclusions of law are made.

Any of the foregoing Findings of Fact that are more properly designated as Conclusions of Law are hereby re-designated as such.

CONCLUSIONS OF LAW

Any of the following Conclusions of Law that are more properly designated as Findings of Fact are hereby re-designated as such.

1. The Board is the licensing authority for the regulation of Advanced Life Support, including paramedics, in the State of South Dakota.

2. The Board has jurisdiction over this matter pursuant to SDCL §36-4b et. seq.

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3. Mr. Starner received adequate notice of hearing, adequate opportunity to prepare for a contested hearing, and he received a full and fair hearing on the matter.

4. The board may deny the issuance or renewal of a license or suspend or revoke the license of any advanced life support personnel issued . . . "upon satisfactory proof of the person's incompetence, or unprofessional or dishonorable conduct as defined in §36-4-30 . . ." (SDCL 36-4B-31)

5. Reason for a denial of license is contained in SDCL §36-4-30. Relevant here are the following subsections:

36-4-30(12) Sustaining any physical or mental disability which renders the further practice of a licensee's profession dangerous;

36-4-30(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; (emphasis added)

36-4-30(20) Engaging in gross or immoral sexual harassment or sexual contact; and

Upon the foregoing, the following recommendation is made.

RECOMMENDATION

Mr. Starner has demonstrated that he is unable or unwilling to disclose events, occurrences and conditions relevant to his applications for licensure. In his last two applications here and in the Minnesota application, Mr. Starner failed to disclose serious matters. Whether this is due to misapprehension of the events and the corresponding necessity to make a disclosure on the applications, or an unwillingness to make the disclosures, the effect is that the Board is deprived of information critical in nature to the decision to issue a license. Without complete disclosure along with an accurate description of the relevant events, the Board is severely disadvantaged in its ability to safeguard the public.

Additionally the detailing of his troubles performing duties in both Lisbon and in Aberdeen does nothing to alleviate the concern. Mr. Starner's misperceptions of his interactions

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with others is similarly concerning. Substantial Reason for denial of a license exists under each of the factors listed in §36-4-30 above.

Accordingly, it is hereby recommended that David Starner's application for reinstatement of license be DENIED.

Dated this 13th day of February, 2015.

Paul Henry
BERREAU LAW OFFICE
111 N Main St
Canton, SD 57013
Telephone (605) 558-1100

HEARING EXAMINER

02/13/2015 16:11 FAX 0005/0005

THE BOARD OF MEDICAL AND
OSTEOPATHIC EXAMINERS OF THE
STATE OF SOUTH DAKOTA

IN THE MATTER OF	)	NO. 14-056
	)	
DAVID R. STARNER EMT/PARAMEDIC	))	POST HEARING MEMORANDUM OF DAVID R. STARNER
	)	
Respondent.	))	

David R. Starner respectfully submits this brief in support of his application for a reinstatement of his paramedic license. The Investigatory Review Panel has recommended that Starner's application be denied.

Introduction

This case presents the question whether the Board should effectively end a paramedic's career based on unintentional failure to disclose disciplinary actions by an employer or his termination by that same employer.

Argument

1. Starner's termination from the Aberdeen Fire Department does not constitute unprofessional conduct.

No one has questioned Starner's moral character or his knowledge of his profession when he reapplied for his paramedic license. Rather, the Board asserts that Starner's termination from Aberdeen Fire Department during his initial probationary period constitutes "unprofessional" conduct as defined by SDCL § 36-4-30's "catch-all" provision. *See* Petition for Board of Medical and Osteopathic Examiners.

Engaging in "unprofessional" conduct is grounds for denial of the issuance or

license renewal of any advanced life support personnel. SDCL §§ 36-4B-31, 36-4-30 (22). SDCL § 36-4-30 (22) does not describe a specific type of conduct, but rather is a catch-all provision providing that "unprofessional or dishonorable conduct" includes:

> 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.

SDCL § 36-4-30(22). The South Dakota Supreme Court has held that, due to the difficulty of cataloguing all types of unprofessional misconduct, this catch-all provision is constitutional. *In re Setliff*, 645 N.W.2d 601, 606 (S.D. 2002). But to avoid vagueness concerns, conduct considered under the catch-all provision "'should not be given an overly broad connotation, it must relate to conduct which indicates an unfitness to practice medicine.'" *Id.* (quoting *Chastek v. Anderson*, 416 N.E.2d 247, 250 (Ill. 1981)). *Setliff*, however, did not attempt to establish any method for determining what type of conduct is sufficient to indicate an unfitness to practice medicine.

Other courts have recognized that general terms such as "unprofessional" or "dishonorable" do "'not authorize revocation for trivial reasons or for a mere breach of the generally accepted ethics of the profession.'" *Georgia Bd. of Chiropractic Examiners v. Ball*, 160 S.E.2d 340, 342 (Ga. 1968) (quoting 41 Am. Jur. *Physicians and Surgeons* § 175-76 [now 61 Am. Jur. 2d *Physicians, Surgeons, Etc.* § 77 at 201]) (holding chiropractor's violation of rules against display advertising and free x-ray services did not constitute unprofessional conduct sufficient to justify revocation of license); *Arizona St. Bd. of Medical Examiners v. Clark*, 398 P.2d 908, 915 (Az. 1965) ("as applied in the licensing and revocation cases 'unprofessional conduct' has been construed to include

serious offense, such as intentional violations of law or recognized professional standards").

2. The evidence shows that Starner did not engage in a practice or conduct which is a danger to the public or patients.

The Board has not demonstrated that Starner engaged in any practice or conduct which is a danger to the public or patients, or is otherwise "unfit" to be a paramedic. The Board relies exclusively upon a series of incidents leading to termination from the Aberdeen Fire Department.

A. The January 17, 2013 Coaching and Counseling Memo

Starner testified that this incident arose because his supervisor unprofessionally yelled at a coworker in front of medical staff after he hit a bump while transporting a patient. When Starner asked another fire fighter how best to handle the matter, his supervisor became upset and concluded he had shown an "attitude. However, there was no evidence that Starner acted inappropriately or unprofessionally. The matter is best characterized as a personality conflict which has nothing to do with the quality of care provided by Starner.

B. The March 28, 2013 Work Rule Memo

This memo arose from Starner's alleged failure to arrive at a scene without wearing his protective gloves. Starner testified that he had been trained not to drive with the gloves, but rather survey the scene prior to donning the protective equipment. Once the Aberdeen Fire Department communicated its preferred policy to Starner, he complied without incident. Again, there was no danger to the public, or any impairment of the

quality of care.

C. The June 14, 2013 Work Rule Memo

This incident arose from his supervisor's conclusion that Starner took too long to arrive on the scene. Starner testified that he took a wrong turn, but that the delay in arriving at the scene was not due to negligence or inattention to his duties. Starner testified that there was no danger to the patient. Starner further testified he had passed the map test and that it is not uncommon for drivers to take a wrong turn on the way to a scene.

D. The July 16, 2013 Work Rule Memo

Starner testified at length concerning this incident. The Aberdeen Fire Department alleged that Starner failed to follow the Department's chest pain protocol. However, Starner testified that the patient never complained of chest pain, and the patient denied any chest pain. Starner testified that his interpretation of the "chest pain protocol" was that it was not necessary to implement the protocol it in the event the patient does not complain of chest pain. Starner did not "diagnose" the absence of any heart involvement. To the contrary, he testified that he worked extensively to convince a patient to go to the hospital for a full evaluation. Without Starner's persistent and professional counseling, the patient may well have refused transportation to the hospital. Rather than being reprimanded for failing to follow a protocol which likely did not apply, he should be commended for his professionalism in convincing a recalcitrant patient to seek diagnosis from a physician at the hospital. It is important to note the patient was not suffering from any heart involvement and was released from the hospital within 45 minutes following

his arrival.

E. The August 19, 2013 Termination

There is nothing remarkable about the termination. Starner was merely terminated for the incidents previously discussed. Starner testified his employer told him the "last straw" was his failure to complete a certification. However, Starner testified that the employer was incorrect, and that he had, in fact, completed the certification, a copy of which was introduced into evidence.

3. Starner's failure to make disclosures for a paramedic certification in Minnesota does not constitute unprofessional conduct.

SDCL § 36-4-30 (15) provides that "unprofessional or dishonorable conduct" includes:

> 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.

First, I submit that the "board" referenced in SDCL § 36-4-30 (15) applies to a false statement made to the South Dakota Board of Examiners and does not contemplate statements made to other state licensing agencies.

Second, Starner testified that he did not believe that he was required to disclose the South Dakota Consent Agreement with Reprimand to the Minnesota Board of Examiners because the Minnesota application question did not include the word "reprimand." Whether Starner's interpretation was correct or not, he testified he did not intend to provide false information, and had spoken to Minnesota Board representatives about the matter.

Starner also testified that he was diagnosed with a learning disability at an early age. Starner testified this disability has adversely impacted his reading comprehension and affects activities such as completing professional applications.

There was no evidence that Starner provided incorrect or incomplete information in order to obtain a license "by fraud or deception." In any event, Starner testified that he did not believe that the Minnesota application question triggered disclosure of the South Dakota Consent Agreement.

4. **Starner's failure to disclose Aberdeen Fire Department performance memoranda does not constitute unprofessional conduct.**

Starner testified that he did not believe the performance communications provided to him during his employment with Aberdeen Fire Department triggered a requirement for him to disclose the information to the South Dakota Board of Examiners. He viewed the communications as a matter between an employer and employee which originated with, what he believed to be, a personality conflict.

When considering the testimony and evidence in its entirety, it is clear that Starner was not attempting to avoid scrutiny or otherwise obtain a license by failing to disclose information which he had a duty to provide. This is due in part, to the learning disability to which he testified, and also his belief that these matters did not rise to the level of a "complaint" necessitating disclosure. Given an analysis of each of the "incidents" communicated to him by the Aberdeen Fire Department, it is difficult to argue that they are of such a significant nature that the public or patients would be in danger should this information not be communicated to the board of examiners.

Conclusion

Regardless of how this hearing is resolved, however, Starner has already paid a heavy price for any mistakes. He has effectively been suspended for a significant period of time. He has had to face the possibility that, if the Panel's recommendation is accepted, his paramedic career will be over. Starner is a good and passionate paramedic.

We respectfully submit that ending his paramedic career by denying him a license under these circumstances would be inappropriate.

Dated this 3rd day of October, 2014.

WOODS, FULLER, SHULTZ & SMITH P.C.

By _____

David C. Kroon
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Post Office Box 5027
Sioux Falls, South Dakota 57117-5027
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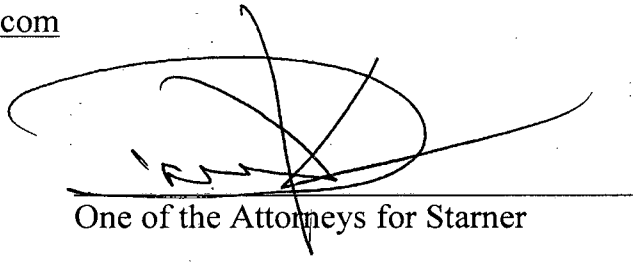
Attorneys for David Starner

Certificate of Service

I hereby certify that on the 3rd day of October, 2014, I served the foregoing Post-Hearing Brief of David Starner by emailing and depositing of a copy of it in the U.S. mail, first-class postage pre-paid and addressed to the following:

Mr. William Golden
Assistant Attorney General
South Dakota Attorney General's Office
317 N. Main
Sioux Falls, SD 57104
William.Golden@state.sd.us

Judge Paul Henry
Office of Hearing Examiners
210 E. 4th Ave.
c/o 500 E. Capitol Ave.
Pierre, SD 57501
paulhenry264@gmail.com



One of the Attorneys for Starner

1 SOUTH DAKOTA BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

2 *

3 IN THE MATTER OF: * TRANSCRIPT OF

4 THE LICENSE OF * HEARING

5 DAVID R. STARNER, EMT/P *

6 *

7 BEFORE: Mr. Paul E. Henry, Hearing Examiner
300 North Dakota Avenue, Suite 216
8 Sioux Falls, South Dakota 57104

9 APPEARANCES: Mr. William H. Golden
Assistant Attorney General
10 317 North Main Avenue
Sioux Falls, South Dakota 57104
11
Attorney for the South Dakota Board of
12 Medical and Osteopathic Examiners Staff.

13 Mr. David C. Kroon
Woods, Fuller, Shultz & Smith, P.C.
14 300 South Phillips Avenue, Suite 300
Sioux Falls, South Dakota 57104
15
Attorney for David Starner.
16
ALSO PRESENT: Mr. David Starner
17
Ms. Margaret B. Hansen, PA-C, MPAS
18 Executive Director
South Dakota Board of Medical and Osteopathic
19 Examiners

20 Ms. Misty Rallis
Board Investigator
21 South Dakota Board of Medical and Osteopathic
Examiners
22
PROCEEDINGS: The above-entitled matter came on for hearing
23 on the 26th day of September, 2014,
commencing at the hour of 9:30 a.m. at the
24 offices of the South Dakota Board of Medical
and Osteopathic Examiners, Sioux Falls, South
25 Dakota.

INDEX TO WITNESSES

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BOARD EXHIBITS

NUMBER	DESCRIPTION	MARKED	OFFERED	RULED ON
1	11/26/12 SDBMOE/Starner letter.	5	32	32
2	11/28/12 Starner/SDBMOE letter.	5	34	34
3	03/04/13 SDBMOE/Starner letter.	5	21	22
4	03/12/13 Starner/SDBMOE letter.	5	14	15
5	06/17/13 License Renewal.	5	18	18
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7	08/15/13 Aberdeen Fire Rescue letter notice of termination.	5	9	9
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11	10/21/13 SDBMOE/Starner letter.	5	20	21
12	10/13 SDBMOE/Starner emails.	5	20	20
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14	03/27/14 License Application.	5		
15	Timeline of events.	5	45	45
16	Minnesota Emergency Medical Services Regulatory Board - Stipulation and Consent Order for Voluntary Surrender of Certificate.	5		

1 INDEX TO EXHIBITS (Continued)

2 APPLICANT EXHIBITS

NUMBER	DESCRIPTION	MARKED	OFFERED	RULED ON
(Applicant Exhibits A-E, L-N were marked but not utilized.)				
F	Certificate of Completion EMT-P to Paramedic.	5	80	80
G	Continuing Education hours Heart Failure course.	5	79	79
H	Continuing Education hours STEMI Care.	5	79	79
I	Continuing Education hours Sudden Cardiac Death.	5	79	79
J	Certificate of Completion PHTLS.	5	74	74
K	03/27/14 Ringdahl letter of recommendation.	5	98	98
O	Starner compilation of documents.	5	81	81

19 Original transcript and exhibits provided to the South Dakota Board of Medical and Osteopathic Examiners.

1 (Board Exhibit Numbers 1 through 16, inclusive,
2 marked for identification.)
3 (Applicant Exhibits A through O, inclusive, marked
4 for identification.)
5 HEARING EXAMINER HENRY: Let's go on the record in
6 the matter of David Starner. Would the parties make
7 introductions first? Mr. Golden.
8 MR. GOLDEN: William Golden on behalf of the Medical
9 Board Staff.
10 MR. KROON: David Kroon on behalf of David Starner.
11 HEARING EXAMINER HENRY: And your client is present.
12 MR. KROON: Yes.
13 HEARING EXAMINER HENRY: Are both parties ready to
14 proceed at this juncture?
15 MR. KROON: We are.
16 MR. GOLDEN: The Board is prepared.
17 HEARING EXAMINER HENRY: Are there any infirmities
18 with service, Mr. Kroon, or do you contend that adequate
19 service was provided and you're willing to proceed at
20 this juncture?
21 MR. KROON: We are willing to proceed. Adequate
22 service has been made.
23 HEARING EXAMINER HENRY: Very well. Mr. Golden,
24 would you care to start us off?
25 MR. GOLDEN: Thank you. The first witness would be

1 Alan Ruhlman from Aberdeen and we will be calling him at
2 his desk in order to lay some foundation for some
3 exhibits.
4 HEARING EXAMINER HENRY: Very well.
5 (Whereupon, a call was placed on speaker phone.)
6 UNIDENTIFIED VOICE: Aberdeen (unintelligible).
7 MR. GOLDEN: Carla, this is Bill Golden from the
8 Attorney General's office. We are calling for Alan.
9 UNIDENTIFIED VOICE: Just a moment.
10 MR. RUHLMAN: Human Resources Department, Alan
11 speaking.
12 MR. GOLDEN: This is Bill Golden.
13 MR. RUHLMAN: Yes, Bill. How are you doing?
14 MR. GOLDEN: Good. How are you doing?
15 MR. RUHLMAN: Good.
16 MR. GOLDEN: We are here present in the Board's
17 conference room for the hearing concerning David Starner.
18 MR. RUHLMAN: Okay.
19 HEARING EXAMINER HENRY: And present is Paul Henry,
20 who is a Hearing Examiner; David Kroon, who is the
21 attorney for David Starner; Mr. Starner is present. We
22 have a court reporter present as well, Terri. The
23 Executive Board Secretary is present, Meg Hansen,
24 Margaret Hansen. And then the Board's Investigator,
25 Misty Rallis, is in the room.

1 MR. RUHLMAN: Okay.
2 MR. GOLDEN: Okay?
3 MR. RUHLMAN: Thank you.
4 MR. GOLDEN: I would ask that the witness be sworn in
5 at this time.
6 HEARING EXAMINER HENRY: I will. Can you give me
7 your last name again, please, sir?
8 MR. RUHLMAN: Yes. It's Alan, A-L-A-N, and then it's
9 Ruhlman, R-U-H-L-M-A-N.
10 HEARING EXAMINER HENRY: Sir, can you raise your
11 right hand, please?
12 ALAN RUHLMAN,
13 called as a witness at 9:34 a.m., having been first duly sworn
14 by the Hearing Examiner, testified as follows:
15 HEARING EXAMINER HENRY: Very well. Mr. Golden?
16 MR. GOLDEN: Thank you.
17 DIRECT EXAMINATION
18 BY MR. GOLDEN:
19 Q Would you please introduce yourself?
20 A Okay. I'm Alan Ruhlman and I'm the Human Resource
21 Director for the City of Aberdeen. I have been employed
22 since -- I have to look it up here -- been here since
23 1986.
24 Q And what does your job entail?
25 A You know, basically as HR Director for the City of

1 Aberdeen I'm responsible for policy implementation,
2 consistency through departments, records retention,
3 personnel records retention, the hiring and disciplining
4 of employees involved in that, compliance with federal
5 regulations and city ordinances.
6 Q Would one of the departments that you work with be the
7 Aberdeen Fire Department?
8 A That is correct.
9 Q And were you in that position and were you providing
10 those services to the Aberdeen Fire Department during the
11 time that David Starner was employed there?
12 A Yes, I was.
13 Q Are you familiar with this case?
14 A Yes, I am.
15 Q Are you familiar with the documents concerning his
16 employment?
17 A Yes, I am.
18 Q There was a request made from the Board of Medicine for
19 documents. Are you familiar with those documents?
20 A Yes, I am.
21 Q We have marked those documents as Exhibit Number 7.
22 A Okay.
23 Q And those documents entail an August 15, 2013, letter; an
24 Aberdeen Fire & Rescue Coaching & Counseling document; an
25 Aberdeen Fire Department violations, work rules and

1 regulations document that is dated March 28, 2013.
2 A Okay.
3 Q There is also a June 14, 2013 --
4 A Okay.
5 Q -- and a July 16, 2013.
6 A Okay.
7 Q Are those all documents that your office regularly keeps?
8 A Yes, it is.
9 Q Are those documents ones that are used in disciplining
10 employees or at least documenting in their files?
11 A Yes, they are used for disciplining, and yes, they are
12 kept in the personnel file in my office.
13 Q And they are also the documents that were sent to the
14 Medical Board concerning this matter?
15 A That is correct.
16 MR. GOLDEN: I would offer Exhibit Number 7 at this
17 time.
18 MR. KROON: No objection.
19 HEARING EXAMINER HENRY: Exhibit Number 7 will be
20 received.
21 BY MR. GOLDEN:
22 Q I believe there was a letter that was sent to Mr. Starner
23 at one point which terminated his employment with
24 Aberdeen Fire Department. Are you familiar with that?
25 A The August 15 letter?

1 Q Yes. That's the front letter on Exhibit Number 7.
2 A Yes, yes, I am familiar with it.
3 MR. GOLDEN: Thank you. Those are all the questions
4 that I have at this time.
5 HEARING EXAMINER HENRY: Counsel, go ahead.
6 CROSS-EXAMINATION
7 BY MR. KROON:
8 Q Mr. -- is it Ruhlman?
9 A Ruhlman, yes.
10 Q Mr. Ruhlman, Dave Kroon here. Sorry you can't see me.
11 Do you have any personal knowledge of any of the
12 circumstances giving rise to the documents that you have
13 just identified?
14 A No, I would not.
15 Q So whatever information is contained in Exhibit 7 is
16 based on other people's information, not yours; correct?
17 A That is correct.
18 MR. KROON: Okay. No other questions.
19 HEARING EXAMINER HENRY: Mr. Golden, anything to
20 follow-up from that?
21 MR. GOLDEN: No, I don't.
22 HEARING EXAMINER HENRY: Very well. Is there any
23 other need to keep Mr. Ruhlman on for any more testimony?
24 MR. GOLDEN: Nothing from the Board, no.
25 MR. KROON: Nothing from here.

1 HEARING EXAMINER HENRY: Very well. Thank you,
2 Mr. Ruhlman, for appearing telephonically and we are
3 going to cut you off now.
4 THE WITNESS: Okay. Thank you very much.
5 (Whereupon, the witness was excused at 9:40 a.m. and
6 the conference call was concluded.)
7 MR. GOLDEN: Next I would call Ted Huss. Hopefully
8 we will be able to get him by phone as well.
9 HEARING EXAMINER HENRY: Yes, because I didn't see
10 him here.
11 MR. GOLDEN: I think he is in Ipswich.
12 (Whereupon, a call was placed on speaker phone.)
13 UNIDENTIFIED VOICE: Golden Living Center.
14 MR. GOLDEN: This is Bill Golden from the Attorney
15 General's Office calling for Mr. Huss.
16 UNIDENTIFIED VOICE: Okay. Just a moment.
17 MR. HUSS: Ted Huss.
18 MR. GOLDEN: Ted, this is Bill Golden. How are you
19 doing this morning?
20 MR. HUSS: Good. How are you?
21 MR. GOLDEN: Good. We have Paul Henry is the Hearing
22 Examiner here in the Board's office today. We have Terri
23 court reporting for us. Margaret Hansen is in the room,
24 Misty Rallis is present, as well as David Kroon who is
25 representing David Starner, and Mr. Starner is present as

1 well.
2 MR. HUSS: Okay.
3 MR. GOLDEN: And we will have you sworn in at this
4 time, okay?
5 MR. HUSS: Yes.
6 HEARING EXAMINER HENRY: Mr. Huss, will you raise
7 your right hand, please?
8 TED HUSS,
9 called as a witness at 10:42 a.m., having been first duly
10 sworn by the Hearing Examiner, testified as follows:
11 DIRECT EXAMINATION
12 BY MR. GOLDEN:
13 Q Mr. Huss, would you please introduce yourself?
14 A My name is Ted Huss, a former Board Investigator for the
15 South Dakota Board of Medical and Osteopathic Examiners.
16 Q What's your educational experience?
17 A I have a Bachelor's degree in sociology and a Master's
18 degree in business.
19 Q And what is your employment history?
20 A I have been certified law enforcement for ten years, and
21 investigator for the Board Of medicine for -- I was there
22 about four and a half years.
23 Q And where are you currently employed?
24 A Currently employed at Golden Living Center in Groton as a
25 Nursing Home Administrator.

1 Q Thank you. Do you remember David Starner?
2 A Yes.
3 Q How did he initially come to your attention?
4 A I received an e-mail, a complaint was forwarded to me
5 from the EMS office in Pierre.
6 Q And based on that complaint, what did you do?
7 A I reviewed the complaint and also Mr. Starner's
8 Application. And then based on that, I informed
9 Mr. Starner that he would be under investigation.
10 Q And what specific issue was he under investigation for?
11 A At that time it was failure to disclose that he was a
12 Respondent to a Protection Order involving being accused
13 of sexually harassing a woman.
14 Q Did you go ahead and get any documents concerning that
15 matter?
16 A Yes, I did. I obtained copies of police reports, court
17 documents, or excuse me, the Protection Order document
18 involving that case.
19 Q And did you ask for a response from Mr. Starner?
20 A Yes. I asked Mr. Starner to provide an explanation,
21 which he did.
22 Q Okay. And did his explanation involve the questions on
23 the Application?
24 A Would you repeat that question?
25 Q Did his response involve the questions on the Application

1 that were at issue?
2 A His response involved -- I guess in his response he
3 addressed one specific question on the Application.
4 Q And which question was that?
5 A Number 13. I can read it. "Been accused of or been
6 disciplined. . ."
7 Q Could I stop you for a second?
8 A Yes.
9 Q Are you looking at one of the exhibits?
10 A I am. Sorry.
11 Q Which exhibit would that be?
12 A I was reading Exhibit 4.
13 Q Okay. And Exhibit 4, would you please describe what
14 Exhibit 4 is?
15 A Exhibit 4 is Mr. Starner's response to me.
16 Q Okay.
17 A Dated March 12, 2013.
18 MR. GOLDEN: I would offer Exhibit Number 4 at this
19 time.
20 MR. KROON: Judge, I'm going to object to the line of
21 questioning concerning this whole matter. This has been
22 previously adjudicated. We will stipulate to the fact
23 that he received a reprimand from the Board concerning
24 this. Our position would be that would have really no
25 relevance to the issues concerning his termination from

1 Aberdeen Fire. This matter is finished. A letter of
2 reprimand was issued, a consent. I think any further
3 questioning along these lines really prejudices him with
4 respect to the real issues, and that is his termination
5 from Aberdeen Fire.
6 HEARING EXAMINER HENRY: Mr. Golden?
7 MR. GOLDEN: Your Honor, these were just preparatory
8 questions to discuss with Mr. Huss the fact that he
9 actually spoke with Mr. Starner and went through the
10 Application and explained the questions to him. One of
11 the issues here today is whether or not there were
12 truthful answers on later Applications that is before the
13 Hearing Examiner at this time.
14 HEARING EXAMINER HENRY: Then the line of questioning
15 will be permitted as foundational. If we get into an
16 area where we are starting to get res judicata, then we
17 need to reexamine that. But for foundational purposes,
18 the testimony can come in. Overruled.
19 MR. GOLDEN: And I offered Exhibit Number 4.
20 HEARING EXAMINER HENRY: Exhibit Number 4 is received
21 without further objection; is that the case? Very well.
22 Exhibit 4 is received.
23 BY MR. GOLDEN:
24 Q Mr. Huss, did you have a conversation with Mr. Starner at
25 some point concerning your investigation?

1 A Yes.
2 Q During that did you have a conversation about the
3 questions on the Application?
4 A Yes.
5 Q What did you discuss with Mr. Starner?
6 A I went through a few of the questions via a phone call
7 and was trying to point out or explain how the current
8 situation should have prompted a disclosure.
9 Q When you say that, when you were going through the
10 questions, were you looking at the Application and
11 reading them to him, were you just generally discussing
12 them, how did that happen?
13 A I recall talking to him on the phone and reading specific
14 questions, trying to educate him on I guess how to read
15 them or point out that they should have prompted a
16 disclosure.
17 Q And would that have been on his 2012 Application or was
18 that on the 2013?
19 A At that time it would have been reviewing the 2012
20 Application. The later renewal, later Application would
21 have been a Renewal Application.
22 Q But the initial Application would have been the 2012?
23 A Yes.
24 Q So out of that there was a Consent Agreement that was
25 reached between the parties?

1 A Correct.
2 MR. GOLDEN: And I would ask the Hearing Examiner at
3 this time to take that as judicial notice. I believe I
4 marked it as an exhibit.
5 HEARING EXAMINER HENRY: Any objection to that,
6 Counsel?
7 MR. KROON: No objection.
8 MR. GOLDEN: It would be Document Number 13.
9 HEARING EXAMINER HENRY: Very well. I will take
10 judicial notice of Item 13 then. Is it also to be
11 admitted under the same criteria?
12 MR. GOLDEN: That's the request.
13 HEARING EXAMINER HENRY: Any objections to me
14 receiving 13 in order to take judicial notice of that? I
15 suppose I would have access to it.
16 MR. KROON: No, no objection.
17 HEARING EXAMINER HENRY: Exhibit 13 is received.
18 BY MR. GOLDEN:
19 Q Mr. Huss, so that matter, that Exhibit Number 13 which is
20 the Consent Agreement ended that investigation?
21 A Correct.
22 Q Now, there was a Renewal Application that was filed
23 during this period of time that the ongoing investigation
24 was going on?
25 A Yes. I don't have the dates of the renewal Application.

1 It would have been 2013.
2 Q And 2013, during that time did Mr. Starner come back to
3 your attention?
4 A He did.
5 Q How did that happen?
6 A I received notice from the Aberdeen Fire Department that
7 he was terminated.
8 Q Okay. Was a letter sent to you?
9 A That is correct.
10 Q Okay. Did you -- go ahead, what did you do next?
11 A I obtained copies of Mr. Starner's personnel file that
12 were related to this termination.
13 Q Did you review Mr. Starner's Renewal Application?
14 A Yes.
15 MR. GOLDEN: That's marked as Exhibit Number 5 and I
16 would offer Mr. Starner's Application at this time.
17 MR. KROON: No objection.
18 HEARING EXAMINER HENRY: Exhibit 5 is received.
19 BY MR. GOLDEN:
20 Q When you were reviewing that document and the questions,
21 did anything come to your attention?
22 A I found that Mr. Starner failed to disclose the
23 happenings that I learned of from the Aberdeen Fire
24 Department.
25 Q Okay. And are you talking about the termination or are

1 you talking about the discipline at Aberdeen?
2 A I'm talking about the multiple occasions of discipline.
3 Q And does the Application ask questions concerning
4 investigations or discipline in the Application?
5 A Yes, it does.
6 Q And were there any disclosures concerning Aberdeen in the
7 2013 Application?
8 A There was none.
9 Q Okay. Now, in reviewing that Application did Mr. Starner
10 go ahead and disclose all of the information from the
11 previous investigation?
12 A Yes, he did.
13 Q Based on the review of the Application and the
14 termination notice, what did you do next?
15 A I presented the case to a Board member with
16 recommendation for revocation.
17 Q At some point in time did you communicate that to
18 Mr. Starner?
19 A Yes.
20 Q And what was Mr. Starner's response at that time?
21 A From my recall, I believe it was his request to just
22 withdraw his license as opposed to receiving a
23 revocation.
24 Q And was that received by e-mail?
25 A Discussing withdrawing his license?

1 Q Yes.
2 A Yes, I believe that was e-mailed.
3 Q Exhibit Number 12 is the -- I believe it's in Exhibit
4 Number 12 and that was a letter or a document addressed
5 to you from Mr. Starner asking you to -- saying that he
6 didn't want a South Dakota license any longer. Is that
7 what you were testifying to?
8 A I do not have Exhibit 12 in front of me, but that is my
9 recall.
10 MR. GOLDEN: I would offer Exhibit 12 at this time.
11 MR. KROON: No objection.
12 HEARING EXAMINER HENRY: Exhibit 12 is received.
13 BY MR. GOLDEN:
14 Q And that once again went ahead and was a completion of
15 your investigation in this matter?
16 A Yes.
17 Q And I believe we have marked an Exhibit Number 11 which
18 is an October 21 letter that you had sent out initially
19 telling Mr. Starner he was under investigation. Are you
20 familiar with that document?
21 A I believe that would be notice of investigation for the
22 second -- for that Renewal Application.
23 MR. GOLDEN: Okay. We have marked that as Exhibit 11
24 and I would offer it at this time.
25 MR. KROON: Bear with me. I'm trying to find that

one. No objection.

HEARING EXAMINER HENRY: Exhibit 11 is received.

BY MR. GOLDEN:

Q Mr. Huss, you said that you had received a response from Mr. Starner outlining what had occurred during your investigation. I believe it's been marked as Exhibit Number 10.

A I believe Exhibit 10 is his response to the discipline at the Aberdeen Fire Department.

Q Okay. And that was supplied by Mr. Starner to you?

A Correct.

MR. GOLDEN: I would offer Exhibit Number 10 at this time.

MR. KROON: No objection.

HEARING EXAMINER HENRY: Exhibit 10 is received.

BY MR. GOLDEN:

Q There is a March 4, 2013, letter that's been marked as Exhibit Number 13. I'm sorry, Number 3.

A Yes.

Q What would that be?

A March 4, 2013, Exhibit 3, are two letters, one informing Mr. Starner he is under investigation along with his rights. The second page of that exhibit is my request for a detailed and complete explanation.

MR. GOLDEN: I would offer Exhibit Number 3 at this

1 time.
2 MR. KROON: No objection.
3 HEARING EXAMINER HENRY: Exhibit 3 is received.
4 MR. GOLDEN: I believe we discussed Exhibit Number 4
5 and it was admitted.
6 HEARING EXAMINER HENRY: For clarity, Exhibit 4 has
7 been received.
8 MR. GOLDEN: Exhibit Number 5 is the June 17, 2013,
9 Application of Mr. Starner. If it hasn't been received,
10 I would move to offer it at this time.
11 MR. KROON: No objection.
12 HEARING EXAMINER HENRY: No objection or some
13 objection?
14 MR. KROON: No objection.
15 HEARING EXAMINER HENRY: I think Exhibit 5 has been
16 received and it will be received now in case we made some
17 mistake there.
18 BY MR. GOLDEN:
19 Q Exhibit Number 8 is an e-mail from Mr. Huss and a letter.
20 Are you familiar with that, Mr. Huss? It's dated
21 September 3, 2013.
22 A Not off of the exhibits that were received via e-mail.
23 If you would describe it to me.
24 Q It's a September 3, 2013, letter to Mr. Starner in
25 Aberdeen and it starts with, "The South Dakota Board of

1 Medical and Osteopathic Examiners received information
2 that you were involuntarily terminated from the Aberdeen
3 Fire Department for failure to successfully complete your
4 probationary period." And it then goes on to say that,
5 "Your response and all data collected during your inquiry
6 are deemed confidential." Is that the initial
7 investigation letter that you sent?
8 A That is correct.
9 MR. GOLDEN: I would offer Exhibit Number 8 at this
10 time.
11 MR. KROON: No objection.
12 HEARING EXAMINER HENRY: Exhibit 8 is received.
13 MR. GOLDEN: I believe those are all of the exhibits
14 that I wanted to get in through this witness and all the
15 testimony so I would rest at this time.
16 HEARING EXAMINER HENRY: Very well. Counsel, cross?
17 CROSS-EXAMINATION
18 BY MR. KROON:
19 Q Mr. Huss, Dave Kroon here. I just have a few questions.
20 A Sure.
21 Q I think you testified that you had or the Board had
22 received a copy of the termination letter from Aberdeen
23 Fire to Mr. Starner. Is that correct?
24 A That is correct.
25 Q In your experience -- how long were you serving as an

1 Investigator for the Board?
2 A Approximately four and a half years.
3 Q In your experience, was that unusual to receive a copy of
4 a termination letter at the same time it was given to the
5 employee?
6 A I would -- no. We routinely get notification of EMS
7 staff that no longer work with ambulances. They notify
8 the Board immediately as a standard practice.
9 Q In your experience, that's not a uniform practice?
10 A I believe that is uniform practice.
11 Q So that happens every time?
12 A That ambulance services across the state notify the
13 Board, from my experience, when someone no longer works
14 there, even in non-derogatory situations.
15 Q I believe you testified that you sat down with
16 Mr. Starner concerning his failure to disclose the
17 Protection Order; is that correct?
18 A I had a conversation with Mr. Starner, yes.
19 Q So in your opinion, if you have one, do you believe that
20 his omission was intentional?
21 A You're asking just my personal opinion?
22 Q Yes.
23 A I would say my opinion is yes, it's intentional, based on
24 there is 30 questions that are very clear and there are
25 multiple questions that disclosure would fall into.

1 Q So when Mr. Starner was visiting with you, did he appear
2 confused about how to answer the questions that you were
3 discussing with him?
4 A Would you repeat that question?
5 Q When you visited with Mr. Starner about the Application,
6 did he appear confused about the questions and how to
7 answer them?
8 A I guess I can't really -- I'm not sure how to answer
9 that. I don't recall if he appeared confused. I mean I
10 guess I would agree that even in this letter he stated,
11 you know, that he was -- that he didn't -- he stated he
12 didn't believe, you know, that he was required to
13 disclose it.
14 Q Okay. I just want to make sure I'm clear on one aspect
15 of your testimony, Mr. Huss. Did you indicate that part
16 of your meeting with Mr. Starner about the Application
17 was to educate him about how to answer those questions?
18 A I was trying to -- like I just said, he didn't believe
19 that there was any question that should have disclosed
20 those previous facts. So I was reviewing with him to
21 point out the specific questions that it would fall into.
22 Q One last question, Mr. Huss. I think on what's been
23 previously marked as Exhibit 5, that's the license
24 Application or renewal, I believe you testified that at
25 least from the Board's perspective, he should have

1 disclosed some of the -- I think your term was
2 disciplinary action issued by Aberdeen Fire. Is that a
3 fair statement?
4 A Yes, he should have disclosed that.
5 Q And just so I'm clear of your interpretation of that, are
6 you saying that that is Question 4, "Have you been
7 subject to any complaint, investigation, or proceeding
8 involving any entity?"
9 A I believe there is multiple questions, Number 4 being one
10 of them, yes.
11 Q I'm just looking at Exhibit 5. So which questions on
12 Exhibit 5 should he have answered affirmatively, in your
13 opinion?
14 A Number 1.
15 Q So Number 1, just so I understand, is the question, "Is
16 this a true statement for your licensure? My licensure
17 has not experienced adverse action." That's the question
18 you believe he should have answered "yes"?
19 A I apologize, I was looking at the other exhibit.
20 Q Okay.
21 A The questions for Exhibit 5 I do not have in front of me.
22 Q Okay. Just -- go ahead, Bill.
23 MR. GOLDEN: I can e-mail them to him if you want me
24 to, if that would help.
25 MR. KROON: Yes. Let me just ask one question here.

1 Q So what's been submitted as Exhibit 5 then, is it your
2 testimony there is nothing in Exhibit 5 that he should
3 have answered affirmatively?
4 A No, that is not my testimony.
5 Q Okay. Which questions on Exhibit 5, in your opinion,
6 should he have answered affirmatively?
7 A Is it possible to have Mr. Golden have that e-mailed to
8 me?
9 MR. KROON: Absolutely. I shouldn't say that. I
10 shouldn't speak for Bill.
11 MR. GOLDEN: I can.
12 HEARING EXAMINER HENRY: Should we take a brief break
13 and get this e-mailed to him?
14 MR. GOLDEN: Yes, please.
15 HEARING EXAMINER HENRY: Very well. Let's take a
16 recess.
17 (Whereupon, a recess was taken from 10:06 a.m. to
18 10:15 a.m.)
19 HEARING EXAMINER HENRY: Let's go back on the record.
20 We are taking the testimony of Investigator Ted Huss.
21 Mr. Golden, you were doing -- no, I take that back.
22 Mr. Kroon, you were on cross-examination. Go ahead,
23 please.
24 MR. KROON: We were asking about Exhibit 5 and I
25 think Mr. Huss was going to receive a full version of the

1 Application.
2 THE WITNESS: Yes, I have received Exhibit 5.
3 MR. KROON: Bill, do we have a copy I can look at
4 here that was sent to him?
5 MR. GOLDEN: If you want, I can pull the questions
6 up.
7 MR. KROON: Can I borrow that?
8 BY MR. KROON:
9 Q Mr. Huss, I guess we started this out by I was asking you
10 which of the questions in Exhibit 5 would have required
11 Mr. Starner to answer "yes" based on --
12 A My mistake.
13 Q Let me just finish my question. -- based on the
14 disciplinary actions by Aberdeen Fire.
15 A Okay, thank you.
16 Q Yes.
17 A As previously I believe you mentioned Question Number 4,
18 "Have you been subject to any complaint, investigation or
19 proceeding involving any entity?"
20 Q Okay.
21 A And I'm just going through them here.
22 Q That's fine.
23 A Number 11. "Is this a true statement for you? I have
24 experienced no adverse action in privileges at any
25 hospital, clinic or health related entity." This would

1 be the inverse. This should have been a "no" answer.
2 And I believe that would be the questions.
3 Q Thank you.
4 MR. KROON: Can I have one moment?
5 HEARING EXAMINER HENRY: Certainly.
6 MR. KROON: Thanks, Mr. Huss. I don't have any
7 further questions.
8 THE WITNESS: Thank you.
9 HEARING EXAMINER HENRY: Mr. Golden, do you have any
10 redirect?
11 MR. GOLDEN: Briefly.
12 REDIRECT EXAMINATION
13 BY MR. GOLDEN:
14 Q Mr. Huss, would you look at Question Number 2 for me?
15 A Of Exhibit 5?
16 Q Yes.
17 A Yes, I will. Yes, Mr. Golden.
18 Q Okay. Adverse action I believe at the end of this is
19 defined by the Application?
20 A Yes. Reviewing Number 2, I would add that to my list of
21 questions that should have prompted disclosure.
22 Q And the definition section is attached to the
23 Application?
24 A Yes, it is.
25 MR. GOLDEN: Okay. I have no further questions.

1 MR. KROON: Nothing further.
2 HEARING EXAMINER HENRY: Very well. With no further
3 questions of Mr. Huss, he will be dismissed. Thank you
4 for appearing, Ted, and we look forward to seeing you
5 again.
6 THE WITNESS: All right. Thank you all.
7 MR. GOLDEN: Thank you.
8 (Whereupon, the witness was excused at 10:21 a.m. and
9 the conference call was concluded.)
10 MR. GOLDEN: I would next call Misty Rallis.
11 MISTY RALLIS,
12 called as a witness at 10:21 a.m., having been first duly
13 sworn, testified as follows:
14 DIRECT EXAMINATION
15 BY MR. GOLDEN:
16 Q Ms. Rallis, would you please introduce yourself?
17 A I am Misty Rallis, the Board Investigator for the South
18 Dakota Board of Medical and Osteopathic Examiners.
19 Q And how long have you been in that position?
20 A Six months.
21 Q What is your education?
22 A I attended the University of South Dakota and am a
23 Registered Nurse.
24 Q And what is your employment history?
25 A Here for the last six months. Prior to that I worked for

1 Technical Investigative Services out of Sioux Falls as an
2 administrative assistant. I did cause and origin fire
3 investigations.
4 Q Thank you. Are you familiar with the David Starner file?
5 A Yes.
6 Q How did it initially come to your attention?
7 A He applied for a South Dakota ALS license March 27 of
8 2014. At that time the case was assigned to me because
9 he was previously investigated for his termination with
10 the Aberdeen Fire Department and had voluntarily
11 surrendered his license.
12 Q And how did you go about initially conducting your
13 investigation?
14 A Mr. Starner had actually requested an interview with the
15 South Dakota Board of Medicine so we conducted an
16 interview on April 15 of 2014.
17 Q Did you review a file in this matter prior to the
18 interview?
19 A Yes.
20 Q Did you review at some point in time his original
21 Application?
22 A Yes.
23 Q In that original Application it's been marked Exhibit
24 Number 1, it's a November 25, 2012 --
25 A I don't have a copy of that Application.

1 Q Oh, not the Application. Exhibit Number 1.
2 A Oh, the letter?
3 Q Yes.
4 A Okay, yes, I do have that.
5 Q Are you familiar with that?
6 A Yes.
7 Q Who is Randi Sterling?
8 A She is the Licensing Specialist with the South Dakota
9 Board of Medical and Osteopathic Examiners.
10 Q Are you familiar with the format of that letter?
11 A Yes.
12 Q Is that a normal letter that is sent out by a Licensing
13 Specialist from the Medical Board?
14 A Yes.
15 MR. GOLDEN: I would offer Exhibit Number 1 at this
16 time as a business record.
17 MR. KROON: No objection.
18 HEARING EXAMINER HENRY: Exhibit 1 is received.
19 BY MR. GOLDEN:
20 Q And what is the date again on Exhibit Number 1?
21 A November 26, 2012.
22 Q And what information in that exhibit is Ms. Sterling
23 requesting?
24 A She is requesting Mr. Starner to provide a detailed
25 statement on the following discrepancies that showed up

1 on -- not reported on his Application, but that were
2 given to us through an employment verification. So she
3 was asking him to explain why he didn't tell us about the
4 verbal reprimand for not following a narcotic control
5 policy, regarding a very difficult time accepting policy
6 and protocols that he disagreed with, and not getting
7 along with other staff members, and a personal
8 relationship with a co-worker.
9 Q What is an employment verification?
10 A It is a verification that the Licensing Specialists send
11 to previous employers disclosed on the Application just
12 to review their employment history.
13 Q And so the information there, where would it have come
14 from?
15 A The information from the license verification?
16 Q Yes.
17 A It was from his former EMS employer in Lisbon, North
18 Dakota.
19 Q And the exhibit is asking for this information because it
20 wasn't provided initially in the Application by
21 Mr. Starner?
22 A Correct.
23 Q Was there any action that was taken based on this
24 information?
25 A He was just asked to respond. His response was received

1 and then his Application -- his license I believe was
2 issued following his response.
3 Q If you would look at Exhibit Number 2. Do you recognize
4 what that is?
5 A If we're talking the same one, I have his response to
6 Ms. Sterling.
7 Q And that was his explanation for the employment
8 verification?
9 A Yes.
10 MR. GOLDEN: I would offer Exhibit Number 2 at this
11 time.
12 MR. KROON: No objection.
13 HEARING EXAMINER HENRY: Exhibit 2 is received.
14 BY MR. GOLDEN:
15 Q Did you have an opportunity to review Exhibit Number 7?
16 A Yes.
17 Q The issues when you reviewed Exhibit Number 7 and after
18 looking at what's been marked as Exhibit 1 and 2, do you
19 have any opinion on whether or not they are similar?
20 A Yes.
21 Q How?
22 A The employment verification stated that he was verbally
23 reprimanded for not following a narcotic control policy
24 and difficulty with accepting policy and protocols he
25 disagreed with. And then in Exhibit 7 the violations for

1 work rules and regulations were based off of failing to
2 follow protocol and issues following orders and showing
3 attitude toward his commanding officers with treatment of
4 patients and following the Aberdeen Fire & Rescue
5 protocol and procedures.
6 Q Let's back up for a second. Where did you receive your
7 training as a nurse?
8 A University of South Dakota.
9 Q What did that entail?
10 A It was a two-year program just with the nursing courses
11 alone. Clinical rotations, a preceptorship, two years of
12 clinical rotations.
13 Q And did you successfully complete that program?
14 A Yes.
15 Q Are you currently licensed?
16 A Yes, I am.
17 Q As a licensed nurse, is one of the areas that you are
18 trained concerning protocols?
19 A Yes.
20 Q What is a protocol?
21 A It's basically a standardization of care that you follow
22 or implement based off of how your patient is presenting
23 to you at the time.
24 Q Would it be -- is a protocol the same thing as diagnosing
25 a patient?

1 A No.
2 Q How is it different?
3 A With the protocol you're not actually diagnosing what's
4 wrong with the patient. You are just specifically
5 implementing certain things such as maybe applying oxygen
6 if there is symptoms that would present that they would
7 need oxygen. We call it a standing order is what we
8 refer to it as a nurse.
9 Q As a nurse are you allowed to diagnose a patient?
10 A No.
11 Q Are you allowed to prescribe a course of treatment?
12 A No.
13 Q So do the protocols or standing orders set forth what a
14 physician has instructed will be done under certain
15 circumstances?
16 A Yes.
17 Q Okay. So when we're talking about protocols, is that
18 what allows a nurse to perform certain procedures?
19 A Correct.
20 Q Are the protocols optional, can you vary from them?
21 A Not usually, no.
22 Q When you say, "Not usually," what do you mean?
23 A Well, they are there for a reason. They are based off of
24 evidence-based practice as the best way to treat certain
25 signs and symptoms.

1 Q Do you have the -- we have already said that a nurse
2 isn't able to diagnose someone. Are you able to
3 prescribe a course of treatment?
4 A I wouldn't use the word prescribe. We are able to act on
5 those standing orders if the patient's condition
6 warrants.
7 Q Okay. But those are determined by a physician and that
8 authority is, in essence, set forth in the standing order
9 or the protocols which allows you to do that?
10 A Yes.
11 MR. KROON: I'm going to object to the continuing
12 line of questioning asking Ms. Rallis to opine as to
13 protocols for Registered Nurses. We are not dealing with
14 a Registered Nurse here and so I just don't see the
15 relevance to the line of questioning concerning her views
16 on protocols.
17 HEARING EXAMINER HENRY: I see that and I imagine
18 that Mr. Golden is going to tell me that it's
19 foundational. But Mr. Golden, what's the reason we are
20 doing this?
21 MR. GOLDEN: Your Honor, first I was establishing
22 that she has training and experience to go ahead and
23 explain as, in essence, more than a lay witness
24 particularly, possibly an expert witness as far as what
25 protocols are in the medical world that we are going to

1 then move into protocols for EMTs. My next questions
2 would be is there any difference between the protocols
3 for an EMT and a Registered Nurse and where they come
4 from.
5 HEARING EXAMINER HENRY: Under those circumstances
6 I'm going to overrule the objection. It may be subject
7 to a further objection as you go down this road, but for
8 now again I'll overrule that objection. Go ahead,
9 Mr. Golden.
10 BY MR. GOLDEN:
11 Q Are protocols put in place by physicians?
12 A Yes, they are approved by physicians.
13 Q Protocols for Advanced Life Support, who comes up with
14 these protocols?
15 A Typically the Medical Director.
16 Q Who is the Medical Director?
17 A A physician.
18 Q So would these be the same type of protocols that nurses
19 operate under?
20 A I would say similar, yes.
21 Q Okay. Does a nurse have a broader scope of practice?
22 A Yes.
23 Q So an Advanced Life Support actually has a narrower scope
24 of practice than a Registered Nurse?
25 A I would say so, yes.

1 Q But the instructions, the protocols, the standing orders
2 still come from a physician?
3 A Yes.
4 Q And in essence, the rules are the same between Advanced
5 Life Support and nurses as far as obeying protocols?
6 A I would agree, yes.
7 Q Did you review Mr. Starner's response to Mr. Huss in
8 Exhibit Number 10?
9 A Yes.
10 Q In Mr. Starner's response, was a portion of that
11 concerning protocols?
12 A Yes.
13 Q When you interviewed Mr. Starner, did you discuss the
14 issues of protocols with Mr. Starner, did that issue
15 come up?
16 A We discussed this on the first and second page of his
17 response, this one in particular, the chest pain
18 protocol.
19 Q Okay. And what was the issue concerning the chest pain
20 protocol?
21 A Aberdeen Fire & Rescue had given him a written warning
22 for failing to follow the medical protocol and Aberdeen
23 Fire & Rescue's standard of care in not implementing a
24 chest pain protocol.
25 Q And did Mr. Starner explain to you the situation?

1 A Yes.
2 Q What did he tell you?
3 A Basically a call had come in to dispatch from I believe
4 the wife of a patient and she said he was complaining of
5 chest pain and was worried that he might be having a
6 heart attack. Mr. Starner and a colleague went out to
7 the call. They said upon arrival the patient was not
8 complaining of chest pain, was more saying it was kind of
9 an indigestion type issue, didn't really want to go to
10 the hospital. So they spent a lot of time convincing him
11 that he needed to go and get checked out and eventually
12 did transport him to the facility. But the chest pain
13 protocol was never implemented.
14 He said -- Mr. Starner said they did not implement
15 the protocol because when they arrived, he was not
16 complaining specifically of chest pain. However, during
17 the course of his visit with the patient he did tell the
18 patient that his abdominal pain, upset stomach,
19 indigestion could be the precursor of an MI or masking a
20 heart attack. So he told him that information, but still
21 did not implement the chest pain protocol.
22 Q As you were sitting there listening to Mr. Starner, did
23 you have an observation about his understanding of what
24 he was telling you?
25 A I don't know if he realized that by telling the patient

1 that this abdominal upset or indigestion, whatever he was
2 having, being a precursor to a heart attack or a sign
3 that he could be having a heart attack, I don't think he
4 realized that he should have still implemented the chest
5 pain protocol based off of even those symptoms because
6 epigastric pain can be a sign of a heart attack as well,
7 which he told the patient.
8 Q And once again, what are you doing with these protocols,
9 why are they in place?
10 A They are in place to standardize the care and to provide
11 the safest care for that patient to reduce their, you
12 know, risk of damage.
13 Q Physicians are allowed to diagnose?
14 A Yes.
15 Q And treat?
16 A Yes.
17 Q Physician Assistants, they can do the same?
18 A Yes.
19 Q Certified Nurse Practitioners?
20 A Yes.
21 Q Can Advanced Life Support diagnose under their scope of
22 practice?
23 A No.
24 Q Can they go ahead and treat without protocols?
25 A They need to follow the protocols to treat the patient.

1 Q So they are not to exercise their individual judgment on
2 whether or not somebody is suffering a heart attack or
3 diagnose a condition, they are supposed to treat the
4 symptoms under the protocols?
5 A Yes.
6 Q So when Mr. Starner was talking to you about explaining
7 to the patient that they were in distress and that this
8 might be a heart attack, you're saying at that point in
9 time he should have implemented the protocols?
10 A In my opinion, yes, because he was telling him that his
11 indigestion could be masking a heart attack. So at that
12 time the safest thing for the patient would have been to
13 implement that chest pain protocol to try to prevent any
14 damage that could have been going on. That's why the
15 protocol is in place.
16 Q And that conversation, that interview that you had with
17 him, that was concerning what Aberdeen had disciplined
18 him for?
19 A Correct.
20 MR. GOLDEN: Could we take a short break, please?
21 HEARING EXAMINER HENRY: Yes.
22 (Whereupon, a recess was taken from 10:40 a.m. to
23 10:51 a.m.)
24 HEARING EXAMINER HENRY: We are back on the record
25 and Mr. Golden is proceeding with his direct examination.

1 Go ahead, Mr. Golden, and continue.
2 BY MR. GOLDEN:
3 Q During your interview was there a conversation concerning
4 how the reprimand occurred?
5 A Yes.
6 Q Was there also a conversation about the surrendering of
7 Mr. Starner's previous ALS license?
8 A Yes.
9 Q Approximately how long did that conversation go on?
10 A Probably about 30 to 45 minutes.
11 Q From your observations, did Mr. Starner seem to
12 understand how that occurred?
13 A Not necessarily. We kind of walked him through the
14 course of events and what led to the reprimand, what led
15 to the voluntary surrender of his license, and the
16 reporting to the National Practitioner Data Bank, and
17 just kind of a timeline of how everything developed.
18 Q Did Mr. Starner seem to understand that?
19 A I'm not sure if he did or he didn't. We tried to explain
20 it the best way possible.
21 Q Did he seem confused at points?
22 A Yeah, I would say so, just with, you know, keeping each
23 investigation separate and what happened when was maybe a
24 little confusing.
25 Q Okay. When you say confusing, was it confusing because

1 of the subject matter or are you saying that Mr. Starner
2 was confused?
3 A I think he maybe was confused or just didn't understand
4 everything with the reprimand and with the voluntary
5 surrender and the reporting aspects of his voluntary
6 surrender to the National Practitioner Data Bank.
7 Q After all the explanations do you think he understood at
8 that point?
9 A I don't believe so.
10 Q I'm directing your attention to Exhibit Number 15. Do
11 you recognize what that is?
12 A The Minnesota --
13 Q No, that would be your timeline.
14 A Oh. I don't believe I have a copy. Thank you.
15 Q Do you see Exhibit Number 15?
16 A Yes.
17 Q Do you recognize what that is?
18 A Yes.
19 Q Who prepared that?
20 A I did.
21 Q In general terms, what is it?
22 A It's basically just a timeline of from when Mr. Starner
23 initially applied through our meeting with him and what
24 happened on what dates.
25 Q Okay. When did you note was the original Application in

1 this matter, what date?
2 A October 18, 2012.
3 Q And was there a notation made on November 7, 2012?
4 A Yes. That's when the employment verification was
5 received from First Medic Ambulance in Lisbon, North
6 Dakota, stating Mr. Starner was verbally reprimanded for
7 not following narcotic control policy.
8 It also stated he had a hard time accepting policies
9 and protocols, that he didn't get along well with other
10 staff, and had a personal relationship with a co-worker
11 that caused issues.
12 Q The rest of the timeline is, in essence, the exhibits and
13 the different events that have taken place during the
14 investigations?
15 A Yes.
16 MR. GOLDEN: I can continue to lay foundation and go
17 through the entire document or I can offer it at this
18 time.
19 MR. KROON: I would be happy to stipulate to the
20 timeline.
21 MR. GOLDEN: Okay. I would offer Exhibit Number 15
22 and then we will just let the document speak for itself.
23 HEARING EXAMINER HENRY: Under those circumstances
24 then Exhibit 15 is received.
25

1 BY MR. GOLDEN:
2 Q On yesterday afternoon did you receive a document from
3 Minnesota?
4 A Yes.
5 Q That's been marked I believe as Exhibit Number 16.
6 A I have that one.
7 HEARING EXAMINER HENRY: Okay, good.
8 A Thank you, though.
9 Q What is the document?
10 A It is a document for a Stipulation and Consent Order for
11 the voluntary surrender of his certificate in Minnesota.
12 Q Were you aware at some point that Mr. Starner had a
13 license in Minnesota?
14 A He had told us during his interview in April that he had
15 a Minnesota license and that they were requesting that he
16 voluntarily surrender. At that time he had told us he
17 was wanting to go to a hearing with the Minnesota EMS.
18 Q At that time did you know why?
19 A I did not.
20 Q Have you reviewed the document from Minnesota?
21 A Yes.
22 Q In there does it state the reason that they were
23 seeking -- there was an action on his license in
24 Minnesota?
25 A Yes.

1 Q What is the reason in the document?
2 A The reason in the document is for his failing to disclose
3 on his Paramedic License Application in Minnesota his
4 Consent Agreement with Reprimand in South Dakota.
5 MR. GOLDEN: I have no further questions.
6 CROSS-EXAMINATION
7 BY MR. KROON:
8 Q Ms. Rallis, just a few. With respect to your knowledge
9 of protocols that you testified to earlier, do you
10 consider yourself an expert on protocols?
11 A I don't know if I would consider myself an expert, but I
12 have experience with them in my nursing.
13 Q With respect to the employment verification you testified
14 to earlier, I believe you testified -- and this is from
15 the Lisbon employer, as I recall; correct?
16 A Correct.
17 Q You testified that the comments included a reprimand
18 concerning narcotics?
19 A A verbal reprimand for not following a narcotic control
20 policy.
21 Q So if you recall, could you explain what it was that they
22 had reported concerning the narcotics policy?
23 A I am not sure what the details or the specifics of it
24 are, just that he was verbally reprimanded for not
25 following. In Mr. Starner's response in Exhibit 2, I

1 believe, he said he had made a narcotic documentation
2 error and that was his only recall of his verbal
3 reprimand.
4 Q But there was no allegation you're aware of of missing
5 narcotics or anything like that?
6 A Not to my knowledge.
7 Q I believe you also testified that the Lisbon folks
8 thought that he showed attitude and had trouble getting
9 along with other staff members?
10 A The Aberdeen Fire Department had the attitude towards
11 FTOs on their -- that was on his first I believe coaching
12 and counseling session. On the Lisbon one I believe it
13 was just difficulty with relationships with co-workers is
14 what they stated.
15 Q So you're not suggesting that getting along with
16 co-workers is a basis for a licensure loss, are you?
17 A No, not if it's just disagreeing with a coworker, no.
18 MR. KROON: That's all I have. Thank you.
19 HEARING EXAMINER HENRY: Any redirect?
20 MR. GOLDEN: No.
21 HEARING EXAMINER HENRY: Then I think we're done with
22 your testimony.
23 (Whereupon, the witness was excused at 11:00 a.m.)
24 HEARING EXAMINER HENRY: Mr. Golden, do you have
25 anything else for us?

1 MR. GOLDEN: No. The Board Staff would rest at this
2 time.
3 HEARING EXAMINER HENRY: Mr. Kroon?
4 MR. KROON: I would call David Starner.
5 DAVID R. STARNER, JUNIOR,
6 called as a witness at 11:01 a.m., having been first duly
7 sworn, testified as follows:
8 DIRECT EXAMINATION
9 BY MR. KROON:
10 Q David, could you state your full name for the record?
11 A David Robert Starner, Junior.
12 Q Where do you reside right now?
13 A In Goodwin, South Dakota, with my wife.
14 Q How long have you been married?
15 A Since June 7.
16 Q And how many kids do you guys have?
17 A We have five.
18 Q She brought those with her?
19 A Yes.
20 Q Okay. Are you currently employed anywhere?
21 A No.
22 Q And why is that?
23 A I am holding out for hopefully to get my paramedic
24 license back. I have my family and I have a job
25 opportunity in Winfield, Kansas.

1 Q What kind of opportunity is that?
2 A It's a firefighter/paramedic.
3 Q Is that contingent upon you receiving your South Dakota
4 license?
5 A Or just not necessarily receiving it, just being
6 reinstated or eligible for it because then I can get
7 National Registry's and then I can get Minnesota's and
8 then Kansas. But Kansas is the one that we're hoping
9 for. So I did all the interviews down there, went two
10 different times, and even went and met with the Board
11 down there in Kansas. It's a 100 percent go.
12 Q So it's fair to say that all that's contingent upon
13 resolving the issues here in South Dakota?
14 A Yes.
15 Q Tell me a little bit about your educational background
16 starting with high school.
17 A Got my GED in '94. I initially went down -- I grew up on
18 a farm and we have foreign exchange students and so I
19 went down to Florida in the winter to work on a farm with
20 one of our foreign exchange students from Germany. Then
21 I came back and I didn't go to college so I went to a
22 local community college. Didn't know exactly what I was
23 doing. I struggled. I was a lifer, so to speak, in
24 college. I would bounce around trying to find out what I
25 was going to do with my life or what career I was going

1 to do. Went to multiple schools. Took four years to get
2 my two-year degree.
3 Q Where did you get your two-year degree?
4 A From Fergus Falls Community College.
5 Q And that was an Associate of Arts degree?
6 A Yes.
7 Q So I know you mentioned that you had some difficulties in
8 school; is that right?
9 A Yes.
10 Q Why was that?
11 A When I was five, I believe I was five, I was diagnosed
12 with a learning disability, ADD and ADHD, and a reading
13 comprehension problem. And then when I went to school,
14 into college, I couldn't take tests. So even studying I
15 had a problem. So I had tutors help and they would read
16 it to me. When I took tests I would get help from a
17 teacher to take the test because I couldn't -- I had a
18 difficult time understanding what they wanted for the
19 test and I would fail if I didn't get help.
20 Q You have heard the testimony from Mr. Huss and Ms. Rallis
21 earlier about your completion of various applications and
22 the meanings of questions; correct?
23 A Yes.
24 Q Do you believe that your ADD/ADHD has some bearing on
25 your inability to answer those to the satisfaction of the

1 Board?
2 A I don't know if it's the ADD/ADHD or just the reading
3 comprehension problem. Maybe it's all bound up together.
4 Yes. It's the same as when I was in school trying to --
5 I can do things hands-on, learn that way. But as far as
6 trying to understand what's in front of me and then being
7 able to get what they want out of it, I have a difficult
8 time.
9 Q Do you feel that your reading comprehension issues has
10 any adverse impact on what you do in your profession as a
11 paramedic?
12 A No. We are not out there reading books on what a patient
13 presents. We are out there looking at what we see,
14 getting our physical assessments and also getting vitals
15 and seeing what the patient presents, get a history from
16 them. No, there is no books out there or no --
17 Q Okay. So when did you first begin doing any kind of
18 ambulance related work?
19 A In 2006 I went to Glendale Community College for my EMT.
20 Q Let me back up a little bit. Did your mom run a
21 volunteer ambulance?
22 A She did for 17 years. And while she was doing that I was
23 basically her guinea pig. She volunteered and taught
24 classes all around the area. So when she would teach
25 classes, any time they used children I would go in there

1 and they would basically practice on me. They would come
2 out to the farm and do farm drills and I still remember
3 that. She did a lot of training.
4 Q Where was that at?
5 A In Hoffman, Minnesota. She started the ambulance with
6 Doc Sampson. The area didn't have an ambulance and it
7 would respond from Alexandria, which was 20 miles away.
8 So she wanted for the community and with the doctor to
9 get something local. It's still up and running today.
10 Q I interrupted you. You started talking about your first
11 EMT class. You want to tell us about that?
12 A Yes. I started in 2006 and then I got my -- passed that,
13 started or I passed National Registry to be an EMT and I
14 got my first job at -- boy, I have a brain freeze here.
15 It was -- oh, the best paying job I ever had in the EMS
16 career. They would come into our class. There is a big
17 need for EMTs so they come in proposing what they are
18 offering, they all had signing bonuses. The first
19 company was pay per call, too, on top so it was awesome,
20 good experience. Nonemergency though. And when you're
21 an EMT you want to get into working with the paramedics
22 or the Fire Department. I put my six months in there.
23 I'm trying to think of. . .
24 Q Was this out in California someplace?
25 A Yes. And that was -- I have it on my resume. For

1 whatever reason I'm drawing a blank.
2 Q That's okay.
3 A But I did six months there. There was an opening with
4 Schaefer Ambulance.
5 Q And where is that at?
6 A They are based out of Pomona, California. I worked in
7 Glendale or not in Glendale, in Glendora and around
8 there, Zeus was my station. That was working -- you did
9 emergency, 911, and you worked with the LA County Fire
10 Department. So you would -- we were the transport and we
11 worked right along with the paramedics.
12 Q What did you do after that?
13 A I started paramedic school while there and I was
14 full-time. And it was really after I was done with, oh,
15 EMT school there, the school brought me on to help teach
16 EMT. So I would go and teach EMT there. And then I
17 worked at Schaefer, started paramedic school there. At
18 Schaefer I worked Monday, Wednesday, Friday, every other
19 Saturday, 24 and 48-hour shifts. My class was Tuesdays,
20 Thursdays. So I would get off my shift at 8:00 and class
21 started at 9:00 and then ended at 6:00. Go home, rest
22 for a couple hours, go back the next day on shift. So I
23 was full-time.
24 I passed the didactic portion of paramedic and then I
25 had to go to clinicals. The owner or the company won't

1 let you go part-time. I needed -- my clinicals wouldn't
2 work like paramedic school, Tuesdays or Thursdays or
3 every other Saturday or Sunday, they just didn't work
4 that way. They had your schedule set out, it would be a
5 Monday or a Thursday or a Friday. So I had to make a
6 decision between staying with my job or continuing
7 advancing my career at paramedic and of course I chose
8 the paramedic. So then I found a company that would work
9 with my schedule, which was Good Shepherd, and they
10 brought me on to be an FTO.
11 Q What's an FTO?
12 A Field Training Officer.
13 Q Okay.
14 A To help new EMTs. You basically have a new one right
15 along with you.
16 Q So they thought highly enough of you they were allowing
17 you to train the newbies?
18 A Yes. The manager that was there, Scott Ryan, worked with
19 me at Schaefer and at the first job, too, I was at. So
20 he knew me and he brought me on to be the instructor.
21 Q So at some point you left California and headed to North
22 Dakota?
23 A Yes. From there another friend of mine started an
24 ambulance company in San Diego and asked me to come help
25 train EMTs and get them ready for his business. So I

1 went down there. I passed my -- during that time I
2 passed my clinicals for paramedic, I passed my field
3 internship.
4 I was starting to miss home. One of the people that
5 my mom instructed, Randy Fisher, my mom told me to get
6 ahold of him. He works in Morris and told me that Lisbon
7 needs a paramedic. I told him, you know, I'm passionate
8 about teaching, I like teaching.
9 Q So when did you begin your employment in Lisbon?
10 A That was August 2012.
11 Q Okay.
12 A Is that correct? Somewhere --
13 Q Maybe 2011 maybe?
14 A Or 2011. Yeah, I'm trying to get my --
15 Q Okay. That's not that -- the date I don't think is that
16 critical.
17 A Okay.
18 Q Who was your supervisor in Lisbon?
19 A In Lisbon that was Vicki.
20 Q Vicki. What's her last name?
21 A Vicki Berreth.
22 Q And as part of your duties there did you work with the
23 hospital EMT group?
24 A I worked -- we worked with the hospital. They would come
25 in, the hospital would come over, we'd train together or

1 talk about what they would like from us or what we'd like
2 from them. Whenever they had a critical call the
3 hospital would call us to come over there and assist the
4 hospital.
5 Q So did the hospital have protocols or requirements that
6 you had to follow?
7 A Yes.
8 Q Who was the individual that you worked with or reported
9 to at the hospital?
10 A It's Michelle Smith, she is the Manager and Director.
11 Q And you have received your paramedic license in North
12 Dakota; is that correct?
13 A Yes.
14 Q Why did you end up leaving Lisbon?
15 A When I left Lisbon, it was for a job opportunity in
16 Aberdeen. I was hired in Aberdeen. I left because my
17 dream was to be a firefighter/paramedic and the salary
18 doubled. I was in Lisbon a big part of the community. I
19 did a lot of teaching. I even traveled teaching. I
20 taught advanced classes, ACLS classes, PALS classes,
21 PHTLS classes. I taught EMR, which is first responder.
22 I taught EMT classes, I taught advanced EMT classes. I
23 was also a liaison and educator for Fort Ransom and
24 Enderlin first responders. And then I also worked
25 directly with the Fire Department and would instruct in

1 the Fire Department and also taught the hospital staff
2 the advanced class.
3 Q So you left on your own from Lisbon?
4 A Yes, I left on my own. I gave -- once I knew I was
5 getting hired there, I gave my two-week notice.
6 Q Let me ask you other than the termination from Aberdeen,
7 have you ever been terminated from any job?
8 A No.
9 Q You have heard Misty Rallis's testimony about an
10 employment verification from Lisbon?
11 A Yes.
12 Q You were present during that testimony?
13 A Just now?
14 Q Yes.
15 A Yes.
16 Q One of the items, David, that was mentioned, and I
17 believe I'm referring to Exhibit 1, is that you were
18 verbally reprimanded for not following a narcotic control
19 policy. Is that correct?
20 A That's what it says, but it's not true.
21 Q What happened?
22 A We do -- when you get off your shift, you write down, you
23 do checks on a log with narcotics. And when you do, you
24 look at the numbers, it's up in the locked shelf in the
25 ambulance. So then you write it down on a piece of

1 paper. Instead of putting an eight, I put a five. You
2 know, you could have just taken that five and put it up
3 to a -- made it an eight, you know. So it was just a
4 document error, or she saw it as an error. She showed me
5 and told me that, you know, when we do these, we turn
6 them in to the State or whatever so just make sure your
7 penmanship is good. I didn't get yelled at, I didn't get
8 reprimanded, I didn't get in any trouble or nothing.
9 Q You viewed it more as kind of a teaching moment; is that
10 fair to say?
11 A Basically telling you to do better with your penmanship
12 or pay attention to the number you're writing. I didn't
13 get yelled at, nothing.
14 Q So you don't believe you were reprimanded?
15 A No.
16 Q Did you receive anything in writing concerning this?
17 A Nothing. Not a single thing in writing. And the
18 owner --
19 Q There was never any allegation that there were narcotics
20 missing --
21 A Nothing.
22 Q -- or anything like that?
23 A Nothing.
24 Q I think you also heard Ms. Rallis's testimony that the
25 employment verification indicated you didn't get along

1 with staff members. What's your explanation of that?
2 A That is -- I don't know how to answer that. That's -- I
3 got to be a big part of the community, big part of with
4 my co-workers. We'd hang out, we'd play darts, even play
5 softball and stuff like that. We all got along.
6 Q I think you also maybe heard Ms. Rallis's testimony
7 concerning the employment verification that you had a
8 difficult time accepting policy and protocols you dealt
9 with?
10 A No.
11 Q Is that true?
12 A I wrote the protocols.
13 Q Tell me about that.
14 A When I got there they needed help with the protocols. So
15 I wrote -- Vicki asked me if I can write the protocols
16 for EMTs, advanced EMTs and paramedics. So I wrote the
17 protocols and we reviewed it with the hospital and with
18 our Medical Director. Once they found out that I wrote
19 these and they reviewed it, the State of North Dakota
20 found out that I wrote the protocols and designed them.
21 So the State contacted Vicki to ask if they could -- not
22 necessarily hire me, but bring me on to be part of a
23 committee with other -- I think it was one other
24 paramedic and two doctors for the State of North Dakota
25 to write the protocols for EMS for the whole state.

1 Vicki asked if I wanted to and I said, "Yeah, I would be
2 ecstatic," and represent the company, too. So they got a
3 grant for me to write the protocols.
4 Q So again, you had no -- your testimony is you had no
5 trouble accepting policy and protocols; is that right?
6 A No. I wrote them.
7 Q So let's shift gears a little bit. You then moved to
8 Aberdeen?
9 A Yes.
10 Q So tell me about your position in Aberdeen. Who was your
11 employer there?
12 A The City of Aberdeen. And I was a title of firefighter,
13 probationary firefighter/paramedic.
14 Q Okay. And who was your supervisor there?
15 A Rob Senger was our -- which would be our officer. He was
16 also the EMS Coordinator. Then Battalion Chief Todd
17 Sulfring. And then Kevin VanMeter is the Chief.
18 Q Okay. I'm going to hand you, David, what's been
19 previously submitted as Exhibit 7?
20 A Can I take a drink of water?
21 Q David, in that Exhibit 7 I think the first page is a
22 termination letter. The second is the coaching and
23 counseling memo dated January 17, 2013.
24 A Yes.
25 Q Kind of explain in your own words what happened that gave

1 rise to this coaching and counseling memo.
2 A My partner had sent -- can I say my partner's name?
3 Q Of course, yeah.
4 A Okay. Zach, my partner Zach and I responded to the call.
5 Zach is a new probationary firefighter/paramedic just the
6 same as me. And Rob Senger, our EMS coordinator and FTO,
7 rode along with us. He was hoping to see how I was doing
8 in the field and clear me for to be on my own. We
9 responded to a call. My partner was the driver, I was
10 the navigator and the patient care guy. So we get to the
11 call and get the patient, load the patient up, and Rob is
12 with me in the back.
13 We go -- my partner -- we're at a trailer park and
14 they have those speed bumps so he hit it and instead of
15 taking a right to go out of the trailer park, he took a
16 left and then took a roundabout turn. Then when he got
17 in the hospital he turned a little too sharp and hit a
18 curb. We get into the hospital on a bay and I take my
19 patient and do my patient care report and had the patient
20 over to the hospital.
21 I come back to go in the ER bay and there is a
22 doctor and nurses looking through the window and I hear
23 yelling. So I go in there and Rob is yelling, swearing,
24 just screaming at my partner for hitting a bump too hard,
25 taking the wrong way to the hospital, and then hitting

1 the curb, going absolutely ballistic. The people are
2 just out there watching this show. My partner is in
3 tears. You know, I consider him a friend of mine, you
4 know, felt bad for him. I didn't know what to do. I
5 talked to him a little bit. He's destroyed.
6 So I talked to a firefighter. I didn't know what to
7 do. So I talked to a firefighter about what happened and
8 he is like, "Okay, I'll go talk to the Chief about it."
9 So the next day I come on shift. Rob pulls me up into
10 the training room and says, "Do you have a problem with
11 me? And if you do, you tell me to my face." And I told
12 him, "I do have a problem with you. I have a problem
13 with how you dealt with my partner, you know."
14 Q And again just to clarify, Rob is your supervisor?
15 A Yes, yes. And what happened is that from that day I got
16 back or from when this happened to the day I got back,
17 everyone in the station knew what happened. Everyone
18 knew, everyone at the hospital knew. And Rob viewed it
19 that I went behind his back.
20 Q Do you think that colored your relationship with your
21 supervisor for the balance of your employment there?
22 A Absolutely. Up until that point I was helping him, they
23 were redoing protocols and he knew my past experience for
24 protocols so I was helping him and Mariah with the
25 protocols and we worked together up even in the training

1 room. Yeah, it all ended. That was it.
2 Q So in that Exhibit 7, the coaching and counseling memo,
3 when it refers to attitude, what's your understanding of
4 what he meant by that?
5 A He was upset that -- he was upset at me for talking to
6 someone else about what happened and that it spread
7 around.
8 Q Okay. Let's turn the page then and talk about I think
9 it's probably the third page on that exhibit. Is that a
10 work rules and regulations memo?
11 A Yes.
12 Q Dated March 28?
13 A Yes.
14 Q Why don't you describe that for me.
15 A What happened is I had been working for six, seven years
16 in EMS, had been doing a lot of teaching, too, on top of
17 it. As I was instructed, when you go to a call, you
18 know, put your gloves on because the equipment you
19 touch -- if you have gloves on, I don't know if that's
20 subconsciously, but anything you touch is contaminated.
21 So when you go in to see your patient and before you
22 touch your patient, you take that five seconds to put
23 your gloves on. In that five seconds you can take a deep
24 breath, you can look at your surroundings, you can look
25 at your patient, see how your patient's breathing, skin

1 temperature, moisture, just take in your surroundings.
2 Takes five seconds. And then you go ahead and touch the
3 patient. I also taught that. So they wanted me to -- if
4 I'm driving, have my gloves on while I'm driving; or if
5 you're the navigator and patient care guy, have your
6 gloves on before you get out of the vehicle. I told
7 them, "Okay, no problem. I'll do that if that's what you
8 guys want."
9 My problem I had, and I talked to the Chief about
10 this, is that for five months there was no problem with
11 my going on calls. For five months I have been doing
12 what I was doing. And then all of a sudden I get written
13 up for it.
14 Q And this happened after the yelling incident with your
15 supervisor?
16 A Yes.
17 Q So once you were told to do things differently with your
18 protective equipment, did you follow their rules?
19 A Absolutely.
20 Q Okay. Let's go to the next one, David. That's the work
21 rule regulation memo dated June 14. Do you want to tell
22 me about this one?
23 A We got dispatched to Elizabeth Drive. I know where it's
24 at. We had to take a map test and we took multiple of
25 them and I passed them. I know where things are and I

1 knew where Elizabeth is, it's right down by Church and
2 Gorder and it's a little tricky down there. So I knew
3 where it was. I was the driver and my partner was the
4 navigator/patient care guy. He has been there for seven
5 years and he is a lead paramedic. So we go out. And
6 when they say about the sirens, the night before the
7 Battalion Chief and us were working on different siren
8 noises. So my partner told me to go out here. So I did.
9 So I'm working on the sirens to get the tones that we
10 were trying to learn the night before.
11 So my partner, we get on 6th Avenue, I believe it was
12 6th Avenue, he told me to take a left. So you're a
13 probationary firefighter, you have a senior paramedic
14 that's been there seven years and tells you to take a
15 left, you follow his instructions and take a left. So
16 then he is like, "Oh, crap." So we had to divert and go
17 around a block, a couple blocks or whatever and turn
18 around to get there and we were delayed, took us two and
19 a half minutes to get there.
20 Q Was there any harm to the patient --
21 A None.
22 Q -- because of the delay?
23 A No harm at all. Patient was absolutely fine.
24 Q In your experience, is it unusual to take a wrong turn in
25 your line of work?

1 A No. I mean my partner -- when I got this write-up, or
2 not write-up, coaching and counseling, my partner took a
3 left out of the trailer park and not a right like Rob
4 wanted to and he didn't get written up.
5 Q So let me ask you this again: Do you think this was due
6 in part to the yelling incident that we talked about
7 before?
8 A Yes.
9 Q All right. Let's go to the next one, David. I think
10 again it's a work rules and regulations memo dated
11 July 16, 2013. Do you have that in front of you?
12 A Yes.
13 Q Why don't you describe your understanding of what led to
14 this.
15 A This is the one where I gave the explanation to. This is
16 the failing to meet the protocol. Okay. We got -- my
17 partner Eric and I, he is another -- there was four new
18 hires on A shift. Three of the four -- I was the only
19 one with experience, they were brand new. So I had
20 another new firefighter/paramedic. I was the
21 navigator/patient care guy. My partner was the driver
22 and the assistant. We get dispatched or it comes over
23 dispatch as chest pain, heart attack. Truck 1 got
24 dispatched to the call, too. We get there and just go up
25 one flight of stairs, my partner and I, get in there and

1 I see the patient and I assess the patient. My partner
2 is getting vitals and I see that the patient -- I'm
3 confident my partner and I can handle this call without
4 Truck 1 coming. So Truck 1 was canceled, sent back to
5 the station.
6 The patient explained to me what was going on, that
7 he woke up at 3:00 with discomfort right around the belly
8 button area. He said that he ate way more than usual the
9 night before and thinks that that's the cause of it.
10 Q Did this patient ever complain of chest pain?
11 A Never complained of chest pain.
12 Q Did you ask the patient whether he had chest pain?
13 A I asked the patient multiple times, "Do you ever have
14 chest pain, chest discomfort, chest pressure, anything
15 leading up this way?" He denied it every single time.
16 Q So how did the call come in that you had a patient with
17 chest pain then?
18 A His wife, his wife thought that he was having chest pain
19 and was having a heart attack. When I first got there,
20 if I knew it wasn't a male, I would have thought she was
21 the patient. She was worked up pretty good. So after --
22 when we got there his skin was just fine. And you know,
23 one of the precursors to if you got something going on in
24 your heart, you're going to start showing it with your
25 skin or your breathing. You can just visually see

1 someone do that. I've done this not as long as some
2 people, but my experience out in LA, we run very high
3 call volume. We ran almost 1400 calls myself a year,
4 where other places around here you run probably maybe 200
5 if you're lucky. I ran 1400 a year. You get to see it,
6 you really pay attention to what you visually see and
7 then you put it together by getting the vitals, getting
8 the monitor on and just talking to the patient. So
9 through talking to the patient and the wife now is
10 starting to calm down, that and the patient had a
11 pacemaker for his heart. On the monitor it showed a good
12 paced rhythm. Per the Aberdeen Fire & Rescue if there is
13 a pace strip and then we see it, heart related or not,
14 you don't do a 12 or five lead, you can get a better
15 picture of it.
16 Q What lead, what are you talking about?
17 A It's where you can get better angles and a better picture
18 of what's going on in the heart. It tells you -- you can
19 find out if -- you can see if they have got a block, if
20 they have got a potential MI, if they have got an
21 irregular rhythm, you know. You can -- I mean you could
22 see a lot in a 12 and even a 15 lead that's for
23 right-sided MI if you need to check.
24 Q You were present when the testimony was that you failed
25 to follow the cardiac protocol --

1 A Yes.
2 Q -- of Aberdeen Fire. Why didn't you follow that
3 protocol?
4 A The patient didn't have chest pain or chest discomfort.
5 Had nothing to do with chest pain or chest discomfort.
6 Q You have heard the testimony that as a paramedic you're
7 not supposed to diagnose. Were you making a diagnosis?
8 A No. You make field impressions and you treat off of your
9 field impressions. That's what we're supposed to do.
10 We're out there because the doctors can't be out there so
11 we're trained to be able to see what's going on. We
12 don't treat dispatch complaints, you know. It comes in,
13 you could have someone, you know, a stabbing or man down,
14 a stabbing or something, and you get there and he stubbed
15 his toe or something like that. You don't -- you just
16 get a general idea of what dispatch -- and new people pay
17 attention to what's going on from dispatch complaint.
18 Them new paramedics, EMTs, whatever comes out on
19 dispatch, in their mind on the way to the call they're
20 thinking, running through how they're going to go through
21 this protocol of chest pain heart attack so you're going
22 there thinking that. If you have after -- I'm sorry,
23 after a while you get some experience and stuff, you
24 understand you just take it in with a grain of salt. But
25 when you get in, you actually treat how your -- you treat

1 a patient how you see it and the physical findings.
2 Q How long did it take you to get this patient to the
3 hospital?
4 A We were on scene for 45 minutes.
5 Q How come it took so long?
6 A Trying to convince him to go to the hospital.
7 Q So he was refusing to go in?
8 A Refused multiple times, multiple, multiple, multiple
9 times.
10 Q So what happened once the patient went into the hospital?
11 A They released him 40 minutes, 40 or 45 minutes later,
12 Doctor didn't get any -- they wanted to run a troponin
13 test, which is an indicator if you have -- if it's high
14 you can get a -- it could be saying you have a heart
15 attack. Couldn't even get that. So the patient was in
16 and out. No harm to the patient.
17 Q Okay. You have heard the testimony earlier about your
18 not disclosing these workplace issues on your license
19 applications and renewals; correct?
20 A Mm-hmm.
21 Q Did you think you had to disclose these on the
22 Application?
23 A On the renewal?
24 Q Right.
25 A My -- Rob Senger --

1 Q Yes.
2 A -- my EMS coordinator, was the one telling me what to
3 fill out on the Application.
4 Q So when you were completing the Application you were
5 working with your Aberdeen Fire supervisor?
6 A EMS Director, too. He is my supervisor and EMS Director.
7 Q And he advised you to answer "no" to these questions?
8 A Everything, every single thing on there he was right
9 there working. I believe it was Zach Hansen was also
10 doing an application right next to us, or I think it was
11 Zach. We were doing them and Rob was sitting right there
12 because we had -- it was -- because we dealt with that
13 restraining order I think or whatever and we had to put
14 that on the Application, too, I think.
15 Q Okay.
16 A And so yes, everything on there Rob was telling me what
17 to answer, what to do.
18 Q Let me ask you a question. When you were told you were
19 terminated, what reason did they give you?
20 A Because the last straw -- I knew after -- I already knew
21 after the first couple that I was on my way out. I
22 just -- you know that. You get a feeling. So I just
23 kind of knew that. But they said that my last straw was
24 my not having or failing PHTLS.
25 Q What's that?

1 A Pre-Hospital Trauma Life Support.
2 Q Is that a certification?
3 A It's a certification that's required. And I have taught
4 PHTLS. When I was in Lisbon we traveled across North
5 Dakota to teach it. I explained to the Chief and to I
6 believe Alan, the guy on the phone -- no, I gave Alan or
7 Chief documents showing that because the firefighter that
8 instructed me failed me. So Vicki Schrenk is the
9 hospital coordinator and I believe she is the
10 Pre-Hospital Trauma Life Support, one of the main ones
11 for the State of South Dakota, I think there is three of
12 them. But anyway, she passed me with no problems. I
13 showed Chief that I have this certificate. That is not
14 the -- it's the Pre-Hospital Trauma Life Support.
15 MR. KROON: Do you mind if I approach the witness?
16 HEARING EXAMINER HENRY: No.
17 Q Make sure I have the right one here.
18 A Yes. Yes.
19 Q I'm going to hand you what's been marked as Exhibit J.
20 David, could you just describe what that is?
21 A This is a cert recognized throughout the nation or
22 actually, well, stating that I successfully completed the
23 PHTLS class and the skills portion and I have my cert and
24 it doesn't expire until 2017.
25 MR. KROON: I suppose I should get this in. I would

1 like to move to introduce Exhibit J.
2 MR. GOLDEN: No objection.
3 HEARING EXAMINER HENRY: Exhibit J is received.
4 BY MR. KROON:
5 Q David, once you showed this to your supervisor, what did
6 he say?
7 A Well, I showed it to Chief and I -- because he said,
8 "This is the last straw or, you know, because you failed
9 the PHTLS, you know, we can't keep you on." And I showed
10 him, I'm like, "I have my PHTLS cert right here." I gave
11 it to Chief. I even had a writeup about what was going
12 on. Because when I got the writeup about the protocol
13 thing, I wrote up a -- tried to explain what was going on
14 so people would -- I'm a probationary firefighter, I
15 can't refuse to sign anything. I can't appeal anything
16 until my probationary period is done. So anyway, I
17 showed him I had this and he said, "Sorry, I can't do
18 anything," and said he was going to take it up to Al,
19 this and my explanation. But this is why he -- this said
20 why it was the last straw and why I was terminated, yet I
21 have my cert.
22 Q David, you had mentioned I think in the course of your
23 testimony that you have done a lot of teaching?
24 A Yes.
25 Q Could you kind of briefly summarize some of the teaching

1 that you have done?
2 A Okay. Started -- I don't remember the exact years, but
3 when I was going to college I was in Big Brother, Big
4 Sister so I started and I had a little brother and had
5 him for five years. Got to see the young boy grow into
6 now a man and married, got two kids. I started out with
7 Big Brother, Big Sister. I have taught EMT, I have
8 taught multiple EMT classes. I've taught multiple first
9 responder classes. Basically been teaching -- even when
10 I was in Aberdeen I would teach advanced classes. I
11 taught Advanced Life Support or ACLS, PALS, PHTLS, and I
12 also volunteered at the hospital there in Aberdeen
13 because they needed some instructors. They were doing a
14 lot of teaching so I volunteered teaching there. I did a
15 lot of teaching in Lisbon. I taught all kinds of classes
16 there. I traveled teaching.
17 I also -- I coach football now, I volunteer coach
18 football. Was in Lions Club as a volunteer, I don't know
19 if that counts, not EMS related.
20 Q Let me shift gears for a second. I think you have seen
21 what the Board has introduced as Exhibit 16 which is a
22 Stipulation and Consent Order in Minnesota. I will bring
23 this up to you.
24 A Okay.
25 Q I think you have heard the testimony that that was

1 furnished to the Board yesterday. Do you want to, in
2 your own words, can you tell me what that is?
3 A When I did the Renewal Application --
4 Q Where at?
5 A For Minnesota.
6 Q Okay.
7 A When they on here said that I answered "no" to the
8 self-disclosure question, "Is there any other health
9 related licensing authority that denied, revoked,
10 suspended, or placed conditions on your right to
11 practice," and I checked "no". The problem they had is
12 that I had a Consent Agreement with the reprimand. And
13 when I answered "no" on here, it didn't say, "Health
14 related licensing authority denied, revoked, suspended,
15 placed conditions on your right to practice or a
16 reprimand," so I checked "no".
17 And I went to the -- I had a meeting with the Board
18 in Minnesota and I explained what was going on, I
19 explained what's going on here in South Dakota. At that
20 time during that Board meeting they had no problem with
21 what was going on, my explanation. They were comfortable
22 with it. They told me they were going to, until this is
23 settled here, not renew my license, just refuse to renew
24 it. Well, they renewed it and I had a current license.
25 So I got this and I talked to Rose there and I said, "My

1 biggest problem with National Registry is that I
2 surrendered my license in South Dakota. I can't do this
3 in Minnesota to surrender it." And she is like, "You
4 take care of South Dakota. You're in good standing with
5 Minnesota." I'll get my license back with no problem.
6 Q So let me -- but why did you answer "no"? It's just a
7 few months after you entered into the Consent Decree in
8 South Dakota. Can you tell me why you answered "no"?
9 A Because it didn't say -- or are you asking why I signed
10 it?
11 Q No. Why did you answer "no" to the question?
12 A Because it didn't say reprimand in, "Has any health
13 related licensing authority denied, revoked, suspended,
14 placed conditions and right to practice or reprimand."
15 Q So because the word reprimand wasn't in there you didn't
16 think you had to disclose it?
17 A No.
18 Q So you understand the National Data Bank and how that
19 works?
20 A Everything you do is -- anyone can look at and see.
21 Q So did you know when you entered into the Consent Decree
22 in South Dakota that that would show up on the National
23 Data Bank?
24 A I knew everything that's going on here is public, yes.
25 Q So you knew that Minnesota would know about that in any

1 event because --
2 A What's going on here, yes. I even -- I'm sorry.
3 Q No. So did you intentionally not disclose that so
4 Minnesota wouldn't find out about it?
5 A No. And when I -- they were okay after I explained. I
6 was in a hearing kind of like this, but they had more
7 people there. But I explained what was going on and they
8 met and they were absolutely comfortable with my
9 explanation, what was going on.
10 Q So talk -- this may be the last few questions. Talk
11 about the -- Terri, are you doing okay?
12 THE REPORTER: Yes.
13 Q Talk about some of the education that you have done since
14 all this began. Have you continued your education?
15 A I have. I have done heart class, I have taken some --
16 with five kids and not working, I'm mostly staying home.
17 So I'm home. I continue my education when I can. I did
18 some three classes on heart related issues and training.
19 I believe I have got five hours of that or something like
20 that, three, four and a half, five hours. And then I did
21 a 22-hour transition course.
22 Q David, I gave you what's been mark as Exhibits G, H, and
23 I. Could you kind of briefly explain what G is?
24 A It's a course. It's a -- you get one and a half hours of
25 CEs for each of these courses. I understand that when I

1 took the courses I understood that there is still -- I
2 don't have any type of license, but I want to stay on
3 top, I wanted to learn or keep learning because if you
4 stop taking classes or stop in the books or training,
5 your brain shuts down.
6 Q So which one -- look at G. Which course is that?
7 A Heart failure.
8 MR. KROON: I'd like to introduce the Certificate of
9 Completion and admit G into evidence.
10 MR. GOLDEN: I have no objections to any of those.
11 HEARING EXAMINER HENRY: G is received.
12 Q Same question for H, David.
13 A It's STEMI Care.
14 MR. KROON: Okay. Move to admit that as well.
15 MR. GOLDEN: No objection.
16 Q Same with I, David.
17 A Sudden Cardiac Death.
18 MR. GOLDEN: No objection.
19 MR. KROON: Thank you.
20 HEARING EXAMINER HENRY: Those two exhibits are
21 received as well.
22 MR. KROON: Thank you.
23 A I also have a 22-hour course.
24 Q Why don't you describe that one.
25 A This is National Registry wants you to go from

1 EMT/paramedic to paramedic and it is a course where
2 you -- it's familiarizing you with some of the equipment
3 that's just coming out or been out and also educating you
4 on different aspects of what's going on in health.
5 Q What letter is that, David?
6 A F.
7 MR. KROON: I would move that F be admitted as well.
8 HEARING EXAMINER HENRY: Do you have an objection to
9 F?
10 MR. GOLDEN: I'm sorry, no objection.
11 HEARING EXAMINER HENRY: No problem. F is admitted,
12 received.
13 BY MR. KROON:
14 Q One last question, David. I'm going to give you what's
15 been marked as Exhibit O. Could you describe what that
16 is?
17 A This is explaining basically what's been going on in
18 South Dakota.
19 Q So is this what you -- are these the papers that you
20 compiled and gave to the Board?
21 A I'm not sure -- yes. This is what I compiled, yes.
22 Q And so who did you give this to?
23 A Did I give it to you, Mr. Golden?
24 Q Tell me just your best recollection who you gave it to.
25 A Misty.

1 MR. KROON: Okay. And again I just would like to get
2 this in the record so the Board has this so I would move
3 the admission of O.
4 MR. GOLDEN: No objection.
5 HEARING EXAMINER HENRY: O is received.
6 MR. KROON: I have no further questions.
7 HEARING EXAMINER HENRY: Very well. You're looking
8 at that, Mr. Golden. Does that mean you would like to
9 proceed?
10 MR. GOLDEN: I need a five-minute break at the very
11 minimum, but I didn't know if we wanted to take a break
12 for lunch or if we want to continue.
13 MR. KROON: I have one other witness that may take
14 five minutes, that's what I would have left.
15 MR. GOLDEN: I will try to restrain myself and be
16 short.
17 HEARING EXAMINER HENRY: So for cross here maybe --
18 MR. GOLDEN: I'm hoping -- and you understand that
19 attorneys' estimates of time are not to be relied upon --
20 but 15 to 20 minutes.
21 HEARING EXAMINER HENRY: Let's go off the record at
22 this point.
23 (Whereupon, a recess was taken from 11:51 a.m. to
24 11:59 a.m.)
25 HEARING EXAMINER HENRY: Let's go back on the record.

1 Mr. Golden, it's your opportunity for cross-examination
2 of the witness.
3 MR. GOLDEN: Thank you.
4 CROSS-EXAMINATION
5 BY MR. GOLDEN:
6 Q Mr. Starner, do you remember sending in various documents
7 to the Board and being interviewed by the Board, two
8 different things, but do you remember having lots of
9 communications with the Board?
10 A Like with you?
11 Q With me, with Misty, with Ted, with Randi Sterling?
12 A Yes, I have talked -- been in contact either on the phone
13 or e-mail.
14 Q Have you had a chance to go through all of the exhibits,
15 the different documents?
16 A That are here?
17 Q Yes.
18 A Yes, I have gone through these.
19 Q Your responses are in those exhibits, what you sent to
20 the Board and explained to the different --
21 A I sent the stuff to the Board, yes.
22 Q When I have reviewed them or as we have gone through them
23 here today or as Ms. Rallis testified, there hasn't been
24 any previous mentions of you having a learning
25 disability, has there?

1 A Only with my attorney.
2 Q Okay. Really simple question. You haven't told the
3 Board before you were sitting in that chair that you had
4 any type of learning disability?
5 A Correct.
6 Q Do you remember receiving a letter from Randi Sterling
7 concerning your employment in Lisbon?
8 A That's one of the things we reviewed over there? Yes.
9 Q And that would have been I believe marked as Exhibit 1
10 and I'm putting it up on the screen for you. I've blown
11 it up and put it on the screen so you can look either
12 direction and see it. That's from a previous employer
13 that sent in a verification concerning your Application.
14 You're aware of that?
15 A Yes.
16 Q And you responded to that and sent to the Board in
17 Exhibit 2 your response; correct? Do you recognize your
18 letter?
19 A Yes, yes.
20 Q I would ask you to turn your attention to the second
21 paragraph. Do see what it says there? Would you go
22 ahead and take a moment to read it?
23 A (Witness examines document.) Okay.
24 Q Did you prepare this document yourself?
25 A Yes.

1 Q Okay.
2 A Like did I write it?
3 Q Yes.
4 A Yes. You're asking if -- yes, this is --
5 Q Is this your document?
6 A Yes, this is what I sent to you.
7 Q Okay. So you wrote down what you wanted the Board to
8 understand?
9 A Yeah. I believe I had at that time my mom, yeah, I
10 believe my mom helped me out.
11 Q Okay. Explain to me what you mean by she helped you out.
12 A Like when I write stuff before I send it in, I would have
13 her like review it, make sure the sentences are good or
14 my spelling is not messed up.
15 Q Okay.
16 A Or if she had any suggestions.
17 Q So she helps you edit?
18 A Yes. Or if she had some suggestions on how better to
19 word things.
20 Q Okay. Because you raised the issue of having a learning
21 disability, that's why I'm asking you this question,
22 which is: If you prepared this document, how much
23 assistance are we talking about?
24 A About what?
25 Q How much assistance do you need to prepare a document

1 like this?
2 A Well, it would be multiple e-mails. Mom and I would
3 e-mails back and forth, I would send it to her. Is that
4 what you're asking?
5 Q Yes. I'm just trying to get an idea. Is it difficult
6 for you to write things?
7 A To make it so it's clear and the point is across and no
8 spelling errors and grammar errors, yes. Doing a -- yes.
9 It's --
10 Q But from that paragraph is there anything in there that
11 you disagree with or that at this point in time that is
12 what you meant to get across to the Board?
13 A Well, can I tell you what I mean on here? Is that what
14 you're asking?
15 Q Okay. Yes.
16 A Because Ed Gregoire, I talked to him because I wanted to
17 find out what was going on, if I was in good standing, if
18 there is anything like if I had any problems or anything,
19 like anything bad.
20 Q So what this paragraph is saying is that when you found
21 out that there is employment verification from Lisbon
22 saying you had problems up there, you were completely
23 surprised by that?
24 A Yes.
25 Q Now, I want to go back to when Mr. Huss was talking to

1 you about the Protection Order. Do you remember that
2 event, the investigation?
3 A Okay.
4 Q You had a woman who accused you of rape; correct?
5 MR. KROON: I'm going to object to the relevance. I
6 already have one objection on the record about the
7 relevance of any line of questioning concerning those
8 allegations and I really don't want him testifying as to
9 those allegations.
10 MR. GOLDEN: I do not intend to go into the
11 allegations other than to ask if he is aware of the
12 allegation.
13 MR. KROON: Okay. I will withdraw my objection if
14 that's his question.
15 HEARING EXAMINER HENRY: Very well.
16 BY MR. GOLDEN:
17 Q You're aware of the allegation?
18 A Yes.
19 Q In your response to Mr. Huss you told him that you were
20 surprised by her reaction; correct?
21 A By whose reaction?
22 Q By the complaint, by the allegation.
23 MR. KROON: I'm going to object. This goes beyond
24 being aware of the allegation. Now we are getting into
25 the substance of the allegation.

1 MR. GOLDEN: I will rephrase.
2 MR. KROON: Okay.
3 BY MR. GOLDEN:
4 Q When you spoke to Mr. Huss, initially you told him that
5 you were unaware or surprised by her reaction and what
6 she was alleging. That's what you told the investigator;
7 correct?
8 MR. KROON: I'm sorry, I'm going to have to object
9 again. I mean we have got a record, we have got
10 documents in the record about what he communicated to the
11 Board. I think those should speak for themselves. To
12 the extent that we have to go beyond that, again I would
13 just object on the basis of relevance.
14 HEARING EXAMINER HENRY: I'm going to overrule it on
15 relevance. He can ask the question, or answer the
16 question rather. If you have a different objection, I'm
17 happy to hear it. But I'm going to overrule it on
18 relevance because he said it to an investigator, it's
19 relevant here.
20 A I don't know what to do.
21 MR. KROON: Wait for the question.
22 BY MR. GOLDEN:
23 Q Simple question. When you spoke to Mr. Huss, you were
24 surprised by her initial -- you acknowledged that you
25 were surprised that she had even made the complaint

1 against you initially.
2 A When Mr. Huss was asking, during that time Al and the guy
3 was on the phone, the attorney, and whatever I was doing
4 they were advising, they were helping me. I can't
5 remember the attorney's name.
6 Q Mr. Huss also during that period of time advised you that
7 there had been a second complaint; correct? And you were
8 completely unaware of that investigation; correct?
9 A Correct.
10 Q Okay. Now, with the Aberdeen complaint you're saying
11 that the workplace violations was because of a
12 personality conflict with your supervisor; is that fair?
13 A I don't know if it's personality or if it was -- I felt
14 like it was vengeance. He was -- I was helping Mariah
15 and Rob with protocols, was involved and stuff, went out
16 and had drinks afterwards after work and stuff. We
17 actually did stuff. After that incident -- I don't know
18 if you can say it's personality conflict because we did
19 get along. I don't know if revenge is a personality, but
20 my honest opinion is I think it was more revenge on me or
21 hate or something.
22 Q Here is what I'm trying to show you. The Board initially
23 had a workplace verification which had some minor
24 derogatory information about your employment in Lisbon.
25 The Board learned about a Protection Order and about two

1 criminal investigations, one of which you were unaware
2 of, and learned about the personnel matters with Aberdeen
3 where they're saying you're having problems getting along
4 with people. Your response to all of these different
5 episodes where people are saying that you have
6 interpersonal problems, you sent the responses to the
7 Board which are either, one, you're surprised and didn't
8 know about that. In fact, that probably covers Lisbon
9 and the complaints by the women; correct?
10 A I know Lisbon was a definite surprise.
11 Q Okay. Didn't you indicate to Mr. Huss that you didn't,
12 from your interactions with them, you didn't expect these
13 things -- you didn't think that there was any problems
14 with the women in this case from your perspective?
15 A I was working with Al and the lawyer on those.
16 Q Okay.
17 A Because they wanted -- yeah, I was working with -- I
18 can't remember his name. He is a city attorney.
19 Q Very simply I'm asking you this: You seem to have a
20 documented history of having problems with employment or
21 other individuals. But you either do not recognize you
22 have had a problem with them or you have a very different
23 version of how you're interrelating with other people.
24 Do you see that?
25 A No. Can I ask you --

1 Q No. I get to ask questions.
2 A Okay.
3 Q I'm asking you. You don't -- if I explain it that way,
4 you see no pattern?
5 A I don't see it that way, no.
6 Q I'm not asking if you see it that way. I'm asking if I
7 explain it that way, can you follow along with me?
8 A I understand what you're trying to get across, yes.
9 Q What is that?
10 A There is a pattern of a problem in Lisbon and then in
11 Aberdeen so you connect those two and think that that's
12 who I am.
13 Q Okay. Or can you follow along if I'm trying to say that
14 you seem to have a pattern of not recognizing when you're
15 not getting along or not having problems and these things
16 surprise you down the road and until somebody tells you
17 or the Board said something, you didn't recognize it?
18 A Can I disagree?
19 Q I'm just asking you to answer it. Answer it as you wish.
20 A I don't agree with that. Or can you rephrase it?
21 Q What I'm trying to ask you is there seems to be a pattern
22 where your interactions with people, what they say and
23 what they say about those interactions surprise you and
24 are very different from what you see?
25 A So I have a skewed view of reality is what you're saying

1 or something? Or is that --
2 MR. KROON: Do you understand the question?
3 A No.
4 MR. KROON: Can you rephrase it?
5 A I don't know what you're -- so you're saying that I have
6 a different view of what's going on?
7 Q If that -- from the documentation we have, quite a bit of
8 your responses are, "I didn't know there was a problem
9 with this individual." Do you get that from the
10 documentation?
11 A I didn't. I didn't even know I had a problem.
12 Q That's my question.
13 A And I got it, okay.
14 Q That's what I'm asking.
15 A Okay. I didn't.
16 Q You didn't know there was a problem in all these
17 situations, but people are sending documents and telling
18 the Board there was a problem. But you don't seem to
19 have any idea there was a problem?
20 A In Lisbon I didn't. I have the owner that gives me a
21 letter of recommendation, highly recommended me. But
22 he -- I mean that's the owner. As far as the other one,
23 I was with Al and the attorney.
24 Q Okay. And I'm not going to go into any more with the --
25 I'll just reserve that.

1 Exhibit Number 4. I'm going to have you -- it's the
2 second page, first paragraph, it's up on the screen.
3 A (Witness examines document.)
4 Q That is a document that you prepared and sent to the
5 Board; correct?
6 A Yes.
7 Q The Board didn't take any action whatsoever based on
8 these incidents. You understand that?
9 A Yeah, they did.
10 Q Let me rephrase. The reprimand was because you didn't
11 disclose the Protection Order on your Application. Do
12 you agree with that?
13 A Yes.
14 Q Okay. But as far as the Board giving any credence to
15 this or the Board investigating this or making any
16 findings, you understand the Board never ruled on this;
17 correct? Didn't weigh in on this. There is no
18 discipline concerning this event. Do you understand
19 that?
20 A Yes.
21 Q And in there the incident with the woman, from what you
22 have told the Board in that statement, was on that night
23 when you left you didn't believe there was any problems
24 with her; correct?
25 MR. KROON: I'm going to object. I mean I think

1 anything to do with this has been handled, it's res
2 judicata, it's irrelevant. I mean he has already been
3 disciplined for failing to disclose it.
4 MR. GOLDEN: It's being offered for deception.
5 HEARING EXAMINER HENRY: I'm going to overrule the
6 objection. Go ahead, Mr. Golden.
7 BY MR. GOLDEN:
8 Q Do you remember meeting with Misty Rallis and being
9 interviewed?
10 A Who?
11 Q Misty Rallis.
12 A Oh, when I came here?
13 Q Yes.
14 A Yes.
15 Q Do you remember talking about trying to convince the
16 patient who had the stomach pains that you were called
17 out for?
18 A Yes.
19 Q Do you remember trying to talk him into going to the
20 hospital because you were talking about the fact that
21 stomach pains and indigestion can be precursors to a
22 heart problem?
23 A Yes.
24 Q And you were using that to try to persuade him that he
25 needed to go in and get checked out by a hospital?

1 A That was one of the main ones that I used, yes.
2 Q So you recognize that there was -- the stomach problems
3 could be a precursor to a heart attack in that situation;
4 right?
5 A Right. Yes.
6 Q You believed you needed to go ahead and attempted to get
7 him to go and get checked out by the hospital?
8 A Yes, that was my -- I felt that was -- yes.
9 Q Now, Aberdeen had a problem with the fact that based on
10 that information, you didn't follow all of the protocols
11 for a patient who may have a heart condition; correct?
12 A No. Can I explain?
13 Q No.
14 A All right.
15 Q I turn your attention to Exhibit Number 7. This would be
16 July 16, 2013, it's dated, time of 1700. Would you take
17 a moment and read that?
18 A (Witness examines document.) I'm familiar with that.
19 Q Okay. What are they saying in that rules violation
20 report that you did not do?
21 A In there that I didn't follow under the protocol of chest
22 pain and the treatment that goes under the chest pain
23 protocol.
24 Q Right. And you just told us that a precursor to a heart
25 condition can be stomach pain; correct?

1 A It can be, yes.
2 Q And you used that information in order to get the patient
3 to go, one of the pieces of information you used to get
4 the patient to go to the hospital; correct?
5 A Yes.
6 Q Because that stomach pain could have been an indication
7 that he was either suffering a heart condition or about
8 to; right?
9 A Potentially, yes.
10 Q And that is the issue they are talking about as far as
11 protocols, that when that is the situation that you're
12 supposed to follow the medical protocols that Aberdeen
13 has in place; right?
14 A No. That's not what -- what you see there is my partner
15 was Eric. Rob, when they found out or were finding out
16 what's going on, Rob took Eric, my partner, into his
17 office. Eric apparently said that the patient was
18 complaining of chest pain. That's what Eric said to me.
19 Or Rob was saying that's what Eric said.
20 Q You also told us that Minnesota doesn't have any problems
21 with giving you a license back; correct?
22 A Right. As soon as I -- once I get this done, even though
23 I voluntarily surrendered my license, before I did that I
24 wanted to make sure and talk to Rose there that, you
25 know, I don't want -- I don't want to go through what

1 I've been going through in South Dakota here, there. She
2 assured me that once South Dakota is taken care of, it
3 would be a very simple process. I go and present what's
4 happened to -- it would be, I don't know, the Board maybe
5 again, same thing I did, and I would get my license.
6 Q I believe what I heard you say was that your explanation
7 of what happened in South Dakota with Minnesota, they
8 were comfortable with your explanation. Do you remember
9 saying that?
10 A Yes.
11 Q Okay. Do you stand by that statement?
12 A That -- can you restate that?
13 Q That Minnesota was comfortable with your explanation on
14 what was going on in South Dakota.
15 A They are comfortable about -- well, no, they are not
16 comfortable because they won't license me until I'm done,
17 until South Dakota is taken care of.
18 Q So when you were saying that you explained everything to
19 them and they were comfortable with it, you understand
20 they still won't license you?
21 A Right. Until I get this taken care of in South Dakota.
22 Q And also on the Consent Agreement and Voluntary Surrender
23 you failed to go ahead and disclose this in your
24 Application to Minnesota; right?
25 A Yes. And we dealt with that when I went to the Board

1 meeting and talked about it and explained what happened.
2 And that was -- when I left there, they took a break and
3 talked about it, they were okay after understanding what
4 was going on, that they had a good understanding.
5 Q And they didn't agree to sign a Consent Agreement and
6 give you your license?
7 A They were going to initially deny my renewal and there
8 would be nothing on the National Data Practitioners
9 Database or anything like that. And once this is taken
10 care of, I could just reapply. But in that process they
11 issued me a license so I had a license. So it was a
12 month, three weeks later they called me and said -- and
13 they didn't know what they were going to do yet. They
14 called me and told me, "You have a license. You can't
15 practice. We're not sure what we're going to do yet."
16 So that's then they sent this letter to have me surrender
17 it. But we already dealt with it at the Board. They
18 were just not going to renew it, but they renewed it.
19 Q Okay. Initially they were going to deny it; right?
20 A Or deny renewing it until this was done, yes. So it was
21 like I had -- I had no license in Minnesota. But there
22 would have been nothing on the database or anything, just
23 that I didn't renew my license.
24 MR. GOLDEN: Can I have about a two-minute break?
25 HEARING EXAMINER HENRY: Yes, two minutes is fine.

1 We will be in recess for two minutes.
2 (Whereupon, a recess was taken from 12:25 p.m. to
3 12:30 p.m.)
4 MR. GOLDEN: I have no further questions.
5 HEARING EXAMINER HENRY: Let's move on to any
6 redirect.
7 MR. KROON: I just have one line.
8 REDIRECT EXAMINATION
9 BY MR. KROON:
10 Q David, I'm going to give you what's been marked as
11 Exhibit K.
12 MR. GOLDEN: I have no objection.
13 HEARING EXAMINER HENRY: K is received.
14 Q Will you tell me what that is, very briefly?
15 A It's the owner of the company I worked for in Lisbon, and
16 this is his letter of recommendation about stating how I
17 worked there and what I did in the community.
18 MR. KROON: So if it's been admitted --
19 HEARING EXAMINER HENRY: I received K, yes.
20 MR. KROON: Okay. No further questions. You're
21 done.
22 THE WITNESS: So now what?
23 MR. KROON: You can come back here.
24 HEARING EXAMINER HENRY: You don't have anything
25 further?

1 MR. GOLDEN: I do not. I had rested.
2 HEARING EXAMINER HENRY: Very well.
3 (Whereupon, the witness was excused at 12:29 p.m.)
4 MR. KROON: I have one telephonic witness and I will
5 try to find a phone number here very briefly.
6 (Discussion off the record.)
7 MR. KROON: Michelle, Dave Kroon. I have you on
8 speaker phone. I'm sitting in a room in Sioux Falls.
9 Present we have David Starner; the attorney for the
10 Board, Bill Golden; the Hearing Examiner; and Terri is
11 our court reporter. Are you ready to give us some
12 testimony here?
13 MS. SMITH: Certainly, yes.
14 MR. KROON: I think we will want you to be sworn in.
15 HEARING EXAMINER HENRY: Can you raise your right
16 hand for us, please?
17 MICHELLE SMITH,
18 called as a witness at 12:32 p.m., having been first duly
19 sworn by the Hearing Examiner, testified as follows:
20 HEARING EXAMINER HENRY: Very well. You may
21 continue.
22 DIRECT EXAMINATION
23 BY MR. KROON:
24 Q Michelle, Dave here again. Michelle, can you tell me
25 where I'm reaching you at today?

1 A I am at work at CHI Lisbon Health.
2 Q Where is that located?
3 A In Lisbon, North Dakota.
4 Q So what does your job entail up there?
5 A I am the Clinical Nurse Manager and the biggest portion
6 of that is that I am the ER and Trauma Coordinator here
7 at the hospital.
8 Q So in the course of your employment did you have an
9 opportunity to meet David Starner?
10 A Yes, I sure did.
11 Q Can you kind of tell me the circumstances of that?
12 A He worked for the ambulance company that is in our
13 community. We are a separate entity so the ambulance
14 isn't a part of our hospital, but we work very closely
15 together. So I got to meet him through my interactions
16 in the Emergency Department with the ambulance.
17 Q What generally was your experience with Mr. Starner?
18 A He was always very in control of the patient, he was
19 always very knowledgeable, very skillful. He had a lot
20 of respect from the staff, the doctors. Everybody that
21 worked with him in the ER really looked up to him and to
22 him for care of the patients, they had a lot of
23 confidence in him.
24 Q So was there ever any problem regarding his competency up
25 there?

1 A Regarding what? Excuse me, I'm sorry.
2 Q His competency.
3 A Absolutely not. No. In fact, I believe he really helped
4 the local ambulance grow in that capacity because he
5 brought a lot of experience with him, a lot of knowledge,
6 and he was always very willing to share it with his
7 teammates to make them a better company.
8 Q Could you give me an example of that?
9 A He just always was teaching, teaching the EMTs that he
10 was working with, you know, instructing them. If we were
11 bagging a patient, he would give them very clear, very
12 good, thorough instructions on going faster and/or slower
13 and telling them why. I know he worked with the local
14 Fire Department.
15 In fact, we were in conversation with them not too
16 long ago when somebody mentioned how well -- we actually
17 had like a pretty big trauma here, we had a plane crash,
18 and one of the firemen there referred to Starner as,
19 "Dang it, I wish he was here because when he came to a
20 scene he took control. We didn't always know what to do
21 and he just said, 'You do this, you do this, you do
22 that.'" They were just very confident with him around.
23 Q Is it fair to say that the hospital requires various
24 protocols for its EMTs and paramedics?
25 A The hospital doesn't concerning the EMTs and paramedics.

1 We of course have our own. But we work very closely with
2 the ambulance here. They come over and help us all the
3 time. So if there is a concern about how somebody did
4 something, we work back and forth with staff. But no, we
5 don't have protocols for the EMS providers as far as the
6 hospital is concerned.
7 Q Based on your observation, did he work well -- did he
8 play well with others?
9 A Absolutely, yes.
10 Q When he left, kind of describe your thoughts about his
11 departure.
12 A My thoughts are that it was a very -- it was a very sad
13 day for not only our hospital, but our whole community
14 because he really was an asset to the community as far as
15 our ability to respond to emergency situations within our
16 rural community. We're in a small community and we don't
17 have a lot of skillful medics available to us and Dave
18 definitely brought that to Lisbon. When he left, we lost
19 a lot of that.
20 MR. KROON: That's all I have.
21 MR. GOLDEN: No questions.
22 MR. KROON: No questions.
23 THE REPORTER: Could you please state and spell your
24 full name?
25 THE WITNESS: M-I-C-H-E-L-L-E, S-M-I-T-H.

1 HEARING EXAMINER HENRY: With nothing further for the
2 witness then, we will dismisses the witness.
3 MR. KROON: Thank you, Michelle.
4 THE WITNESS: Thank you.
5 (Whereupon, the witness was excused at 12:37 p.m. and
6 the conference call was concluded.)
7 MR. KROON: I have nothing further.
8 HEARING EXAMINER HENRY: One last chance, Mr. Golden.
9 Anything further?
10 MR. GOLDEN: No.
11 HEARING EXAMINER HENRY: Would the attorneys care to
12 make some closing arguments or remarks for the case?
13 MR. GOLDEN: I can, yes, Your Honor. Would you like
14 me to proceed?
15 HEARING EXAMINER HENRY: Please. Thank you.
16 MR. GOLDEN: Thank you. There appears to be a very
17 clear pattern in behavior here. From the first
18 Application there was a letter sent out by the Licensing
19 Specialist saying here is an employment verification that
20 has some issues. The response from Mr. Starner was that
21 he was surprised and didn't know there was any of these
22 issues. These issues, when you look at the Aberdeen
23 complaints and employment issues, are very similar in
24 nature involving protocols, problems with individuals,
25 there is overlap.

1 When the Board investigated what turned into a
2 reprimand and the reprimand specifically is on the
3 failure to disclose the Protection Order, it was looked
4 into as far as the investigations on the complaints for
5 these women who made them. They are in the response,
6 they are in the record. But I think the response to that
7 was the same thing as for Lisbon, which was, "I'm
8 surprised that these women are making these allegations.
9 I didn't see this." He has a completely and totally
10 different response from what the allegation is, which is
11 the same thing that he said about Lisbon, which is the
12 same thing that he said about Aberdeen. But yet they are
13 taking the time to write down and document incidents that
14 they believe are employment issues that have to be
15 documented in their file and eventually they are provided
16 to the Medical Board.
17 I tried to give Mr. Starner the opportunity to
18 explain why are people putting in writing here is what we
19 have seen, here is behaviors, here are problems. And his
20 initial response is, "I didn't know about this." And the
21 second response is, "Well, no, that's not what happened."
22 I think it's very concerning that when we talk about
23 the pain protocol or the chest protocols on that, what he
24 was called out, the report was chest pains. When he gets
25 there, what he is using to explain to the patient that he

1 tells us here today is stomach problems can be an
2 indicator for heart problems. You need to go to the
3 hospital and get checked out. But yet he says, "Well,
4 but I didn't need to do the protocols."
5 As was testified by the Board's Investigator, the
6 point of the protocols are Advanced Life Support do not
7 practice medicine. They follow the protocols and
8 procedures.
9 He never testified once that I don't think this is
10 chest pain, picks up the phone and calls the supervising
11 physician. Never happened. He makes the argument to the
12 patient. He persuades the patient. He talks the patient
13 into going to the hospital because there is a concern
14 about this being masking of a heart problem. But then he
15 doesn't connect that well, if it's masking a heart
16 problem and there is a heart issue here, then you have to
17 follow the protocols. That's what it says Aberdeen has a
18 problem with. His explanation is, "Oh, no, my partner
19 went in and told him it was chest pains." I don't know.
20 I know what he testified to, which was he was using the
21 issue that is a possibility you're having a heart attack,
22 and then in the next breath he says, "But I didn't need
23 to follow the chest pain protocols." That's a non
24 sequitur. I think even as lay people you can see that if
25 you're arguing with somebody you may be having a heart

1 attack, that's going force you to go into the chest pain
2 protocols.
3 I don't know if -- I tried to give him every
4 opportunity to explain how if you're making the argument
5 you need to go to the hospital because you can have a
6 heart attack, that doesn't make you go into the
7 protocols. I don't know if he just doesn't see the
8 connection, which would be problematic, because he is
9 supposed to be making those connections.
10 His explanation for Minnesota, I'm not real sure that
11 I fully understand what he was trying to communicate
12 other than he was trying to tell us that Minnesota is
13 okay with everything that he has done and that they would
14 license him and that he seems to be in good standing with
15 them. But we have a document that says he did not
16 disclose the reprimand from South Dakota and they had him
17 voluntarily surrender his license and they will not let
18 him work. But his explanation surrounding it is, "Hey,
19 it's all okay, it's no big deal."
20 We're sitting here today saying we don't think he
21 should have a license because his initial license,
22 Application, the Board didn't take any discipline because
23 of the employment verification. They looked at it and
24 said, "Hey, what's your explanation," and let him go. On
25 the Renewal Application, Protection Orders are a big

1 deal. They investigated it and they found that there was
2 very serious allegations behind that. But based on the
3 investigation, there was a reprimand. There is a
4 conversation with the Board's Investigator which walks
5 him through and says, "These are the ones that you're
6 supposed to be answering, this is why."
7 The next renewal there is clearly written
8 disciplinary action from Aberdeen, having just been
9 reprimanded for not disclosing things in the last
10 Application, is just finishing up right before renewal,
11 we have another didn't disclose. From that investigation
12 and actually looking at the reasons that he is terminated
13 and you go back to the very beginning and you follow this
14 path all the way through and listening to him today, he
15 always has a very different story from what the
16 documentation is or from what a person would perceive.
17 If the State is going to force you to give up your
18 license, they clearly are not okay with your story. They
19 clearly have a problem with you or he would still have a
20 Minnesota license. For him to testify today that
21 everything seems to be okay with them is completely and
22 totally opposite ends of their actions.
23 That's the pattern we have here, is that what he
24 perceives is going on and the documentation that the
25 Board has received and the behaviors that results from

1 them don't match. There is a real concern about him
2 being able to link those together.
3 It would be easy for me to argue that he is not being
4 truthful on all these different applications. I'm not
5 making that argument. I'm concerned that he is either
6 not making the cognitive jump from this question means I
7 need to disclose this. And then when he gets in trouble,
8 usually if somebody touches a hot stove they know that
9 you don't go back for a second one. We barely finished
10 the investigation and he's back again and he surrenders
11 his license. And then he goes to Minnesota and does the
12 same thing again.
13 There seems to be a problem with the learning curve
14 here. Now, I asked the questions about the learning
15 disability and whether or not he disclosed that to this
16 Board previously and I want to make sure that the record
17 is really clear. That had never been disclosed to the
18 Board, it had never been discussed. This is the first
19 time that issue has come up. Having a learning
20 disability is not something that's ever going to bar a
21 person in front of this Board. Being able to perform the
22 functions of the job and being able to be licensed
23 appropriately, one of the things a person has to be able
24 to do is fill out that Application and answer the
25 questions. We have three separate examples or four

1 examples at this point in time where there is a
2 difficulty with that.
3 So we have the issue of being able to fill out the
4 Application, and then we have also his interpersonal
5 relationships with the people that he is working with,
6 and then we have a pattern of not following the
7 protocols. I struggle with a lot of this because what he
8 testifies to are diametrically opposed.
9 I don't have any scope of what he is claiming in his
10 learning disability, but yet he tells us he wrote the
11 protocols for different ambulance services. My reading
12 of statute and laws in the State of South Dakota is
13 physicians write protocols. They are the ones that put
14 them in place. They are orders from doctors. Now, maybe
15 he is writing them and some doctor is adopting them and
16 signing them. I don't know. But if we're talking
17 comprehension, learning comprehension, and then we're
18 talking about drafting protocols and standing orders for
19 physicians, that seems to be diametrically opposed to
20 each other. Which fits a lot of what we heard him
21 testify to, which was everything was wonderful at my
22 employment, I have no idea why they went ahead and sent
23 in something derogatory to the Board. I did everything
24 right on the call out. They shouldn't have been writing
25 me up. These don't match up and they don't make sense.

1 In an application procedure the burden is on the
2 applicant to show good moral character and competency. I
3 think on record before the Hearing Examiner we have an
4 absence of that and because of that, his Application
5 should be denied. Thank you.
6 HEARING EXAMINER HENRY: Thank you, Mr. Golden. Go
7 ahead, Counsel.
8 MR. KROON: Whatever David Starner has done, it
9 certainly doesn't deserve a professional death penalty.
10 If you look at these instances individually, and you had
11 an opportunity to listen to his testimony today, this is
12 a guy that, one, clearly has difficulty with renewal
13 applications and licensing applications. Either he reads
14 too much into them, doesn't read enough into them, but
15 there is certainly no indication that he did so to hide
16 any information. None whatsoever. There is no
17 motivation for him to do that.
18 With respect to Minnesota, he understands -- he
19 testified he understands how the National Data Bank
20 works. I mean he would have known that even if he didn't
21 disclose it, they were going to find out about it. So
22 there was absolutely no motivation for him to hide that.
23 You know, in the future he needs someone sitting down
24 beside him to help him work through those applications.
25 But in and of themselves, I don't think that ought to

1 justify taking away his livelihood or the thing that he
2 is very good and very passionate about.
3 If you look at Aberdeen, individually he was
4 counseled I will say for failing to put on his gloves
5 quick enough when he arrived at a scene. Now, in his
6 mind he is saying, "Really, that's something I have to
7 disclose in an Application?" And maybe the Board takes
8 the position that yeah, you should. But he is not law
9 trained. He is someone that's trying the best he can to
10 comply. But he doesn't think that not wearing gloves is
11 something that he has to disclose. You look at the
12 instances of dissatisfaction from Aberdeen. And you
13 know, whether it was because of a personality conflict
14 with his supervisor or not, I'm not sure it matters in
15 the end. But not wearing protective gloves quick enough
16 certainly isn't a reason to deny the guy a license. When
17 he was counseled about that, he did exactly what they
18 wanted.
19 Concerning taking a wrong turn on a run. He
20 testified it happens all the time. You don't want that
21 to happen, but it's going to happen. Was there any
22 damage to the people, any harm that resulted in that?
23 No.
24 The issue with the cardiac or the chest pain
25 protocol. You know, the reason it took 45 minutes to get

1 this patient to the hospital is Mr. Starner went above
2 and beyond trying to talk a patient to go to the
3 hospital. The guy didn't want to go to the hospital. He
4 is recognizing the fact that there could be complications
5 here. He is the guy that talked him into going to the
6 hospital. Now, in his mind it's a chest pain protocol.
7 It's not a potential heart attack protocol. He is
8 reading that very literally. If there is not chest pain,
9 and he testified that the guy denied chest pain, in his
10 mind he doesn't have to follow the protocol. Was it a
11 judgment call? Absolutely. But again, the patient
12 walked out of the hospital, went home, slept that night
13 45 minutes after he went into the hospital. In and of
14 itself these things probably happen every day out there.
15 But that's not a reason to take his license away. He
16 tried to comply with the protocol. He said, you know, he
17 understood, at least in his mind not believing that there
18 was chest pain, he didn't think he had to comply with the
19 protocol.
20 His employment in Lisbon, the employment verification
21 came back and said he didn't get along with others, there
22 was a narcotics protocol violation. You talk to the
23 people up in Lisbon, they loved him. They thought it was
24 a loss to the community when he left. The supervisor or
25 his supervisor of where he worked in Lisbon sent him a

1 letter, sent a letter of recommendation saying that he is
2 excellent, he got along with people, his medical skills
3 were excellent. So again, in his mind he knows he is
4 well liked up there by everybody and so in his mind these
5 things that come back on an employment verification don't
6 seem significant. In his mind he is thinking this is
7 just something that's in the personnel file. Yeah, I
8 screwed up on a number on the narcotics registry. That
9 happens. I didn't do it again, there was no evil will,
10 no evil intent. It wasn't that big a deal up there.
11 I mean surely you can't disqualify this guy from
12 practicing what he loves even if he doesn't get along
13 with others, which I don't think the record supports.
14 Even if he doesn't get along with others, I don't think
15 that's a reason to deny this guy's license. I mean if
16 that were the case, half the doctors in the United States
17 wouldn't be able to practice medicine.
18 So I think the record indicates that he tried to
19 complete the applications and renewals in good faith, he
20 discharged his duties in Lisbon and Aberdeen in good
21 faith, and tried to follow the protocols in good faith.
22 We are debating whether or not he followed the protocol.
23 If you read the protocol which is in the record, it says,
24 "Chest pain protocol." It does not say, "Suspected heart
25 attack protocol." So we're certainly not conceding that

1 he failed to follow any sort of protocol. The employer
2 obviously thought he did. But that's not what the
3 protocol says.
4 So you have got a gentleman here that in the future I
5 think will do a better job accurately completing the
6 applications. His employment, if you look at each place
7 where he was working, he did a good job. I mean he may
8 have got crosswise with the guy up in Aberdeen. He was
9 on probation. Right or wrong, there were three things in
10 the file to justify the termination. But there is
11 nothing individually that suggests he is not a competent
12 paramedic. There is nothing that suggests that his
13 competency is in question here.
14 Failing to wear -- I mean he was taught not to put
15 gloves on until he gets to the scene. That's not a
16 justification.
17 One instance where there is a dispute of judgment
18 over whether or not he should have followed a protocol is
19 not a basis to deny this guy's livelihood and his
20 passion.
21 So we think we have demonstrated that he has the
22 moral capability, the competency to continue. You know,
23 this is a guy that's very passionate about what he does.
24 By all accounts he is very good at what he does. We just
25 don't think that there is anything here to justify taking

1 away his license.
2 HEARING EXAMINER HENRY: Very well. With expedience
3 in mind, and not that I'm arguing that that should be the
4 way we go, are you okay with that, Mr. Golden or would
5 you like to have a rebuttal?
6 MR. GOLDEN: I think I will decline.
7 HEARING EXAMINER HENRY: Very well. Is there
8 anything else that either party deems necessary at this
9 point so that we can say that we have had this full and
10 fair hearing? Anything by either party that we haven't
11 covered here as a last gap, last chance?
12 MR. KROON: May I have a moment?
13 HEARING EXAMINER HENRY: Yes.
14 MR. KROON: Would it help at all to submit a short
15 brief, a written summary if it were submitted within the
16 next few days?
17 HEARING EXAMINER HENRY: You're welcome to submit a
18 supplemental brief, either party is welcome to submit a
19 supplemental brief. It's not mandatory. If you wish to
20 submit one, a week is fine.
21 MR. KROON: Seven days? That would be good. And if
22 we don't choose to do that, I will advise everybody.
23 HEARING EXAMINER HENRY: Very well.
24 MR. KROON: Thank you.
25 MR. GOLDEN: I think the Board has already submitted

a brief on this one.

HEARING EXAMINER HENRY: Very well. With nothing else then, that will close the matter at this juncture. What happens next is I will get a record and along with that a copy of the exhibits. I will take any supplemental briefs that you may have. And then as your Hearings Examiner I will author Findings of Fact, Conclusions of Law, and issue my recommendation to the Board. The Board will consider it at a later time. Thank you. Thank you both for good arguments, a good presentation of the case. Everybody have a good day.

(Whereupon, the proceedings were concluded at 1:00 p.m.)

* * * * * * * * *

STATE OF SOUTH DAKOTA)
: CERTIFICATE
COUNTY OF LINCOLN)

I, Terri Lembcke Schildhauer, Registered Professional Reporter and Notary Public in the above-named County and State:

Do hereby certify that the witnesses in my presence were first duly sworn by me to testify to the truth, the whole truth, and nothing but the truth relative to the matter in hearing; that the witnesses appearing telephonically were first duly sworn by the Hearing Examiner to testify to the truth, the whole truth, and nothing but the truth relative to the matter in hearing; and that the foregoing pages 1 - 116, inclusive, are a true and correct transcript of my stenotype notes made during the time of the proceedings of the South Dakota Board of Medical and Osteopathic Examiners.

I further certify that I am not a relative or employee or attorney or counsel of any of the parties or a relative or employee of such attorney or counsel, and that I am not financially interested in this action. In testimony whereof, I have hereto set my hand this _____ day of October, 2014.

_/s/Terri Lembcke Schildhauer___
Terri Lembcke Schildhauer, RPR
Registered Professional Reporter
and Notary Public
My Commission Expires: 7/19/17

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SOUTH DAKOTA
BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

SDBMOE
101 N MAIN AVE, SUITE 301
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SDBMOE@STATE.SD.US
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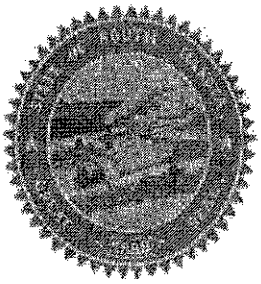

Sent Via Electronic Mail

November 26, 2012

David Starner
1416 10th Avenue SE
Aberdeen, SD 57401

David:

You indicated all "no" answers to the disclosure questions on your application for South Dakota Medical License. Since the receipt of you application, we have received information that conflicts with the answers you provided. Please submit a detailed statement to the Board explaining each of the following discrepancies and why you did not report them in your application.

- Employment verifications have been received stating:
  - You were verbally reprimanded for not following narcotic control policy.
  - You have a very difficult time accepting policy and protocols you disagree with.
  - You did not get along with other staff members and a personal relationship with a co-worker caused issues as well.

Please see the attached Affidavit and Authorization for Release of Information you signed for your application.

Sincerely,

Randi Sterling

Randi Sterling
Licensing Specialist

IN RE
DAVID STARNER
september 26 2014
9-26-14 01 TLS

November 28th 2012

Randi,

I am surprised at the allegations that have come from my previous employer about my work performance. I am having a difficult time and at a loss as to where to begin. I tried to call you Monday, November 26th 2012 to get some clarity and a place to start.

I have made several phone calls to try to clear some of this up. I talked to Ed Gregoire, (State EMS Training Coordinator), who was unaware of any problems with me and my previous employer. He took the time to look up my profile and again said that its "clear" without any infractions.

I talked to my supervisor, Rob Senger and informed him on the letter I received from you. I also forwarded a copy to him. Rob made a very good point, "Why did the City of Aberdeen hire me if these accusations where true"? Or at least the City would have made an attempt to get some clarity on these issues prior to my hiring.

I truly believe these accusations are due to my leaving First Medic Ambulance. Prior to my resignation letter, everything at work was great. I got along with everyone I worked with. I would have co-workers over for breakfast and coffee after we did our rig checks. We would get together on our days off and hang out. When I gave my resignation letter, (I have saved a copy if needed for verification and/or documentation), most of my co-workers, including my manager, Vicki Berreth, treated me very differently. We did not hang out any more. They in fact made it well known that they thought I was abandoning them. Vicki was very upset and in fact didn't talk to me until my last day at work and that was via text message (I have saved the text messages if needed for verification and/or documentation).

Randi, the following are the accusations against me that you wanted explanations for...

- Employment verifications have been received stating:

1) **<u>You were verbally reprimanded for not following narcotic control policy.</u>**
   I made one narcotic documentation error. At every shift, in the morning, we sign off the narcotics stating they are all there. The narcotics are locked up and sealed with a tag which has numbers on it. When I signed off on the narcotics, I wrote down the last number incorrectly. I put down a "5" instead of an "8". There were never any missing narcotics. Vicki explained to me the importance of taking the time to make sure I write down the correct tag numbers. I understood and haven't had a problem since. That is the only case with narcotics that I can think of.

IN RE
DAVID STARNER
september 25 2014
9/26/14 02 TCS

2) **You have a very difficult time accepting policy and protocols you disagree with.**

I am at a loss here. No idea where this came from. In fact, First Medic asked me to rewrite and update our protocols. My work in writing the protocols didn't go unnoticed. The State of North Dakota hired me to be a part of a committee to write the State EMS protocols.

3) **You did not get along with other staff members and a personal relationship with a co-worker caused issues as well.**

I am speechless to say the least. As I stated above, up until the point I turned in my resignation letter, we all got along great. In fact, I considered most of my co-workers friends especially Vicki. She and I would sit for hours and just talk and hang out. But again, once I gave my notice that I am leaving First Medic, the people whom I thought were my friends, no longer wanted anything to do with me. The relationship between Vicki and I was as if we never knew each other.

I am not sure what else to say here. Please email or call me if you have any questions or if I can be of any more help in clearing this up. I am willing to get letters or support statements, or even provide telephone numbers of people you can call to verify the above accusation are in fact false. I am very concerned with any type of "black mark" on my name, and that I will do whatever it takes to get this information removed from my file as it is all false and I feel it is a defamation of my character.

Thank you for your time and consideration in this matter.

Sincerely,

David R. Starner Jr

djstarner@yahoo.com

626-806-0369

SOUTH DAKOTA
BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

EXHIBIT #3

SDBMOE
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HTTP://WWW.SDBMOE.GOV

March 4, 2013

David Starner
1416 SE 10th Ave
Aberdeen, SD 57401

SHIPPED MAR 0 5 2013

Dear Mr. Starner:

I am the Board Investigator for the South Dakota Board of Medical and Osteopathic Examiner's Investigative Review Panel. On your application for licensure you failed to disclose that you were the subject of two investigations of sexual assault and that you were the subject of a protection order. Due to these reasons, your license has been placed under investigation.

Please be aware of the following:

1. You have the right to contest the recommendation at an administrative hearing which will be conducted in accordance with SDCL 1-26. This matter will be presented to a neutral administrative judge.

2. You have the right to be represented by an attorney of your own choosing at the administrative hearing if you so desire.

3. The recommendation of the administrative judge will be referred to the South Dakota Board of Medical and Osteopathic Examiners. The Board may accept, reject or modify the recommendation.

4. If you participate in a hearing, you would then have the right to file an appeal to Circuit Court.

Notification that an investigation has been initiated can be disconcerting, and your first inclination may be to call the office to ask for details or discuss the matter. We respectfully request that you refrain from calling as the Board's policy for maintaining the confidentiality of all investigations prohibits the discussion of investigations over the phone. Should you have questions or concerns, please send them in writing by US mail, or you may send an email to SDBMOE@state.sd.us.

Thank you for your cooperation in this matter.

IN RE
DAVID STARNER
september 28, 2014
9/26/14 03 725

Sincerely,

Board Investigator

EXHIBIT #3

SOUTH DAKOTA
BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

SDBMOE
101 N MAIN AVE, SUITE 301
SIOUX FALLS, SD 57104
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P 605-367-7781 F 605-367-7786
HTTP://WWW.SDBMOE.GOV

March 4, 2013

David Starner
1416 SE 10th Ave
Aberdeen, SD 57401

Dear Mr. Starner:

As you are aware, your paramedic license has been placed under investigation.

Please provide a detailed and complete explanation as to why you failed to disclose on your application that you were accused of sexual harassment on two separate incidents in Grant County and Ottertail County and the fact that you are the Respondent to a protection order.

This detailed and complete explanation should not only explain why you failed to disclose the incidents but also explain the incidents themselves.

Sincerely,

Ted Huss
Board Investigator

EXHIBIT #4

March 12, 2013

Ted Huss
Board Investigator
SD Board of Medical & Osteopathic Examiners
101 N. Main Ave., Suite 301
Sioux Falls, SD 57104

Dear Mr. Huss,

I have reviewed my License Application for SDBMOE (***License application# 12996)***. As far as I can discern, the only disclosure requirement that I may have failed to disclose on my application would have been # 13 under "required disclosures"...

> 13) ***Been accused of or been disciplined, found liable, guilty, or responsible for sexual impropriety, sexual harassment, disruptive or discriminatory behavior?***

... been accused of sexual impropriety: When I filled out this application and specifically #13 (my best guess to what I may have failed to disclose), I interpreted and believed that the accusations would have needed to have come from law enforcement or related to my work. As far as I can tell, there is no other place on the application where this would need to have been disclosed. I did not believe that an accusation by an individual woman, that is not work related, and has not been charged as an offense, was something that I needed to disclose. Any woman could accuse me of sexual impropriety and the fact that she happened to go to law enforcement claiming this. Law enforcement and the county attorney after investigation dismissed it as untruthful. I was told that there was going to be no further proceeding. Mr. Huss, I believe I was truthful and honest when I turned in my application. Below I will explain more in detail about the situation and if you have any further questions, please let me know.

I cannot find in the application that would specifically require me to disclose that I am a subject of an OFP. The facts are that I do have a protection order against me. The Sheriff of Grant County told me that nothing further was going to be done with this order of protection and that this was her way to try to save her marriage. I was informed by the Sheriff of Grant County that they and the County Attorney was not going to proceed further after their investigation and that the Sheriff's department was closing its file on the case. I simply did not appear at Restraining Order hearing because I simply had no reason to ever need to see this person again. Now that I have found that it might adversely affect my employment, I will go back into court and seek to have the Restraining Order removed.

EXHIBIT #4

In short, I had consensual sexual relationship with this woman on a weekend which latter she later told her husband that she had been sexually assaulted by me. Keep in mind; I have been completely absolved by law enforcement and by the County Attorney from these accusations. I was told by the Sheriff of Grant County that there was no truth to her allegations and that the investigation was over. I was never accused by anyone other than her and I have text messages from her proving that she is not being truthful. Again, I did not object to the Order for Protection because I simply believed that it would be the best way to let things resolve without any conflict. When I looked at disclosures, I didn't feel that would mean that any woman in the world could have made an accusation against me and that I would have needed to disclose the OFP. The Sheriff and County Attorney of Grant County did their investigation, brought in witnesses, got theirs and my testimonies, reviewed and recorded the text messages and voice message from her (messages asking me to lie about what happened that night), and in the end, they completely absolved me from all these accusations. After I was absolved from the law, I was given an Order for Protection with an option to appeal. As I stated before and advised by the Grant County Sheriff, that this wouldn't be on my record, nothing would come of this in the future, and I decided to let it go and not appeal it.

As far as there being 2 separate instances of sexual harassment, one in Ottertail County and the other in Grant County. I am unaware of 2 separate instances of sexual harassment. I have hired a lawyer to remove the order of protection and protect me from any further damages. My lawyer advised me there is one case on record (never charged or found guilty by the law) where I have been accused of sexual harassment not two separate cases. My lawyer stated they believe that she may have filed a Complaint in both Grant County and Ottertail County (she lives in Ottertail County). Ottertail County likely told her that the complaint had to be filed in Grant County because that is where the incident took place.

I have hired a lawyer to appeal the restraining and see if we can get that removed. If you have any further questions, or would like to speak to myself or my lawyer, please feel free to call or email me.

David Starner

License Renewal - Paramedic License

Number: EMTP 1668 Renewal Tracking # 36743 Submitted on: 6-17-2013

Name Information

DAVID ROBERT STARNER, EMTP

Alternates *None reported.*

Address

Type	Work Address
Public?	N
Name/Attention	Aberdeen Fire & Rescue
Address	121 Second Ave SE Aberdeen, SD 57401

IN RE
DAVID STARNER
september 26 2014
9/24/14 05 TLS

	****Default****
Type	Home Address
Public?	N
Name/Attention	
Address	1416 10th Avenue SE Aberdeen, SD 57401

Phone and Email

Home	**626-806-0389**	
Work	**605-626-7048**	
Home	**djstarner@yahoo.com**	****Default****

Identification

Date of Birth	3-15-1976
Birth Place	Willmar, MN UNITED STATES
	Gender:M **SSN:**XXXXX3177 **NPI:**
US Citizen	Y

Practice Information

1. Would you say you work primarily in South Dakota (more than anywhere else)?	Y
2. If not working in South Dakota, in which states do you practice?	
3. Are you currently practicing?	Y
4. Are you retired?	N
5. Current Employer / Company / Ambulance Service	Aberdeen Fire and Rescue
5.a,b,c Supervisor Name and contact info	Todd Salfrank **PH:** 605-626-7051 **Email:**

Continuing Education Compliance (36-4B-27)

I have completed the number of required hours of board approved post-graduate studies within the last twelve months, as required by South Dakota Law.

Required Disclosures

In the past year, or since your last renewal:

*01 Is this a true statement for your licensure? "My licensure has not experienced adverse action."	N

Explanation:I have been dealing with Ted Huss, Board Investigator for SD Board of Medical & Osteopathic Examiners. I have recently signed consent agreement with reprimand for failed to disclose to the Board accusations and that I am the Respondent to a Restraining Order on my paramedic license application.

*02 Is this a true statement for you? "I have not experienced adverse action." N

Explanation:I have been dealing with Ted Huss, Board Investigator for SD Board of Medical & Osteopathic Examiners. I have recently signed consent agreement with reprimand for failed to disclose to the Board accusations and that I am the Respondent to a Restraining Order on my paramedic license application.

*03 Has your licensure been subject to any complaint, investigation or proceeding involving any entity? Y

Explanation:I have been dealing with Ted Huss, Board Investigator for SD Board of Medical & Osteopathic Examiners. I have recently signed consent agreement with reprimand for failed to disclose to the Board accusations and that I am the Respondent to a Restraining Order on my paramedic license application.

*04 Have you been subject to any complaint, investigation or proceeding involving any entity? Y

Explanation:I have been dealing with Ted Huss, Board Investigator for SD Board of Medical & Osteopathic Examiners. I have recently signed consent agreement with reprimand for failed to disclose to the Board accusations and that I am the Respondent to a Restraining Order on my paramedic license application.

05 Have you been dishonorably discharged from a branch of the United States military or National Guard? N

06 Have you had any adverse action during any education, residency or training program N

07 Have you had adverse action with your membership or privileges with any entity regarding your ability to participate in any health related program? N

*08 Have you been subject to a criminal or civil complaint, investigation or proceeding other than minor traffic offenses? Y

Explanation:I have been dealing with Ted Huss, Board Investigator for SD Board of Medical & Osteopathic Examiners. I have recently signed consent agreement with reprimand for failed to disclose to the Board accusations and that I am the Respondent to a Restraining Order on my paramedic license application.

*09 Have you had a complaint, investigation or proceeding in any manner concerning sexual impropriety? Y

Explanation:I have been dealing with Ted Huss, Board Investigator for SD Board of Medical & Osteopathic Examiners. I have recently signed consent agreement with reprimand for failed to disclose to the Board accusations and that I am the Respondent to a Restraining Order on my paramedic license application.

10 Is this a true statement for you? "I have not been reported to NPDB (National Practitioners Data Bank) or HIPDB (Healthcare Integrity and Protection Data Bank)."	Y
11 Is this a true statement for you? "I have experienced no adverse action in privileges at any hospital, clinic or health related entity."	Y
12 Have you had any claims paid by you or paid on your behalf for any reason?	N
13 Have you had any liability insurance company, including malpractice carriers, change, deny or cancel your coverage?	N
14 Have you stopped working or practicing for any period of time greater than or equal to 30 consecutive calendar days?	N
15 Do you have a physical, mental or emotional condition which may adversely affect your practice?	N
16 Have you been treated for or do you have a diagnosis for any Mental Health condition. (If yes, please ask your treating provider to send a status letter to the Board office).	N
17 Does your use of alcohol or drugs affect your ability to provide appropriate care to patients?	N
18 Are you currently using illegal drugs or prescription controlled medications in an illegal manner?	N

TERMS AND CONDITIONS:

REGARDING DEADLINES AND LICENSE EXPIRATION:

Important Dates:

- Statutory Suspension of License Date: **7-15-2013**

AUTHORIZATION AND RELEASE:

Any references to the terms "Users" or "Users of this Application" in this authorization shall include the following entities:

- The South Dakota State Board of Medical and Osteopathic Examiners together with its board members, staff members, legal counsels, investigators
- agents, employees, contractees, and authorized representatives hereinafter collectively referred to as SDBMOE;
- Any other state or national medical licensing, medical reporting or medical regulatory board;
- The Federation of State Medical Boards;
- Any other South Dakota or United States agency in furtherance of and incompliance with SDBMOE's duties and responsibilities under my South Dakota Medical Practices Act and its administrative regulations.

I am the person described herein. I have not engaged in any acts prohibited by the criminal or medical statutes of the State of South Dakota. I am the person named on any diploma or certificated that I have received, I am the lawful holder of said diploma or certificate, and the diploma or certificate was given to me in the regular course of instruction and examination without fraud or misrepresentation.

HIPAA AUTHORIZATION: Per 45 CRF 164.512, the Privacy Rule permits covered entities to disclose protected health information without authorization for specified public health purposes. The South Dakota Board of Medical and Osteopathic Examiners, as a health oversight agency, is legally authorized to receive protected health information without authorization for health oversight agency purposes.

THIRD PARTIES:
(The following deals with SDBMOE consulting with and receiving information from third parties.)

I authorize SDBMOE to consult with any third person or party who may have information or evidence concerning my professional, ethical, mental and physical qualifications, or any other matter that SDBMOE deems relevant regarding my continuing qualifications for licensure with SDBMOE. These third persons and parties include hospitals, institutions or organizations, my references, physicians, therapists, previous and present employers, past and present business and professional associates, and local, state, federal or foreign governmental agencies and instrumentalities, courts of any jurisdiction, associations, institutions or law enforcement agencies, together with their representatives thereof, who have custody or control of any documents, records, information or evidence that SDBMOE deems relevant to my renewal application.

I authorize such third persons and parties to unconditionally release to SDBMOE any such information, including documents, records regarding charges or complaints filed against me, formal, or informal, pending or closed, or any other pertinent data or evidence whether favorable or unfavorable that SDBMOE deems relevant to licensure, and to permit the SDBMOE to inspect, receive, and make copies of such documents, records, evidence, medical records and other information for SDBMOE's evaluation of my professional, ethical, mental and physical qualifications that SDBMOE deems relevant to licensure.
I release, discharge and exonerate from any and all claims, damages and liabilities whatsoever such third persons and parties, together with their authorized representatives, who in good faith and without malice, consult with and release to SDBMOE such information, evidence, files or records requested by SDBMOE that SDBMOE deems relevant to licensure.

AFFIDAVIT:
I, the applicant for licensure with the South Dakota State Board of Medical and Osteopathic Examiners (SDBMOE), state that I am the applicant in the above application, that I have read the foregoing application and releases and know the contents thereof, and I unconditionally declare and affirm under the penalties of perjury that the statements made in this application been examined by me, and to the best of my knowledge and belief, are in all things true and correct. I further state that should I furnish any false information in this application, such act shall constitute cause for the denial, suspension or revocation of any license issued to me by the South Dakota State Board of Medical and Osteopathic Examiners.

Signed:

David Starner 3/15/1976

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Definitions:

All questions use the following definitions whether actions were formally, informally, voluntarily or involuntarily committed: Questions refer to both you and your licensure.

A. **Adverse Action** shall refer to having been terminated, stipulated, restricted, limited, conditioned, counseled, reprimanded, suspended, revoked, refused, denied, not renewed, withdrawn or relinquished.

B. **Claim(s)** shall refer to any malpractice, administrative, civil, or criminal final judgments including any pending claims, lawsuits, judgments, and/or settlements.

C. **Complaint** shall refer to any communications which express concerns, warnings or dissatisfaction about personal or profession conduct and rising to the level that the meetings or comments are documented in a written or digital format.

D. **Entity** shall refer to any licensing or disciplinary board, professional agency or committee, academic program, clinic, hospital, or other health-related entity, or governmental agency or organization.

E. **Health related program** shall refer to private or public insurance, Medicare and Medicaid.

F. **Illegal use of drugs** shall refer to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. sec. 812.22. The term does include the unlawful use of prescription controlled substances. It does **not** include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal law.

G. **Investigation** shall refer to any formal or informal inquiry to acquire and examine facts.

H. **Licensure** shall refer to type of licensure and using any licensure nomenclature such as any registration, permit, certificate, and license. Examples include the subject of this application, DEA registration, etc.

I. **Minor traffic offense** shall refer to any violation which is punishable by a maximum of 30 days in jail, a $500 fine or both and does not result in a change of driving privileges.

J. **Proceeding** shall refer to whether you have appeared or been requested to appear in private or in public, for a meeting, counseling, hearing, administrative, civil or criminal actions, or been questioned, reviewed, charged, arrested, plead guilty, plead no

contest, convicted, received a suspended imposition of sentence or suspended sentence by any entity.

K. **Sexual impropriety** shall refer to misconduct including but not limited to discrimination, complaint, assault, the possession of child pornography, sexual contact with patients or other acts, expressions or gestures that disrespect privacy and are demeaning.

L. **You** shall refer to you or any licensure held by you.

THE SOUTH DAKOTA BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

****

Re: DAVID R. STARNER, EMT/P FINAL ORDER

****

The above-entitled matter having come before the South Dakota Board of Medical and Osteopathic Examiners ("Board"), and the Board having been fully advised in the premises thereof;

NOW; THEREFORE, the Board hereby:

APPROVES the Consent Agreement with Reprimand and this Final Order, and directs that the Consent Agreement with Reprimand and this Final Order are public records of the Board and the State of South Dakota and shall be published on the Board's website and reported to the national data banks and any other entity deemed appropriate by the Board and in compliance with State and Federal law.

By: _____ Date: 6/26/13
Mary S. Carpenter, MD
South Dakota Board of Medical and Osteopathic Examiners

STATE OF SOUTH DAKOTA } S.S.
MINNEHAHA COUNTY
I hereby certify that the foregoing instrument is a true and correct copy of the original as the same appears on the record in my office.
Executive Secretary
By MBH
Date 6-27-13

IN RE
DAVID STARNER
September 26 2014
9/26/14 06 TLS

SOUTH DAKOTA BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

****

CONSENT AGREEMENT
WITH
REPRIMAND

In re: DAVID ROBERT STARNER

****

CONSENT AGREEMENT

IT IS AGREED by the South Dakota Board of Medical and Osteopathic Examiners (the Board) and David R. Starner, EMT-Paramedic, (Mr. Starner) as follows:

Mr. Starner failed to disclose to the Board accusations and that he is the Respondent to a Restraining Order on his paramedic license application.

Informal Agreement: It is the intent of the parties to this Consent Agreement with Reprimand to provide for the informal compromise and settlement of all issues which could be raised by a formal contested hearing. This agreement will be presented at a future Board meeting where the Board may accept, modify or reject the agreement.

Waiver of Rights: Mr. Starner understands he has the right to consult with an attorney of his own choosing and has a right to an administrative hearing on the facts in this case. He understands and agrees that by signing this Consent Agreement with Reprimand, he is waiving his rights to counsel and to a hearing. He further understands and agrees that by signing this Consent Agreement with Reprimand he is voluntarily and knowingly giving up his right to present oral and documentary evidence, to present rebuttal evidence, to cross-examine witnesses against him and to appeal the Board's decision to Circuit Court.

Consent Agreement with Reprimand: Mr. Starner agrees that the Board has the authority to enter into this Consent Agreement and to issue the following Reprimand:

REPRIMAND

The Board hereby reprimands you, David R. Starner, EMT-Paramedic, for failing to disclose to the Board accusations and that you are the Respondent to a Restraining Order on his paramedic license application.

It is agreed that this Consent Agreement with Reprimand shall take effect immediately, and it is a public record of the Board and the State of South Dakota. It shall be published on the Board's website and reported to the national databanks and all other entities deemed appropriate with the Board in compliance with state and federal law.

STATE OF SOUTH DAKOTA } S.S.
MINNEHAHA COUNTY
I hereby certify that the foregoing instrument is a true and correct copy of the original as the same appears on the record in my office.
Executive Secretary
By MGH Jay JTP
Date 6-27-13

Mr. Starner has unconditionally accepted this Consent Agreement with Reprimand by affixing his signature to this document.

By: _____ Date: 6-7
David R. Starner

By: _____ Date: _____
Attorney for Mr. Starner (optional)

SOUTH DAKOTA BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

By: Walter O. Carlson, MD Date: 6/26/13
Walter O. Carlson, MD
Board Member, South Dakota Board of Medical and Osteopathic Examiners

Emergency Phone: 911

Aberdeen Fire Rescue
Office: (605) 626-7048
Fax(605) 626-3529
Aberdeen Advanced Care Ambulance
Business Office (605) 626-7045
Routine Calls (605) 626-7048
Fax: (605) 626-3518

Fire Prevention
(605) 626-7024

121 2nd Ave. S.E.
Aberdeen SD 57401 4209

ABERDEEN FIRE RESCUE
ABERDEEN ADVANCED CARE AMBULANCE

Kevin VanMeter, Fire Chief

August 15, 2013

DELIVERED AUG 19 2013

David Starner
1416 10th Ave SE #3
Aberdeen, SD 57401

Dear David:

This letter will serve as official notice of termination of employment with the City of Aberdeen, effective immediately. The reason for this termination is failure to successfully complete your probationary period.

Sincerely

Kevin VanMeter
Fire Chief

IN RE
DAVID STARNER
september 25 2014
9/26/14 07 725

An Equal Opportunity Employer

ABERDEEN FIRE & RESCUE

COACHING & COUNSELING

EMPLOYEE: *David Starner*

DATE: *January 17,2013*

1. *Inform Employee of problem.*

PROBLEM: David has issues of following orders and showing attitude towards FTO's particularly in treatment of patients in following Aberdeen Fire and Rescue procedure and protocols. Secondly, at no times will there be any unnecessary prolong discussion of treatments that challenges the FTO decisions in front of patients.

2. *Guide Employee to resolve issue.*

RESOLUTION: A follow up discussion evaluating each call will take place. Secondly, if issues arise employee will be advised in a reasonable amount of time. Finally, more formal instructing of employee will take place.

3. *Give Employee a time frame for change.*

DURATION OF MODIFICATION: February, 18, 2013 a reevaluation will be conducted by FTO, EMS coordinator and Battalion Chief.

4. *Follow up; 10 days or more, on progress (advise date of follow-up).*

DATE FOR FOLLOW-UP: January, 31 2013

5. *Have both Supervisor and Employee sign and date.*

SIGNING DOES NOT IMPLY AGREEMENT WITH ABOVE BUT MERELY THAT THE CONTENTS HAVE BEEN MADE KNOWN TO ME AND DISCUSSED.

SUPERVISOR: _____

EMPLOYEE: DS 76 _____

Personnel
8-29-07

ABERDEEN FIRE DEPARTMENT

VIOLATIONS
WORK RULES AND REGULATIONS

NAME: David Starner DATE:3/28/2013 TIME: 14:45

REMARKS: David on numerous occasions has not worn the appropriate PPE such as gloves during the exam of patients. This has been reported by coworkers and officers of the department. This has been discussed with David by both Senior Paramedics and Officers of Aberdeen Fire Rescue.

EMPLOYEE: DATE: 4-17-13 SUPERVISOR: DATE: 4/17-2013

SIGNING DOES NOT IMPLY AGREEMENT WITH ABOVE BUT MERELY THAT THE CONTENTS HAVE BEEN MADE KNOWN TO ME AND DISCUSSED.

ACTION TAKEN:

It was discussed with Probationary Firefighter/Paramedic David Starner the importance of following the protocols and policies of the department and the use of appropriate PPE to protect himself. Any further deviation from medical protocol and policies will result in disciplinary action which may include termination

CHIEF'S SIGNATURE

ABERDEEN FIRE DEPARTMENT

VIOLATIONS
WORK RULES AND REGULATIONS

NAME: David Starner DATE: 6/14/13 TIME: 0730

REMARKS: Medic 1 (Langerock / Starner) was dispatched to Elizabeth Drive for a female who was breathing but slow to respond. APD (Kirnan) was on scene initially for welfare check. It took several minutes for Medic 1 to go enroute and arrive onscene. Medic 1 crew states while enroute they were unsure of how to get to the listed address. Medic 1 states they attempted to use State street realizing this was not correct.

Times: Dispatched - 0602:26 Enroute - 0604:56 Arrive - 0613:40

APD Officer did call AFD post medical call and advise concerns of delayed arrival time. Dave was the driver and it was noted that leaving station 1 there was a great deal of time switching the siren tones versus knowing the correct route to take to the medical call.

EMPLOYEE: _____ DATE: 6-17-13 SUPERVISOR: _____ DATE: 6/17/13

SIGNING DOES NOT IMPLY AGREEMENT WITH ABOVE BUT MERELY THAT THE CONTENTS HAVE BEEN MADE KNOWN TO ME AND DISCUSSED.

ACTION TAKEN:

The delayed response was documented and Medic 1 crew was advised to know the location before going enroute. Dave is informed to know the streets in the Aberdeen area better. Dave is also informed he needs to respond enroute to calls quicker. A 2 minutes 30 seconds dispatch to enroute time is unacceptable. Dave also needs to spend less time choosing a siren tone enroute and spend time knowing the correct route to the location of the emergency.

_____

CHIEF'S SIGNATURE

ABERDEEN FIRE DEPARTMENT

VIOLATIONS
WORK RULES AND REGULATIONS

NAME: David Starner DATE: 07/16/2013 TIME: 17:00

REMARKS: FireFighter/Paramedic David Starner failed to follow medical protocol and failed to meet Aberdeen Fire Rescues standard of care. As noted in PCR 1203323 on 07/14/2013 The Patient condition warranted further treatment and the implementation of the chest pain protocol which was not done.

EMPLOYEE: _____ DATE: 7-16-13 SUPERVISOR: _____ DATE: 7-16-2013

SIGNING DOES NOT IMPLY AGREEMENT WITH ABOVE BUT MERELY THAT THE CONTENTS HAVE BEEN MADE KNOWN TO ME AND DISCUSSED.

ACTION TAKEN:

A discussion was had between EMS Coordinator Senger, Shift FTO Rystrom and Firefighter/Paramedic Starner regarding the importance and necessity of following the physician approved medical protocols. Any further violations will result in termination.

_____
CHIEF'S SIGNATURE

Huss, Ted

From:	SDBMOE
Sent:	Tuesday, September 03, 2013 10:35 AM
To:	'djstarner@yahoo.com'
Subject:	Your Response is Urgent
Attachments:	DOC090313-09032013101133.pdf
Importance:	High

Mr. Starner,

Please find the attached letter mailed to you today.

Sincerely,

Ted Huss
Board Investigator
SD Board of Medical & Osteopathic Examiners
101 N. Main Ave., Suite 301
Sioux Falls, SD 57104
Phone 605-367-7781
Fax 605-367-7786
email: SDBMOE@state.sd.us
web site: http://www.sdbmoe.gov

IN RE
DAVID STARNER
September 26 2014
9/26/14 08 TLS

SOUTH DAKOTA
BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

SDBMOE
101 N MAIN AVE, SUITE 301
SIOUX FALLS, SD 57104
SDBMOE@STATE.SD.US
P 605-367-7781 F 605-367-7786
HTTP://WWW.SDBMOE.GOV

September 3, 2013

David Starner
1416 10th Ave SE
Aberdeen, SD 57401

SHIPPED SEP 03 2013

SHIPPED SEP 03 2013

Dear Mr. Starner:

The South Dakota Board of Medical and Osteopathic Examiners received information that you were involuntarily terminated from the Aberdeen Fire Department for failure to successfully complete your probationary period after receiving multiple written warnings. Your response and all data collected during this inquiry are deemed confidential by the Board in accordance with SDCL 1-27-1.5(5).

Please provide your written response to this matter within one week of the date of this letter. Please provide this response by email to SDBMOE@state.sd.us. Thank you for your cooperation, and I anticipate your prompt response.

Sincerely,

Ted Huss
Board Investigator

SOUTH DAKOTA
BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

SDBMOE
101 N MAIN AVE, SUITE 301
SIOUX FALLS, SD 57104
SDBMOE@STATE.SD.US
P 605-367-7781 F 605-367-7786
HTTP://WWW.SDBMOE.GOV

September 23, 2013

David Starner
14158 130th St.
Hoffman, MN 56339

Dear Mr. Starner:

As you are aware, I am the Investigator for the South Dakota Board of Medical and Osteopathic Examiner's. You are also aware on September 3, 2013 I sent you a letter via email requesting an explanation as to your termination from the Aberdeen Fire Department. Due to your termination and other disciplinary action by the Aberdeen Fire Department, your license has been placed under investigation.

Please be aware of the following:

1. You have the right to contest the recommendation at an administrative hearing which will be conducted in accordance with SDCL 1-26. This matter will be presented to a neutral administrative judge.

2. You have the right to be represented by an attorney of your own choosing at the administrative hearing if you so desire.

3. The recommendation of the administrative judge will be referred to the South Dakota Board of Medical and Osteopathic Examiners. The Board may accept, reject or modify the recommendation.

4. If you participate in a hearing, you would then have the right to file an appeal to Circuit Court.

Notification that an investigation has been initiated can be disconcerting, and your first inclination may be to call the office to ask for details or discuss the matter. We respectfully request that you refrain from calling as the Board's policy for maintaining the confidentiality of all investigations prohibits the discussion of investigations over the phone. Should you have questions or concerns, please send them in writing by US mail, or you may send an email to SDBMOE@state.sd.us.

Thank you for your cooperation in this matter.

Sincerely,

Board Investigator

IN RE
DAVID STARNER
september 25 2014
9/26/14 09 TLS

Mr. Ted Huss,

I went on vacation for 2 weeks to help my family. My Mom was going through chemo therapy and my Dad needed my help helping my Mom. When I came back from my vacation, August 19th 2013 I was informed before my shift that I was fired for not passing my PHTLS course and that was basically the straw that broke the camel's back (so to speak). I was informed this by Chief Kevin VanMeter and Battalion Chief Todd Salfrank. They handed me my termination letter and wished me best of luck. At that time I was in shock and didn't know what to say. A few days later I informed chief that I did in fact have my PHTLS course and card to prove it. I never failed. That was false information. Chief said that there is nothing he can do now. I also handed him the following letter and he took it to HR director Al Norman. I have called AL multiple times and have not heard from him. There has been no further explanation concerning this letter or why I was fired even after I had proof that I had the PHTSL certification.

Mr. Huss, I am at a loss at what to do. I am not happy with how I was treated while I was working there and how I was fired. Please if you have any advice after reading this, I am open to hearing what you have to say.

The following is an explanation to my write ups...

Key Points:

1. Patient never complained of chest pain
2. Why treat a patient incorrectly
3. Why are you forcing your medics to treat dispatch complaint and not actual patient
4. Double standards
5. Unsafe work environment
6. Defamation of character
7. Libel
8. Slander

IN RE
DAVID STARNER
september 26 2014
9/26/14 010 TLS

#1: Patient never complained of chest pain

Date: 07/14/2013

Crew: Medic 1: Driver: #15, Attendant: #76 & Truck 1: Mo and FTO Jesse Rystrom

Medic 1 dispatched for a male patient complaining of Chest Pain and heart attack. Medic 1 responding to call. Truck 1 responding to assist Medic 1. Arrived on scene to find patient sitting on edge of the bed. Patient visually appears to be without any immediate life threats, patients skin warm dry pink; respirations with good and equal chest rise and fall, patient speaking in full sentences, patient Alert and Oriented x 4 (Alert/Oriented to Person, Place, Time, and Event). I cancelled truck 1 because I had confidence in my partner (#15) and I could handle this call without occupying Truck 1 and its crew members.

Patient states that he woke up at 3 am with abdominal pain/discomfort around the belly button area. Patient state that he hasn't been able to go back to sleep. Patient also stated, the previous night, he ate a larger amount of food than normal (over eating). I was informed by the patient, that his wife called 911 because she was worried that he was having a heart attack. Patient himself stated that he never had chest pain, chest pressure, chest discomfort, and never was short of breath. Patient stated his wife advised him to take aspirin as a precautionary measure just in case he was having a heart attack. Pt state he took 2 baby aspirin and didn't take his prescribed medications because he was afraid it would upset his stomach even more.

Patient's past pertinent medical history includes, high blood pressure, pace maker. Patient state that he didn't take his high blood pressure that morning because his stomach was upset. Patient's Vital Signs: monitor shows a paced rhythm; O2 saturation 95% on room air; blood pressure 170/80, patient stated that blood pressure is normally that high when he doesn't take his medication. Patients O2 saturation remained 94% or greater, patient skin remained warm, dry and pink.

I advised the patient that he should go to the hospital to get further checked out. Initially, patient refused transport. I advised the patient that he could possibly have a sick heart due to the facts that he was complaining of abdominal pain and indigestion which indirectly could be masking him having a heart attack. Patient again denied for the second time to allow us to take him to the hospital. I reminded the patient that his wife has been up since 3 am with him and that she's really worried about his health, so why don't we take you in to the hospital to play it safe. Patient stated that he didn't know if he wanted to go to the hospital and that he feels foolish for having us there. #15 and I both reassured him that his wife did the right thing by calling us. #15 went down to get the gurney ready and also grab the clip board. I again attempted to try to get the patient to go to the hospital, reminding the patient that indigestion can be a precursor to and acute heart attack and you could die. Patients wife told him to just go in and get checked out to play it safe. Patient finally agreed to allow us to transport him to hospital.

I advised the patient and his wife before we go; I need to explain a few things to my partner before we go. When #15 came up from getting the gurney ready, I informed #15 (in front of Patient and

his Wife) the patient agreed to go to hospital but before we go I need to explain a few things. At 3 am, patient woke up with stomach pain, thinking it was indigestion, at no time has he had any chest pain, chest pressure, chest discomfort or short of breath. I advised the patient that abdominal pain and indigestion can mask a heart attack and that with a paced rhythm we are unable to take a full look at his heart. #15 shook his head and said ok, the patient and his wife acknowledged what I said and said that's correct. The patient looked at me, asked me "can we go"? I replied "yes". The patient got up from his chair without assistance, walked himself down the stairs to the gurney and we transported him to the hospital without any further findings, changes or incidents.

After the call was completed and driving back to station 1, Erik said that it was too bad Dylon wasn't on this call, this would've been a great learning experience for him because you have dispatch complaint of chest pain and heart attack verses on scene patient never having chest pain and more anxiety related induced by his wife. I agreed with Erik and said this would've been a great call for Dylon.

#2: Why treat a patient incorrectly

According to my write up on 07/14/2013...

"FireFighter/Paramedic David Starner failed to follow medical protocol and failed to meet Aberdeen Fire Rescues standard of care."

The following is Aberdeen Fire and Rescue EMS Protocols & Policies for "Routine Care":

ROUTINE CARE

The following assessment is to be performed and information is to be obtained on all patients:

1. Assure scene safety for yourself, your fellow rescuers, and your patient.

...the scene was safe for me and my crew and my patient

2. Initial survey: General Impression:

   A. Airway with cervical spine control if appropriate – oxygen as appropriate maintaining O2 > 94%

   B. Breathing (monitor ETCO2 as indicated)

   C. Circulation with control of bleeding

   D. Disability Determination

      A = alert and conscious

      V = responsive to verbal stimuli

      P = responsive to painful stimuli

      U = unresponsive

      E = exposure

... as stated above in my explanation letter, all these steps were followed

3. Transport Decision.

...delayed due to patient refusing multiple times, eventually transported patient to his desired Hospital

4. Consider Rapid Trauma Exam or Detailed Physical Exam.

... no trauma indicated or found

5. Consider all assessment and treatments as necessary:

   A. ECG monitor (12/15 lead as indicated)

   ... patient on monitor, monitor showing paced rhythm

   B. Capnography and Pulse oximetry

   ... patient placed on pulse oximetry

   C. IV access as appropriate maintaining BP > 90

   ... patient BP remained above >90

   D. Medications per appropriate protocol

   ... no medications indicated for patient complaining of indigestion and abdominal pain

6. Detailed Physical Survey:

   A. Obtain vital signs and perform objective head-to-toe assessment.

   ... vital signs obtained and head-to-toe assessment without significant findings

   B. Obtain history:

   - Patient's name
   - Sex, age, and approximate weight
   - Chief complaint
   - Precipitating factors
   - Significant past medical history
   - Allergies
   - Current medications
   - Private physician's name

   ... all above was obtained

7. Apply appropriate protocol and standing orders based on assessment.

... there are no specific protocols for indigestion and abdominal pain in Aberdeen Fire and Rescue EMS Protocols & Policies

9. Contact Medical Control as designated in protocol or if there are any problems or questions.

... no indication to contact medical control in Aberdeen Fire and Rescue EMS Protocols & Policies

9. Position patient comfortably as indicated by condition or situation.

... patient was positioned in his position of comfort

10. Reassure and calm patient. Loosen any restrictive clothing or remove as indicated.

... patient was reassured and calmed

Conclusion

I am at a loss what I failed to do correctly. I highlighted each and every portion with a brief explanation.

#3: Why are you forcing your medics to treat dispatch complaint and not the actual patient?

According to my write up on 07/14/2013...

Continued "...As noted in PCR 1203323 on 07/14/2013 The Patient condition warranted further treatment and the implementation of the chest pain protocol which was not done."

The following is Aberdeen Fire and Rescue EMS Protocols & Policies for "Chest Pain"

CHEST PAIN

1. Obtain and transmit 12-lead EKG, if 12-lead is unremarkable or showing an Inferior AMI, obtain a 15-lead EKG.

... patient with paced rhythm unable to perform 12/15 lead with accurate reading

2. Establish two IVs 18g or greater with care to avoid the right wrist location if possible, left arm is preferred (per cath lab).

... I did not start an IV or per protocol 2 IV's 18g or greater. Patient didn't complain of chest pain. How many paramedics have started two IV's 18g or greater with a patient complaining of chest pain?

3. Administer:

- 4 baby Aspirin chewable tablets (324 mg) p.o. if the patient is not allergic to Aspirin and does not have ulcer disease

... patient never complained of chest pain

3. If 15-lead is negative for a right ventricular AMI, administer:

- 1 Nitroglycerin spray 1/150 sublingually if systolic blood pressure is greater than 100 mmHg. May be repeated every 5 minutes until:
  - 3 sprays have been administered
  - Pain is relieved
  - Systolic blood pressure falls below 100 mgHg
  - Avoid use of Nitro in pt's that have or are suspected to have taken a phosphodiesterase inhibitor (eg, Viagra)

... ... patient never complained of chest pain

5. If 15-lead is positive for a right ventricular AMI, begin fluid administration with normal saline. Patients may require one liter or more of saline to prevent a drop in blood pressure with nitro administration. Use caution when administering sublingual nitroglycerin spray, a nitro drip is recommended in this situation.

... no 15-lead obtained due to paced rhythm

6. Consider a Nitro Drip beginning at 5 mcg/min, titrate to effect (by increasing by 5 mcg/min) while maintaining BP >100 systolic

... patient never complained of chest pain

7. For pain control consider administering:

- Fentanyl 50-100 mcg slow IV push, this dose may be repeated as needed.

... patient never complained of chest pain

8. **If patients are < 75 years of age with a STEMI, administer a loading dose of Plavix (clopidogrel) 600 mg p.o.**

... we don't even carry Plavix

9. Treat dysrhythmias per protocols.

... patient with a paced rhythm

Conclusion:

Where did I go wrong? You want me to treat the dispatch complaint for patient complaining of chest pain and heart attack? Patient never complained of chest pain.

#4: Double standards

a. Let's pretend my patient was complaining of chest pain, accordingly to protocol, we are to start 2 large bore IV's. How many chest pain calls have medic started 2 large bore IV's? You take 100 past chest pain calls and most of all those calls the medic wouldn't have started 2 large bore IV's. So how come I am singled out and written up? Why do I keep getting harassed even though I am doing my job correctly? Why is EMS coordinator Rob Senger documenting false accusations against me? Why hasn't Rob Senger not written up anyone else for not starting two IV's 18ga or greater on chest pain patients? Why am I singled out? I have talked to other Aberdeen Fire and Rescue FireFighter/Paramedics to find out if they have started two IV's 18ga or greater. Every single Paramedic I talked to stated they haven't or if they have, they did it once. Why haven't they been written up by EMS coordinator Rob Senger?

b. FTO Jesse Rystrom is able to break protocol without any ramification? On 07-16-2013 approx 1230, Medic 1(David Starner, Dylon, and FTO Jesse Rystrom) had a call for a Motor Vehicle Accident (6th ave west by Perkins). Patient with Altered Level of Consciousness. Patient was not cooperating. Patient was initially secured full spinal axial immobilization onto a long board. FTO Jesse Rystrom loosened the bottom 2 "spider" straps that were securing the lower body. The patient now was able to move his whole body from side to side nullifying the objective to protect the patient spine. According to Aberdeen Fire and Rescue EMS Protocols & Policies for "Trauma: Indications for Spinal Immobilization" (page 55) under Blunt trauma, patient with Altered LOC requires Immobilize and Rapid Transport. No indications for clearing or partially clearing spinal immobilization for an Altered LOC patient. FTO Jesse Rystrom had Dylon write the report indicating Dylon was the primary medic providing care. Why can FTO Jesse Rystrom write me up for not following a certain protocol but yet he can justify jeopardizing an Altered LOC patient spine which clearly shows he failed to follow Aberdeen Fire and Rescue EMS Protocols & Policies? How come EMS coordinator Rob Senger didn't write FTO Jesse Rystrom up for failing to follow protocol?

c. My previous write up for not wearing appropriate PPE's? Why isn't there a specific incident or PCR number? Why again am I singled out and written up? I have shown picture and video evidence of other Aberdeen Fire and Rescue not following proper PPE's but yet no one else was written up. How is that fair?

#5: Unsafe work environment

Why do I have to spend so much time defending myself? Why can't I be allowed to work without being afraid to be picked on?

#5: Defamation of Character

Any intentional false communication, either written or spoken, that harms a person's reputation; decreases the respect, regard, or confidence in which a person is held; or induces disparaging, hostile, or disagreeable opinions or feelings against a person.

Defamation may be a criminal or civil charge. It encompasses both written statements, known as LIBEL, and spoken statements, called slander.

#6: Libel

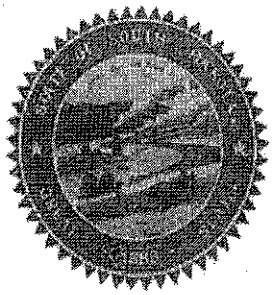
to publish in print (including pictures), writing or broadcast through radio, television or film, an untruth about another which will do harm to that person or his/her reputation, by tending to bring the target into ridicule, hatred, scorn or contempt of others. Libel is the written or broadcast form of defamation, distinguished from slander which is oral defamation.

#7: Slander

oral defamation, in which someone tells one or more persons an untruth about another which untruth will harm the reputation of the person defamed.

SOUTH DAKOTA
BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

SDBMOE
101 N MAIN AVE, SUITE 301
SIOUX FALLS, SD 57104
SDBMOE@STATE.SD.US
P 605-367-7781 F 605-367-7786
HTTP://WWW.SDBMOE.GOV



October 21, 2013

David Starner
14158 130th St.
Hoffman, MN 56339

Dear Mr. Starner:

Please be advised that the Board member of the investigative review panel is recommending the revocation of your paramedic license.

If you wish to contest this recommendation you have the following rights:

1. To contest the recommendation at an administrative hearing this will be conducted in accordance with SDCL 1-26. This matter will be presented to a neutral administrative judge.

2. To be represented by an attorney of your own choosing at the administrative hearing if you so desire.

3. The recommendation of the administrative judge will be referred to the Board of Medical and Osteopathic Examiners. The Board may accept, reject or modify the recommendation.

4. If you participate in an administrative hearing, you would then have the right to file an appeal to Circuit Court.

If you wish to contest this recommendation please contact William H. Golden no later than October 31, 2013, at (605) 367-5880. ext 101

Sincerely,

Ted Huss
Board Investigator

IN RE
DAVID STARNER
september 26 2014
9/26/14 011 725

Cc: William H. Golden, esq.
Assistant Attorney General/Litigation Division
Counsel to the South Dakota Board of Medical and Osteopathic Examiners

Exhibit 11

03/27/2014

To whom it may concern:

This letter is regarding a request from David Starner for professional referral.

David Starner was employed by First Medic Ambulance in Lisbon N.D. as an EMT and later as a Paramedic. He was also employed by Para-Corp Medical Management firm Fergus Falls, MN as an EMT and later as a Paramedic. His duties with both companies were caring for the ill and injured in a multitude of settings and environments. His performance as a member of our medical staff was excellent and his medical knowledge and skills superior. David was kind to patients and well liked among the staff.

I personally and professionally recommend David as a potential hire as a Paramedic with your organization.

Bjorn Ringdahl NREMT-P/GM

Ringdahl EMS/ Para-Corp Medical Management

Fergus Falls, MN.

Pelican Rapids, MN

Jamestown, ND

Lisbon, ND

701-269-9545

Mr. Huss,

I would officially like to request my paramedic license for the state of South Dakota be removed and I would no longer be licensed for the state of South Dakota.

Thank you,

David Starner

Rallis, Misty

From: djstarner@yahoo.com
Sent: Tuesday, October 29, 2013 11:24 AM
To: SDBMOE
Subject: Re: Your phone call

I have received your email. Thank you.

Sent from my HTC

----- Reply message -----
From: "SDBMOE" <SDBMOE@state.sd.us>
To: "'David Starner'" <djstarner@yahoo.com>
Subject: Your phone call
Date: Tue, Oct 29, 2013 10:33 AM

Mr. Starner,

Your request to withdraw licensure while under investigation will be placed on the agenda for the next Board meeting, November 13, 2013. Withdrawal while under investigation is a public board action and will be published on the Board's website and reported to the national data banks and any other entity deemed appropriate by the Board and in compliance with State and Federal law.

Please advise that you received this email and let me know if you have any questions.

Sincerely,

Ted Huss
Board Investigator
SD Board of Medical & Osteopathic Examiners
101 N. Main Ave., Suite 301
Sioux Falls, SD 57104
Phone 605-367-7781
Fax 605-367-7786
email: SDBMOE@state.sd.us<mailto:SDBMOE@state.sd.us>
web site: http://www.sdbmoe.gov<http://www.sdbmoe.gov/>

From: David Starner [mailto:djstarner@yahoo.com]
Sent: Wednesday, October 23, 2013 2:59 PM
To: SDBMOE
Subject: Re: Your phone call

Mr. Huss,

Please see attached document. If you have any further questions, please give me a call.

Thank you,

David R Starner Jr

On Tuesday, October 22, 2013 3:08 PM, SDBMOE
<SDBMOE@state.sd.us<mailto:SDBMOE@state.sd.us>> wrote:
Mr. Starner,

I tried reaching you by phone today at 605-626-1496. You can return my call at my phone number below in my signature block.

Sincerely,

Ted Huss
Board Investigator
SD Board of Medical & Osteopathic Examiners
101 N. Main Ave., Suite 301
Sioux Falls, SD 57104
Phone 605-367-7781
Fax 605-367-7786
email: SDBMOE@state.sd.us<mailto:SDBMOE@state.sd.us>
web site: http://www.sdbmoe.gov<http://www.sdbmoe.gov/>

THE SOUTH DAKOTA BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

****

Re: David R. Starner, EMT Paramedic FINAL ORDER

****

The above-entitled matter having come before the South Dakota Board of Medical and Osteopathic Examiners ("Board"), and the Board having been fully advised in the premises thereof; and

As a condition of licensure, David R. Starner consents to the documents relating to this matter being provided to other state licensing authorities upon their request. NOW, THEREFORE, the Board hereby:

APPROVES the request to withdraw his licensure while under investigation and this Final Order, and directs that the withdrawal while under investigation and this Final Order are public records of the Board and the State of South Dakota and shall be published on the Board's website and reported to the national data banks and any other entity deemed appropriate by the Board and in compliance with State and Federal law.

By: _____ Date: 11/13/13
South Dakota Board of Medical and Osteopathic Examiners

STATE OF SOUTH DAKOTA } S.S.
MINNEHAHA COUNTY
I hereby certify that the foregoing instrument is a true and correct copy of the original as the same appears on the record in my office.
Executive Secretary
By MBH by TLP
Date 11-15-13

IN RE
DAVID STARNER
september 26 2014
9/26/14 013 TLS

License Application - Advanced Life Support

License application# 15366 Submitted on: 3-27-2014

Name Information

DAVID ROBERT STARNER JR, EMTP

Alternates *None reported.*

Address

	****Default****
Type	Home Address
Public?	N
Name/Attention	
Address	14158 130th St. Hoffman, MN 56339

Identification

Date of Birth	3-15-1976
Birth Place	Willmar, MN UNITED STATES
	Gender: M **SSN:** XXX-XX-3177 **NPI:**
US Citizen	Y

Education

Name	NCTI - National College of Technical Instruction
Location	Roseville, CA
Degree	Certificate of completion
Status	Graduated
Dates Attended	03/2009 to 10/2010
Graduated	10/2010

IN RE
DAVID STARNER
september 26 2014
9/26/14 014 TLS

Name	Glendale Community College
Location	Glendale, CA
Degree	Certificate of completion
Status	Graduated
Dates Attended	12/2006 to 06/2008
Graduated	06/2008

ALS Course Information

Course Name	NCTI/ALS
Provider	NCTI
Location	NCTI - National college of technical instruction Riverside, CA 92507
Date of Completion	2010-10-01T00:00:00-05:00

Exam History

Have you taken and passed the examination? Y Score:

Type	Other NREMT EMT
Date	06/28/2007
Pass/Fail	Y

Type	Other NREMT Paramedic
Date	04/04/2011
Pass/Fail	N

Type	Other NREMT Paramedic
Date	06/01/2011
Pass/Fail	N

Type	Other NREMT Paramedic
Date	01/31/2012
Pass/Fail	Y

State or Professional Licensure

Type	OTHER EMT B
State	CA
Date	Issued: 08/2011 Valid through: 07/2013

Type	OTHER Paramedic
State	ND
Date	Issued: Valid through: 06/2014

Type	OTHER Paramedic
State	MN
Date	Issued: 10/2013 Valid through: 03/2014

Chronology of Activities

From: 10/2009
To: 08/2013

Activity: Work
Aberdeen Fire Rescue
121 S. 2nd Street
Aberdeen , SD 57401

Contact: Chief Kevin Van Meter **Ph:** 605-626-7048 **Email:**
Firefighter Paramedic Percent Clinical: 50% Administrative: 50%

From: 08/2011
To: 10/2012

Activity: Work
First Medic Ambulance
1100 Oak Street
Lisbon, ND 58054

Contact: Bjorn Ringdahl **Ph:** 701-683-4721 **Email:**
Paramedic Percent Clinical: 50% Administrative: 50%

From: 01/2011
To: 08/2011

Activity: Work
MaxCare Ambulance
7614 Lemon Avenue
Lemon Grove, CA 91945

Contact: Ryan Karlsson **Ph:** 619-905-9662 **Email:**
EMT-B Percent Clinical: 50% Administrative: 50%

From: 03/2010
To: 10/2010

Activity: Work
Good Shepherd Ambulance
109 Agostino Rd
San Gabriel , CA 91776

Contact: Scott Ryan **Ph:** 562-634-5200 **Email:**
EMT-B Percent Clinical: 50% Administrative: 50%

From: 03/2008
To: 12/2009

Activity: Work
Schaefer Ambulance
324 N Towne Ave
Pomona, CA 91767

Contact: Jimmy McNeil **Ph:** 909-622-1273 **Email:**
EMT-B Percent Clinical: 50% Administrative: 50%

From: 06/2007
To: 12/2007

Activity: Work
Trans Aid Ambulance
1300 Gardena Ave
Glendale, CA 91204

Contact: Scott Ryan **Ph:** 818-265-5151 **Email:**
EMT-B Percent Clinical: 50% Administrative: 50%

Malpractice Liability Claims Information

No information reported.

Practice Information

Current Employer / Company / Ambulance Service

Contact Information

Phone: FAX:

Required Disclosures

Definitions:

All questions use the following definitions whether actions were formally, informally, voluntarily or involuntarily committed. Questions refer to both you and your licensure.

A. **Adverse Action** shall refer to having been terminated, stipulated, restricted, limited, conditioned, counseled, reprimanded, suspended, revoked, refused, denied, not renewed, withdrawn or relinquished.

B. **Claim(s)** shall refer to any malpractice, administrative, civil, or criminal final judgments including any pending claims, lawsuits, judgments, and/or settlements.

C. **Complaint** shall refer to any communications which express concerns, warnings or dissatisfaction about personal or profession conduct and rising to the level that the meetings or comments are documented in a written or digital format.

D. **Entity** shall refer to any licensing or disciplinary board, professional agency or committee, academic program, clinic, hospital, or other health-related entity, or governmental agency or organization.

E. **Health related program** shall refer to private or public insurance, Medicare and Medicaid.

F. **Illegal use of drugs** shall refer to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. sec. 812.22. The term does include the unlawful use of prescription controlled substances. It does **not** include the use of a drug taken under supervision by a licensed health care

professional, or other uses authorized by the Controlled Substances Act or other provision of Federal law.

G. **Investigation** shall refer to any formal or informal inquiry to acquire and examine facts.

H. **Licensure** shall refer to type of licensure and using any licensure nomenclature such as any registration, permit, certificate, and license. Examples include the subject of this application, DEA registration, etc.

I. **Minor traffic offense** shall refer to any violation which is punishable by a maximum of 30 days in jail, a $500 fine or both and does not result in a change of driving privileges.

J. **Proceeding** shall refer to whether you have appeared or been requested to appear in private or in public, for a meeting, counseling, hearing, administrative, civil or criminal actions, or been questioned, reviewed, charged, arrested, plead guilty, plead no contest, convicted, received a suspended imposition of sentence or suspended sentence by any entity.

K. **Sexual impropriety** shall refer to misconduct including but not limited to discrimination, complaint, assault, the possession of child pornography, sexual contact with patients or other acts, expressions or gestures that disrespect privacy and are demeaning.

L. **You** shall refer to you or any licensure held by you.

*01 Is this a true statement for your licensure? "My licensure has not experienced adverse action." N

Explanation: I received a letter from SDBMOE being advised that the Board member of the investigative review panel is recommending the revocation of your paramedic license. Instead of being revoked I decided to voluntarily surrender my license which was accepted by SDBMOE board. Since then, NREMT has also denied my recertification.

*02 Is this a true statement for you? "I have not experienced adverse action." N

Explanation: I received a letter from SDBMOE being advised that the Board member of the investigative review panel is recommending the revocation of your paramedic license. Instead of being revoked I decided to voluntarily surrender my license which was accepted by SDBMOE board. Since then, NREMT has also denied my recertification.

*03 Has your licensure been subject to any complaint, investigation or proceeding involving any entity? Y

Explanation: SDBMOE and NREMT. I received a letter from SDBMOE being advised that the Board member of the investigative review panel is recommending the revocation of your paramedic license. Instead of being revoked I decided to voluntarily surrender my license which was accepted by SDBMOE board. Since then, NREMT has also denied my recertification due to volunteering to surrender my South Dakota Paramedic license while under investigation.

*04 Have you been subject to any complaint, investigation or proceeding involving any entity? Y

Explanation: SDBMOE and NREMT. I received a letter from SDBMOE being advised that the Board member of the investigative review panel is recommending the revocation of your paramedic license. Instead of being revoked I decided to voluntarily surrender my license which was accepted by SDBMOE board. Since then, NREMT has also denied my recertification due to volunteering to surrender my South Dakota Paramedic license while under investigation.

05 Have you been dishonorably discharged from a branch of the United States military or N

National Guard?

06 Have you had any adverse action during any education, residency or training program - N

*07 Have you had adverse action with your membership or privileges with any entity regarding your ability to participate in any health related program? Y

Explanation: SDBMOE and NREMT. I received a letter from SDBMOE being advised that the Board member of the investigative review panel is recommending the revocation of your paramedic license. Instead of being revoked I decided to voluntarily surrender my license which was accepted by SDBMOE board. Since then, NREMT has also denied my recertification due to volunteering to surrender my South Dakota Paramedic license while under investigation.

*08 Have you been subject to a criminal or civil complaint, investigation or proceeding other than minor traffic offenses? Y

Explanation: Order of protection. that I do have a protection order against me. The Sheriff of Grant County told me that nothing further was going to be done with this order of protection and that this was her way to try to save her marriage. I was informed by the Sheriff of Grant County that they and the County Attorney was not going to proceed further after their investigation and that the Sheriff's department was closing its file on the case. I simply did not appear at Restraining Order hearing because I simply had no reason to ever need to see this person again. Now that I have found that it might adversely affect my employment, I will go back into court and seek to have the Restraining Order removed. In short, I had consensual sexual relationship with this woman on a weekend which latter she later told her husband that she had been sexually assaulted by me. Keep in mind; I have been completely absolved by law enforcement and by the County Attorney from these accusations. I was told by the Sheriff of Grant County that there was no truth to her allegations and that the investigation was over. I was never accused by anyone other than her and I have text messages from her proving that she is not being truthful. Again, I did not object to the Order for Protection because I simply believed that it would be the best way to let things resolve without any conflict. When I looked at disclosures, I didn't feel that would mean that any woman in the world could have made an accusation against me and that I would have needed to disclose the OFP. The Sheriff and County Attorney of Grant County did their investigation, brought in witnesses, got theirs and my testimonies, reviewed and recorded the text messages and voice message from her (messages asking me to lie about what happened that night), and in the end, they completely absolved me from all these accusations. After I was absolved from the law, I was given an Order for Protection with an option to appeal. As I stated before and advised by the Grant County Sheriff, that this wouldn't be on my record, nothing would come of this in the future, and I decided to let it go and not appeal it.

*09 Have you had a complaint, investigation or proceeding in any manner concerning sexual impropriety? Y

Explanation: that I do have a protection order against me. The Sheriff of Grant County told me that nothing further was going to be done with this order of protection and that this was her way to try to save her

marriage. I was informed by the Sheriff of Grant County that they and the County Attorney was not going to proceed further after their investigation and that the Sheriff's department was closing its file on the case. I simply did not appear at Restraining Order hearing because I simply had no reason to ever need to see this person again. Now that I have found that it might adversely affect my employment, I will go back into court and seek to have the Restraining Order removed. In short, I had consensual sexual relationship with this woman on a weekend which latter she later told her husband that she had been sexually assaulted by me. Keep in mind; I have been completely absolved by law enforcement and by the County Attorney from these accusations. I was told by the Sheriff of Grant County that there was no truth to her allegations and that the investigation was over. I was never accused by anyone other than her and I have text messages from her proving that she is not being truthful. Again, I did not object to the Order for Protection because I simply believed that it would be the best way to let things resolve without any conflict. When I looked at disclosures, I didn't feel that would mean that any woman in the world could have made an accusation against me and that I would have needed to disclose the OFP. The Sheriff and County Attorney of Grant County did their investigation, brought in witnesses, got theirs and my testimonies, reviewed and recorded the text messages and voice message from her (messages asking me to lie about what happened that night), and in the end, they completely absolved me from all these accusations. After I was absolved from the law, I was given an Order for Protection with an option to appeal. As I stated before and advised by the Grant County Sheriff, that this wouldn't be on my record, nothing would come of this in the future, and I decided to let it go and not appeal it.

*10 Is this a true statement for you? "I have not been reported to NPDB (National Practitioners Data Bank) or HIPDB (Healthcare Integrity and Protection Data Bank)." N

Explanation: SDBMOE reported me

*11 Is this a true statement for you? "I have experienced no adverse action in privileges at any hospital, clinic or health related entity." N

Explanation: I now can not get a job and also cannot get nationally recertified due to SDBMOE deciding to investigate and then revoke my license.

12 Have you had any claims paid by you or paid on your behalf for any reason? N

13 Have you had any liability insurance company, including malpractice carriers, change, deny or cancel your coverage? N

*14 Have you stopped working or practicing for any period of time greater than or equal to 30 consecutive calendar days? Y

Explanation: I fear my career may be over if I do not get this resolved. National registry has denied my recertification due to SDBMOE investigation and ultimately revoking my license.

15 Do you have a physical, mental or emotional condition which may adversely affect your practice? N

16. Have you been treated for or do you have a diagnosis for any Mental Health condition. (If yes, please ask your treating provider to send a status letter to the Board office).	N
17. Does your use of alcohol or drugs affect your ability to provide appropriate care to patients?	N
18. Are you currently using illegal drugs or prescription controlled medications in an illegal manner?	N

Agreements

I am aware of the Health Insurance Portability and Accountability Act of 1996 (thereinafter called HIPAA) and understand the provisions dealing with the privacy of my medical records. With such knowledge an understanding, I agree to the following:

- a. I do hereby authorize the use or disclosure of my health information by the South Dakota Board of Medical & Osteopathic Examiners (SDBMOE), for purposes of licensure in the state of South Dakota.
- b. I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and hospitals, and treatment for alcohol and drug abuse.

I further release, discharge and exonerate all third parties or person(s) from any and all claims, damages, and liabilities of any nature, who in good faith and without malice, release the HIPAA information to the SDBMOE.

AUTHORIZATION AND RELEASE:
Any references to the terms "Users" or "Users of this Application" in this authorization shall include the following entities:

- The South Dakota State Board of Medical and Osteopathic Examiners together with its board members, staff members, legal counsels, investigators, agents, employees, contractees, and authorized representatives hereinafter collectively referred to as SDBMOE;
- Any other state or national medical licensing, medical reporting or medical regulatory board;
- The Federation of State Medical Boards;
- Any other South Dakota or United States agency in furtherance of and incompliance with SDBMOE's duties and responsibilities under my South Dakota Medical Practices Act and its administrative regulations.

I am the person described herein. I have not engaged in any acts prohibited by the criminal or medical statutes of the State of South Dakota. I am the person named on any diploma or certificated that I have received, I am the lawful holder of said diploma or certificate, and the diploma or certificate was given to me in the regular course of instruction and examination without fraud or misrepresentation.

The following deals with SDBMOE consulting with and receiving information from third parties:

I authorize SDBMOE to consult with any third person or party who may have information or evidence concerning my professional, ethical, mental and physical qualifications, or any other matter that SDBMOE deems relevant regarding my continuing qualifications for licensure with SDBMOE. These third persons and parties include hospitals, institutions or organizations, my references, physicians, therapists, previous and present employers, past and present business and professional associates, and local, state, federal or foreign governmental agencies and instrumentalities, courts of any jurisdiction, associations, institutions or law enforcement agencies, together with their representatives thereof, who have custody or control of any documents, records, information or evidence that SDBMOE deems relevant to my Application. I **specifically authorize any state, federal or international law enforcement agency to conduct a background investigation and to report the findings thereof to the SDBMOE.**

I authorize such third persons and parties to unconditionally release to SDBMOE any such information, including documents, records regarding charges or complaints filed against me, formal, or informal, pending or closed, or any other pertinent data or evidence whether favorable or unfavorable that SDBMOE deems relevant to licensure, and to permit the SDBMOE to inspect, receive, and make copies of such documents, records, evidence, and other information for SDBMOE's evaluation of my professional, ethical, mental and physical qualifications that SDBMOE deems relevant to licensure.

I release, discharge and exonerate from any and all claims, damages and liabilities whatsoever such third persons and parties, together with their authorized representatives, who in good faith and without malice, consult with and release to SDBMOE such information, evidence, files or records requested by SDBMOE that

SDBMOE deems relevant to licensure.

I declare and affirm under the penalties of perjury that:

This application for licensure, which includes all the information I have provided and the questions I have answered in the South Dakota Common License Application Form and Addenda thereto, have been examined by me, and to the best of my knowledge and belief, are in all things true and correct. I state unconditionally and without reservation that I absolutely understand each and every question contained in this application for licensure, that I and I have answered all of them completely and truthfully. If any user discovers any derogatory information regarding my personal background that was not disclosed when completing this application, the users may immediately cease all processing of this application, and I agree that such nondisclosure shall disqualify me for licensure in South Dakota.

I understand and agree that my submission of this application and actions subsequent thereto, but prior to licensure, shall bear directly upon my qualifications for licensure, and I fully understand that the SDBMOE may consider all such actions in its determination whether to grant licensure. To that end, I agree that any unprofessional or harassing behavior on my part, or on the part of any agent of mine, with the SDBMOE's members or staff shall establish grounds for the immediate cessation of all processing of this application and disqualify me for licensure in South Dakota. A determination regarding derogatory information or of unprofessional or harassing behavior shall be the sole determination of the SDBMOE, and I will not assert that any other entity, judicial, or otherwise, may make such determination. I understand and agree that cessation of processing of this application by the users as a result of the acts of omissions by myself as described in this paragraph shall not require the SDBMOE, to offer me a hearing or any other due process right, or any other statutory or constitutional rights, and that I will not assert that I am entitled to a hearing.

Signed: David Robert Starner Jr 03/15/1976

</html

David Starner

10/18/2012 – Initial Application for SD ALS License

11/07/12 – Employment verification received from First Medic Ambulance in Lisbon, ND stated Mr. Starner was verbally reprimanded for not following the narcotic control policy. The verification also stated Mr. Starner has a hard time accepting policies and protocols. He did not get along well with other staff and a personal relationship with co-worker caused issues.

11/26/12 – Letter sent to Mr. Starner requesting an explanation as to why he did not report any of the information in the employment verification to the Board

11/28/12 – Response received from Mr. Starner that stated he was surprised at the allegations made by his former employer

12/14/12 – SD ALS License Issued

03/04/13 – Complaint Received - Past sexual assault, notice of Investigation sent to Mr. Starner because failed to disclose on 10/18/2012 application that was subject of two investigations of sexual assault and was also named as the respondent in a protection order, and an explanation was requested

3/12/13 – Explanation from Mr. Starner

6/17/13 – Renewal of SD ALS License

6/27/13 – Consent Agreement with Reprimand for Failure to Disclose

08/19/13 – Letter received from Aberdeen Fire Rescue stating Mr. Starner was terminated for failure to successfully complete his probationary period

8/23/13 – Additional information received from Aberdeen Fire Rescue, written violations for not following protocols, renewal reviewed and Mr. Starner failed to disclose he had received adverse action from Aberdeen Fire Rescue

09/03/13 – Letter sent to Mr. Starner requesting an explanation regarding termination

09/23/13 – Notice of Investigation sent to Mr. Starner

9/24/13 – Response received from Mr. Starner

10/21/13 – Letter sent to Mr. Starner informing him the investigative review panel recommended the revocation of his SD ALS License

10/23/13 – Mr. Starner requested the withdrawal of his SD ALS License

11/13/13 – Mr. Starner's request to withdraw his license was approved at Board Meeting

03/27/14 – Mr. Starner applied for reinstatement of his SD ALS License

04/15/14 – Meeting with Mr. Starner

IN RE
DAVID STARNER
september 26 2014
9/26/14 015 TLS

BEFORE THE MINNESOTA

EMERGENCY MEDICAL SERVICES REGULATORY BOARD

In the Matter of the Certification
of David R. Starner, Paramedic
Certificate No. 978399

STIPULATION AND CONSENT ORDER FOR VOLUNTARY SURRENDER OF CERTIFICATE

IT IS HEREBY STIPULATED AND AGREED by and between David R. Starner, Paramedic ("Respondent"), and the Complaint Review Panel ("Review Panel") of the Minnesota Emergency Medical Services Regulatory Board ("Board") as follows:

JURISDICTION

1. During all times herein, Respondent has been and now is subject to the jurisdiction of the Board from which he holds a certificate as a Paramedic in the State of Minnesota.

2. Respondent has been advised by Board representatives that he may choose to be represented by legal counsel in this matter. The Review Panel is represented by Gregory J. Schaefer, Assistant Attorney General, 1400 Bremer Tower, 445 Minnesota Street, St. Paul, Minnesota 55101-2131, telephone (651) 757-1366.

FACTS

3. For the purpose of this Stipulation and Consent Order, the parties may consider the following facts as true:

a. The Board certified Respondent as a Paramedic in Minnesota on October 3, 2013.

IN RE
DAVID STARNER
september 26 2014
9/26/14 16 TLS

b. On June 26, 2013, Respondent entered into a *Consent Agreement With Reprimand* with the South Dakota Board of Medical and Osteopathic Examiners ("South Dakota Board") for failing to disclose on his Paramedic license application accusations that he was a Respondent to a Restraining Order. The South Dakota Board approved the *Consent Agreement With Reprimand* and issued a *Final Order* on June 26, 2013.

c. On October 3, 2013, Respondent applied for Paramedic certification in Minnesota. On the application submitted to the Board, Respondent answered "No" to self-disclosure question: "Has any other Health-related Licensing Authority denied, revoked, suspended, or placed conditions on your right to practice?"

d. At the time Respondent was completing his application for Paramedic certification in Minnesota, Respondent misrepresented or falsified information on the application by failing to disclose that he was subject to a denial, corrective, disciplinary, or other similar action in another jurisdiction or by another regulatory authority.

e. On November 13, 2013, the South Dakota Board issued a *Final Order* approving Respondent's request to withdraw his Paramedic licensure while under investigation.

STATUTES

4. The Review Panel views Respondent's conduct as inappropriate in such a way as to justify Board action under Minnesota Statutes section 144E.28, subdivisions 4 and 5(a) (2), (5), (10), and Respondent agrees that the conduct cited above constitutes a reasonable basis in law and fact to justify disciplinary action under these statutes.

DISCIPLINARY ACTION

5. The parties agree the Board may take the following disciplinary action and require compliance with the following terms:

A. Voluntary Surrender

6. The Board accepts Respondent's **Voluntary Surrender** of his Paramedic certificate to provide emergency medical services. Respondent shall not engage in any act which constitutes the practice of emergency medical services in the State of Minnesota and shall not imply by words or conduct that Respondent is authorized to do so.

7. Respondent shall surrender to the Board his Paramedic certificate. Respondent shall personally deliver or mail the certificate to the Minnesota Emergency Medical Services Regulatory Board, c/o Pamela Biladeau, Executive Director, 2829 University Avenue S.E., Suite 310, Minneapolis, Minnesota 55414, within ten days of the date of this Order.

B. Reinstatement of Certification

8. Respondent may not petition for reinstatement of his Paramedic certificate until Respondent is able to demonstrate by a preponderance of the evidence that he is capable of performing emergency medical services in a fit and competent manner. At the time of Respondent's petition, Respondent shall meet with a Board Review Panel. The meeting with the Board Review Panel shall be scheduled after Respondent has complied with, at a minimum, the following:

a. Eligibility. Respondent is no longer subject to denial, withdrawal, disciplinary, or other similar action with the South Dakota Board of Medical and Osteopathic Examiners or by another regulatory authority.

b. Certification/Recertification Requirements. Respondent shall meet all certification/recertification requirements in effect at the time of his petition for reinstatement, including but not limited to completing the appropriate application, paying the requisite fees, and completing any necessary continuing education requirements.

c. Additional Information. Respondent shall provide any additional information relevant to his petition reasonably requested by the Review Panel.

9. The Board may, at any regularly scheduled meeting following Respondent's petition for reinstatement pursuant to paragraph 8 above, take any of the following actions:

a. Issue a Paramedic certificate to Respondent;

b. Issue a Paramedic certificate to Respondent with limitations upon the scope of Respondent's practice and/or with conditions for Respondent's practice; or

c. Deny Respondent's request for issuance of a Paramedic certificate based upon his failure to meet the burden of proof.

ADDITIONAL TERMS

10. Within seven days of any change, Respondent shall provide the Board with his current address and telephone information. The information shall be sent to Pamela Biladeau, Executive Director, Emergency Medical Services Regulatory Board, University Park Plaza, 2829 University Avenue S.E., Suite 310, Minneapolis, Minnesota 55414-3222.

11. This Stipulation and Consent Order, related investigative reports, and other documents shall constitute the entire record of the proceeding upon which this order is based. The investigative reports, other documents, or summaries thereof, may be filed with the Board with the stipulation. Any reports or other material related to this matter which are received after the date the Board approves the Stipulation and Consent Order shall become a part of the record and may be considered by the Board in future aspects of this proceeding.

12. In the event the Board in its discretion does not approve this settlement, this Stipulation and Consent Order is withdrawn and shall be of no evidentiary value and shall not be relied upon, introduced in any disciplinary action by either party hereto, except that Respondent

agrees that if the Board rejects this Stipulation and Consent Order and this case proceeds to hearing, Respondent will assert no claim that the Board was prejudiced by its review and discussion of this Stipulation and Consent Order or of any records relating hereto.

13. Respondent waives any further hearings on this matter before the Board to which Respondent may be entitled by Minnesota or United States Constitutions, statutes, or rules and agrees that the order to be entered pursuant to the Stipulation and Consent Order shall be the final Order herein.

14. This Stipulation and Consent Order shall not limit the Board's authority to proceed against Respondent by initiating a contested case hearing or by other appropriate means on the basis of any act, conduct, or admission of Respondent which constitutes grounds for disciplinary action and which is not directly related to the specific facts and circumstances set forth in this document.

DATA PRACTICES NOTICES

15. This Stipulation and Consent Order constitutes disciplinary action by the Board and is classified as public data pursuant to Minnesota Statutes section 13.41, subdivision 5. Data regarding this action will be provided to data banks as required by Federal law or consistent with Board policy. While this Stipulation and Consent Order is in effect, information obtained by the Board pursuant to this Order is considered active investigative data on a licensed health professional, and as such, is classified as confidential data pursuant to Minnesota Statutes section 13.41, subdivision 4.

16. Respondent hereby acknowledges that he has read and understands this Stipulation and Consent Order and has voluntarily entered into the Stipulation and Consent Order without threat or promise by the Board or any of its members, employees, or agents. This Stipulation and Consent Order contains the entire agreement between the parties, there being no other agreement of any kind, verbal or otherwise, which varies the terms of this Stipulation and Consent Order.

CONSENT:

COMPLAINT REVIEW PANEL

DAVID R. STARNER, Paramedic
Respondent

Dated: 8-8-2014, 2014

MATTHEW SIMPSON
Board Member

Dated: 9-4-14, 2014

ORDER

Upon consideration of this Stipulation and Consent Order and all the files, records, and proceedings herein, IT IS HEREBY ORDERED the Board approves and adopts the terms of this Stipulation and Consent Order and accepts the Voluntary Surrender of Respondent's certificate to practice emergency medical services in the State of Minnesota effective this 17 day of September 2014.

MINNESOTA EMERGENCY MEDICAL
SERVICES REGULATORY BOARD

By: _____
PAMELA BILADEAU
Executive Director

Certificate of Completion

this certifies that David Starner has completed the state of North Dakota's requirements for transition from EMT-P to Paramedic on July 17th, 2014

at https://transition.fisdap.net/

Michael Johnson, Program Coordinator

128246
State License Number

This continuing education activity is approved by Fisdap, a CECBEMS accredited organization.

You have participated in a continuing education program that has received CECBEMS approval for continuing education credit. If you have any comments regarding the quality of this program and/or your satisfaction with it, please contact CECBEMS at: CECBEMS, 12200 Ford Road, Suite 478, Dallas, TX 75234 | phone: 972.247.4442 | email: lsibley@cecbems.org

22 hours of F3 CE

CECBEMS activity #12-FISD-F3-0003

FISDAP

FISD6625

CECBEMS represents only that its accredited programs have met CECBEMS' standards for accreditation. These standards require sound educational offerings determined by a review of its objectives, teaching plan, faculty, and program evaluation process. CECBEMS does not endorse or support the actual teachings, opinions, or material content as presented by the speaker(s) and/or sponsoring organization. CECBEMS accreditation does not represent that the content conforms to any national, state, or local standard or best practice of any nature. No student shall have any cause of action against CECBEMS based on the accreditation of the material.

CECBEMS

Inver Hills Community College

EXHIBIT

Applicant F

9/26/14 TRS

Hereby Awards Emergency Medical Service Continuing Education Hours to:

David Starner

for participation in the

24-7 EMS Course

24-7 EMS Online: Heart Failure (V2)

License/Certification No.: 128246

State of Licensure: ND

NREMT No. (if registered): P8066013

Course Date(s): 04/14/2014

Course Location: 24-7 EMS

No. of CE Hours: 1.5

CECBEMS Provider # P247E1100

Category of CE Hours: First Responder, Basic & Advanced

CECBEMS* Activity No.: 13-247E-F3-8303

Jeffrey T. Lindsey, PhD, PM, CFOD
Chief Learning Officer

*This continuing education activity is approved by the Continuing Education Coordinating Board for Emergency Medical Services (CECBEMS). You have participated in a continuingeducation program that has received CECBEMS approval for continuing education credit. If you have any comments regarding the quality of this program and/or your satisfactionwith it, please contact CECBEMS at: CECBEMS — 12200 Ford Road, Suite 478 — Dallas, Texas 75234 — Phone: 972-247-4442 — Lsibley@cecbems.org.

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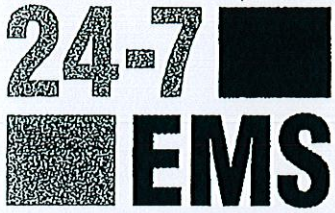
WRK3002a

EXHIBIT
Applicant G
9/26/14 TB



Hereby Awards Emergency Medical Service Continuing Education Hours to:

David Starner

for participation in the

24-7 EMS Course

24-7 EMS Online: STEMI Care (V2)

License/Certification No.: 128246

State of Licensure: ND

NREMT No. (if registered): P8066013

Course Date(s): 04/14/2014

Course Location: 24-7 EMS

No. of CE Hours: 1.5

CECBEMS Provider # P247E1100

Category of CE Hours: First Responder, Basic & Advanced

CECBEMS* Activity No.: 12-247E-F3-0015

Jeffrey T. Lindsey, PhD, PM, CFOD
Chief Learning Officer

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CECBEMS represents only that its accredited programs have met CECBEMS' standards for accreditation. These standards require sound educational offerings determined by areview of its objectives, teaching plan, faculty, and program evaluation processes. CECBEMS does not endorse or support the actual teachings, opinions or material content aspresented by the speaker(s) and/or sponsoring organization. CECBEMS accreditation does not represent that the content conforms to any national, state or local standard or bestpractice of any nature. No student shall have any cause of action against CECBEMS based on the accreditation of the material.

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EXHIBIT
Applicant H
9/26/14 TLS

Hereby Awards Emergency Medical Service Continuing Education Hours to:

David Starner

for participation in the

24-7 EMS Course

24-7 EMS Online: Sudden Cardiac Death (V2)

License/Certification No.: 128246

State of Licensure: ND

NREMT No. (if registered):

Course Date(s): 04/13/2014

Course Location: 24-7 EMS

No. of CE Hours: 1.5

CECBEMS Provider # P247E1100

Category of CE Hours: First Responder, Basic & Advanced

CECBEMS* Activity No.: 12-247E-F3-1211

Jeffrey T. Lindsey, PhD, PM, CFOD
Chief Learning Officer

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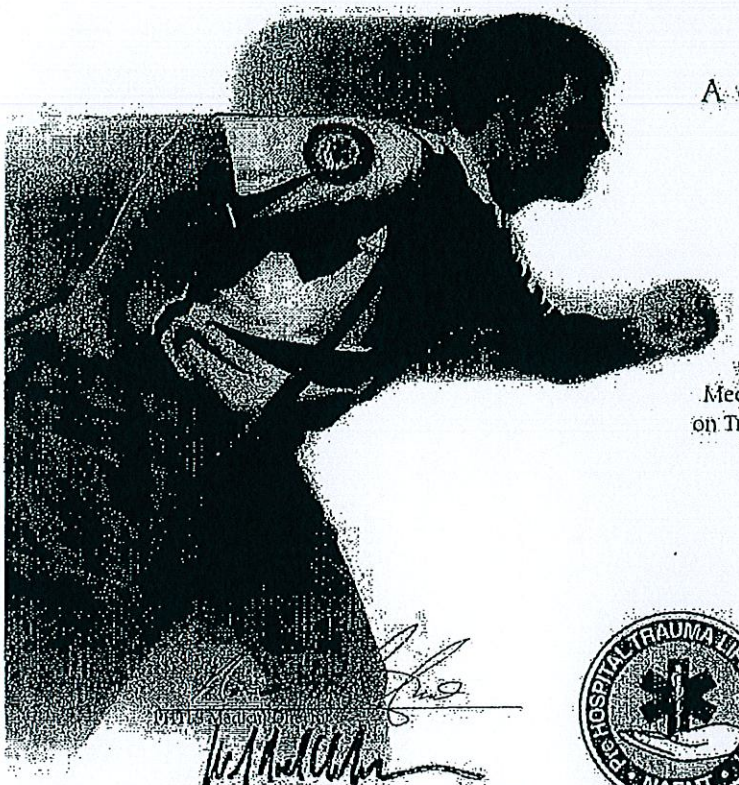
EXHIBIT

Applicant I
9/24/14 TS

Exhibit 12

NAEMT



THIS IS TO
ACKNOWLEDGE THAT

David Starner

has successfully completed the

Prehospital Trauma Life Support

sponsored by the National Association of Emergency Medical Technicians, in cooperation with the Committee on Trauma of the American College of Surgeons and

Avera St. Luke's

PHTLS Medical Director

National PHTLS Chairperson

PHTLS Faculty Representative

PREHOSPITAL TRAUMA LIFE SUPPORT NAEMT

Alex Falk, MD
Course Medical Director

Vickie Schwenk
Course Coordinator

PH-13-2005-17
National Course Number

5/13/13
Date Issued

5/13/17
Date Expired

EXHIBIT
Applicant J
9/26/14 TRS

03/27/2014

To whom it may concern:

This letter is regarding a request from David Starner for professional referral.

David Starner was employed by First Medic Ambulance in Lisbon N.D. as an EMT and later as a Paramedic. He was also employed by Para-Corp Medical Management firm Fergus Falls, MN as an EMT and later as a Paramedic. His duties with both companies were caring for the ill and injured in a multitude of settings and environments. His performance as a member of our medical staff was excellent and his medical knowledge and skills superior. David was kind to patients and well liked among the staff.

I personally and professionally recommend David as a potential hire as a Paramedic with your organization.

Bjorn Ringdahl NREMT-P/GM

Ringdahl EMS/ Para-Corp Medical Management

Fergus Falls, MN.

Pelican Rapids, MN

Jamestown, ND

Lisbon, ND

701-269-9545

EXHIBIT
Applicant K
9/26/14 TLS

Table of contents

(Brief explanation for attached documents)

1. Cover letter for David R Starner Jr. (1 page)
2. Resume: Professional resume for David R Starner Jr. (3 pages)
3. Time Line Resume: Past employment with Dates. (4 pages)
4. Bjorn reference letter. (1 page)
5. Michelle reference letter. (1 page)
6. Brock reference letter. (1 page)
7. Katie reference letter. (1 page)
8. David R Starner Jr explanation for termination from AFD and surrendering South Dakota paramedic license wile under investigation. (10 pages)
9. Official letter from SDBMOE wanting an explanation for employment verifications. (2 pages)
10. David R Starner Jr written response to SDBMOE explaining employment verifications. (2 pages)
11. Official email from SDBMOE accepting my written explanation for employment verifications. (1 page)
12. David R Starner Jr Protection Order explanation. (1 page)
13. David R Starner Jr Attorney Protection Order. (1 page)
14. Official Letter from SDBMOE wanting an explanation for protection order. (2 pages)
15. David R Starner Jr written response to SDBMOE explaining the protection order. (2pages)
16. Official 1st letter from SDBMOE wanting an explanation for termination with AFD. (1 page)
17. Official 2nd letter from SDBMOE wanting an explanation for termination with AFD.
18. Prequel for the next attachment. (1 page)
19. David R Starner Jr written response to SDBMOE explaining termination from AFD. (8 pages)
20. Official Letter from SDBMOE stating that the Board member of the investigative review panel is recommending the revocation of my paramedic license. (1 page)
21. David R Starner Jr written reaction to October 21st 2013 letter from SDBMOE and also explaining why I requested to voluntarily surrender my South Dakota Paramedic license. (1 page)
22. David R Starner Jr written letter to SDBMOE requesting the removal of my South Dakota paramedic license. (1 page)
23. Official Letter from SDBMOE stating they are in receipt of my request to withdraw my South Dakota paramedic license. (4 pages)
24. Official letter from SDBMOE stating they accepted my written request to withdraw my South Dakota Paramedic license. (2 pages)

1 COVER LETTER - David R Starner Jr

I am a highly skilled, resourceful, innovative and committed paramedic with an extensive experience dealing with medical and traumatic emergencies. I provide exceptional pre-hospital emergency care and services while also providing professional patient focused care. I have learned to adapt quickly to addressing my patient's needs while using a calm demeanor. I pride myself in making sure I am experienced in the newest techniques to help my patients in the field. I have a very strong knowledge about medications and the ability to apply this knowledge in a practical sense. I am a strong team player who possesses strong leadership skills. My newest passion is teaching and helping future Pre-Hospital and Hospital providers become the best they can be. I am a certified AMA ACLS and PALS instructor. I am a compassionate paramedic, a teacher who is loving, caring, hard working that demands the most from myself as an instructor. My family (wife & 5 children) and I are looking for a new place to call home. We are very excited about starting a new career, along with being instrumental and active citizens within our new community.

David R. Starner Jr

(320) 288-8707 djstarner@yahoo.com

QUALIFIED PARAMEDIC

A highly skilled, resourceful, innovative and committed paramedic with an extensive experience dealing with medical and traumatic emergencies. Provides exceptional pre-hospital emergency care and services while also providing professional patient focused care. Adapts quickly to addressing medical needs and using a calm demeanor. Experienced in the newest techniques in the medical field with a diverse background in on call environments, industrial safety and field locations. Strong knowledge about medications and the ability to apply this knowledge in a practical sense. A strong team player. Possesses strong leadership skills.

- Skilled at diagnosing nature and extent of illness to determine and prioritize pre-hospital procedures.
- Excellent judgment and ability to prioritize decisions and act quickly in the best interest of the patient.
- Expert in emergency treatment procedures including advanced airway management, RSI (Rapid Sequence Intubation) and cardiac monitoring (12/15 lead interpretation). Instructed under the guidance of Bob Page and his philosophies.
- Extensive background in administering drugs orally or by injection and performing intravenous procedures.
- Understanding orders and the ability to communicate with online direction to get further resources for my patient.
- Software: Med Media & Web Cur for patent care reporting. Fire House for fire records management system.

PROFESSIONAL EXPERIENCE

Aberdeen Fire Rescue **October 2012 – August 2013**

FireFighter Paramedic

- 911 – Provide emergency fire fighting, rescue and paramedic level medical care to residents of Brown County.
- Trained and skilled: RSI; King Vision ETT Intubation; Lucus Chest Compression System; 44 pharmaceutical medications.
- Rural EMS ALS intercept: meeting a BLS unit while it is en route to the nearest appropriate hospital.
- Possess exceptional bedside manner for the comfort of my patients

First Medic Ambulance (Lisbon, North Dakota) **August 2011 – October 2012**

PARAMEDIC

- **Instructor: ACLS; PALS; PHTLS; AHA – CPR/AED; First Responder; EMT-B**
- Liaison and Educator: Enderlin First Responders & Fort Ransom First Responders
- FTO – Field Training Officer
- 911 – Ransom and Sargent County
- IFT – Emergent and Non-Emergent transport calls to a higher level of care.
- Possess exceptional bedside manner for the comfort of my patients

Max Care Ambulance **January 2011 – August 2011**

EMT-B

- FTO – Field Training Officer and Supervisor
- Run emergency and non emergency services calls and transport patients
- Inter-faculty communication
- **CRITICAL CARE TRANSPORTS**
- Possess exceptional bedside manner for the comfort of my patients

Good Shepherd Ambulance **March 2010 – October 2010**

EMT-B

- FTO – Field Training Officer
- Run emergency and non emergency services calls and transport patients
- Inter-faculty communication
- **CRITICAL CARE TRANSPORTS**
- Possess exceptional bedside manner for the comfort of my patients

Schaefer Ambulance **January 2008 – December 2009**

EMT-B

- Run 911 emergency service calls with ***LA County Fire Department***
- High 911 call volume. Ran average of "1,460" 911 calls per year
- Administer basic life support to those in need
- Assist LA County Paramedics with patients requiring ALS interventions
- Possess exceptional bedside manner for the comfort of my patients

Trans Aid Ambulance Service **June 2007 – December 2007**

EMT-B

- Run emergency and non emergency services calls and transport patients
- Inter-faculty communication
- Administer basic life support to those in need
- Possess exceptional bedside manner for the comfort of my patients

Further detailed job history upon request

RESUME - David R Starner Jr

EDUCATION

- NCTI – Riverside, CA Paramedic Program 2009 – 2010 - Certificate of Completion (Paramedic)
- Glendale Community College, CA 2006 – 2007 - Certificate of completion (EMT – B)
- Minnesota State University - Moorhead, MN - AA: General Studies degree

VOLUNTEER

- Liaison for Enderlin and Fort Ransom First Responders
- North Dakota: part of committee for writing protocols for the state of ND
- Lions Club Member 2010 – Current
- Kinship- Big Brothers Big Sisters 1998 - 2003 (Big Brother)

REFERENCES

Ken Myers LAFD Paramedic: EMT Instructor
Phone Numbers: (951)712-1823 (cell) (909) 608-1938 (home)

Brock Wenbourne: EMT Trainee
Phone Number: (619) 871-7496 (cell)

Michelle Smith: RN BSN Clinical Nurse Manager (Lisbon, ND)

Phone Number: (701) 683-6436 (office)

LICENSURE/CERTIFICATIONS

- NREMT Paramedic
- FireFighter I & II (IFSTA)
- ACLS Instructor (current)
- PALS Instructor (current)
- PHTLS (current)
- AHA CPR/AED (current)
- Haz Mat Awareness
- EVOC (Certificate of Completion)
- CEVO II – Ambulance (Certificate of Completion)
- Ambulance Driver's License (California)
- Certificate of Completion: NCTI Paramedic
- Minnesota, North Dakota, South Dakota registered Paramedic
- AHA STEMI Provider Manual (Certificate of Completion)
- Hazardous Materials/WMD Incident Response (Certificate of Completion)
- FEMA: NIMS ICS-100; ICS-200; IS-700a; IS-800b (Certificate of Completion)
- Immunization Record (DT/Td and Hepatitis B)
- AMLS (expired)
- PEPP (Expired)
- ITLS (Expired)

1 TIME-LINE REVIEW - David R Starner Jr

Glacial Ridge Emergency Services

DATES: 11/18/2013 – 12/11/2013. SALARY: $16.78/hr

10 FOURTH AVE SE, GLENDWOOD, MN 56334

GORDON PAULSON, HR MANAGER 320-634-2211

REASON FOR LEAVING: BACK GROUND STUDY DISQUALIFICATION. STATE OF MINNESOTA DENIED MY BACKGROUND CHECK, WAS LET GO PER STATES BACK GROUND CHECK.

JOB DUTIES:

DID NOT PROVIDE PRIMARY CARE

RIDE ALONG PARAMEDIC, 911 AND INTERFACITLY TRANSFERS

Aberdeen Fire and Rescue

DATES: 10/09/2012 – 08/19/2013. SALARY: $41,000/YR

121 S. 2nd St. Aberdeen, SD 57401

Battalion Chief Todd Salfrank or Chief Kevin Van Meter 605-626-7048

REASON FOR LEAVING: PERSONAL. PLEASE INQUIRE VIA CONTACT PHONE NUMBER.

Job Duties:

911 – Provide emergency fire fighting, rescue and paramedic level medical care to residents of Brown County.

Trained and skilled: RSI; King Vision ETT Intubation; Lucus Chest Compression System; 44 pharmaceutical medications.

Rural EMS ALS intercept: meeting a BLS unit while it is en route to the nearest appropriate hospital.

Possess exceptional bedside manner for the comfort of my patients

First Medic Ambulance

DATES: 08/2011 – 10/2012. SALARY: $21,000/YR

1100 Oak St. Lisbon, ND 58054

Bjorn Ringdahl 701-683-4721

REASON FOR LEAVING: CAREER ADVANCEMENT & JOB OPPORTUNITY WITH ABERDEEN FIRE RESCUE.

Job Duties:

Instructor: ACLS; PALS; PHTLS; AHA – CPR/AED; First Responder; EMT-B

Liaison and Educator: Enderlin First Responders & Fort Ransom First Responders

FTO – Field Training Officer

911 – Ransom and Sargent County

IFT – Emergent and Non-Emergent transport calls to a higher level of care.

Possess exceptional bedside manner for the comfort of my patients

MaxCare Ambulance

DATES: 01/2011 – 08/2011. SALARY: $15/HR

7614 Lemon Avenue. Lemon Grove, CA 91945

Ryan Karlsson 619-905-9662 (cell) or 619-303-6705 (office)

REASON FOR LEAVING: JOB OPPORTUNITY IN LISBON, ND AND ALSO ABLE TO BE CLOSER TO HOME.

Job Duties:

FTO – Field Training Officer and Supervisor

Run emergency and non emergency services calls and transport patients

Inter-faculty communication

CRITICAL CARE TRANSPORTS

Possess exceptional bedside manner for the comfort of my patients

GOOD SHEPHERD AMBULANCE

DATES: 03/2010 – 10/2010. SALARY: $13/HR

109 Agostino Rd. San Gabriel, CA 91776

SCOTT RYAN 562-634-5200

REASON FOR LEAVING: MOVED TO SAN DIEGO TO HELP A FRIEND WHO JUST STARTED AN AMBULANCE COMPANY.

Job Duties:

FTO – Field Training Officer

Run emergency and non emergency services calls and transport patients

Inter-faculty communication

CRITICAL CARE TRANSPORTS

Possess exceptional bedside manner for the comfort of my patients

SCHAEFER AMBULANCE

DATES: 03/2008 – 12/2009. SALARY: $12.65/HR

324 N TOWNE AVE. POMONA, CA 91767

JIMMY McNeil 909-622-1273

REASON FOR LEAVING: PARAMEDIC SCHOOL DEMANDS. I FINISHED DIADACTIC PORTION OF PARAMEDIC SCHOOL, NEXT CLINICAL AND FIELD INTERNSHIP. MY CURRENT WORK SCHEDULE WITH SCHAEFER AMBULANCE DIDN'T COINSIDE WITH PARAMEDIC SCHOOL DEMANDS. BECOMING A PARAMEDIC WAS MY PRIORITY.

Job Duties:

Run 911 emergency service calls with ***LA County Fire Department***

High 911 call volume. Ran average of "1,460" 911 calls per year

Administer basic life support to those in need

Assist LA County Paramedics with patients requiring ALS interventions

Possess exceptional bedside manner for the comfort of my patients

TRANS AID AMBULANCE SERVICE

DATES: 06/2007 - 12/2007. SALARY: $15/HR

1300 GARDENA AVE. GLENDALE, CA 91204

SCOTT RYAN. 818-265-5151

REASON FOR LEAVING: CAREER ADVANCEMENT AND JOB OPPORTUNITY WITH SCHAEFER AMBULANCE RUNNING 911 CALLS WITH LA COUNTY FIRE DEPARTMENT.

Job Duties:

Run emergency and non emergency services calls and transport patients

Inter-faculty communication

Administer basic life support to those in need

Possess exceptional bedside manner for the comfort of my patients

STARNER FARMS INC.

DATES: 01/1981 - 12/2006. SALARY: $10/HR

14158 130TH ST. HOFFMAN, MN 56339

DAVID SR OR MARK. 320-986-2387

REASON FOR LEAVING: MOVED TO CALIFORNIA.

Job Duties:

Manage 30,000 plus hogs

Manage 800 plus tillable acres of soybeans and corn

Basic farm responsibilities and daily chores

Other duties as assigned

03/27/2014

To whom it may concern:

This letter is regarding a request from David Starner for professional referral.

David Starner was employed by First Medic Ambulance in Lisbon N.D. as an EMT and later as a Paramedic. He was also employed by Para-Corp Medical Management firm Fergus Falls, MN as an EMT and later as a Paramedic. His duties with both companies were caring for the ill and injured in a multitude of settings and environments. His performance as a member of our medical staff was excellent and his medical knowledge and skills superior. David was kind to patients and well liked among the staff.

I personally and professionally recommend David as a potential hire as a Paramedic with your organization.

Bjorn Ringdahl NREMT-P/GM

Ringdahl EMS/ Para-Corp Medical Management

Fergus Falls, MN.

Pelican Rapids, MN

Jamestown, ND

Lisbon, ND

701-269-9545

Lisbon Area Health Services

905 Main Street

PO BOX 323

Lisbon ND 58054

March 27, 2014

To whom it may Concern,

David Starner served our community as a paramedic and often brought patients to Lisbon Area Health Services, where I am the Emergency Department Manager. He was a pleasure to work with, bringing his attention to detail with every patient. His communication and people skills are excellent, and he has some very innovative ideas.

I can highly recommend him for the opportunity that you have available. It is a very similar position to the one he had here, and he is well suited to the challenges it provides. David is a talented and eager man. Everyone here wishes him all the best with his move to Kansas. If you need any additional information, please contact me.

Best Regards,

Michelle

Michelle Smith, RN BSN
Clinical Nurse Manager

Lisbon Area Health Services
905 Main St. P.O. Box 353
Lisbon, ND 58054
Phone (701) 683-6436
Fax (701) 683-6446

Brock Wenbourne
1836 Laburnum Ave. Apt. 201
Chico, CA 95926
(619) 871-7496
bwenbourne@yahoo.com

03/30/2014

To whom it may concern:

This letter is written to provide my personal recommendation for David Starner as a candidate for a position with your Fire Department. While working with David as an EMT, he always remained professional, caring, and did what was best for his patients.

I first met David while working in San Diego, CA for MaxCare Ambulance. This was my first job as an EMT, and being the new guy I was struggling with the day-to-day operations of the job. While other employees looked at me as a nuisance, David took me under his wing and worked with me to become a great EMT. We became great friends throughout this time and had a great time working together. David always maintained a positive attitude and would perceive the best of people. He would always do his best to make his patient's laugh and was not afraid to go the extra mile as a patient advocate. I can honestly say that if one of my family members were sick, I would really hope a guy like David would come walking through the doors.

After working as an EMS provider for multiple EMS agencies, it has become apparent to me that a great partner or crew can either make of break this job. David was one of those great partners that made the job fun. He is a great friend, mentor, and person. I owe a great deal of my success of becoming a Firefighter Paramedic with Folsom Fire Department to David because he taught me something they can't teach you in Paramedic school or in a Fire Academy; how to have a positive attitude towards the job and how to be a true patient advocate.

Again, I would highly recommend that you not pass up this opportunity to hire David with you Department. He will be an asset to your department, and I ensure you that you will be hiring a great guy who is caring, professional, and is a great person.

Sincerely,

Brock Wenbourne

Brock Wenbourne
Folsom Fire Department
Firefighter-Paramedic

To whom it may concern,

I am writing on behalf of David R Starner JR. David and I were co workers as well as partners for almost a year. In that year I got to see how great of a care giver he is. I also got the privilege of seeing him transform from the role of and EMT to a Paramedic. When it came to patient care, his patient was first and foremost his top priority. He is very confident and knowledgeable in his skills which showed in his patient care.

David is a very good teacher, when on a call if I or any other of his partners had a question in regards to treatment or condition of the patient, after the call he would take time and explain what was going on and why he did what he did. I have been in EMS for six years and the time I spent working with David I can say is what helped me the most, I learned so much.

When it came to working with other services and hospital staff, he got along and worked well with everyone. After transfers we would stop at the hospital to drop off linen and everyone would sit and visit. When we would work codes in the ER, David would be the one keeping everyone calm and organized. We had a very emotional, chaotic call in the ER, I remember how everyone was running around yelling and no one was really in control. What impressed me and still impresses me to this day is how David got down on his knees by the patient and started whispering to everyone in the room. Everyone stopped and calmed down and the rest of the call went so smooth and it really amazed me how fast he got control of the call.

In conclusion to my letter, David is a great Paramedic, and anyone that gets to work with him will see that. I am so appreciative of the time I got to spend working with him and the knowledge I gained.

Sincerely,
Katherine Stangler

(701) 680-0598

1 AFD TERMINATION AND SDBMOE LICENSE - DAVID R STARNER JR

Explanation for termination from Aberdeen Fire Rescue and surrendering South Dakota paramedic license.

I was terminated for failing my probationary period with Aberdeen Fire Rescue. In short, I was unfortunate to be on the wrong side of my lieutenant and in the end I lost my job. South Dakota board of Medical & Osteopathic Examiners were notified I was terminated from work for failing to pass my probationary period due to multiple write ups and they were going to revoke my South Dakota Paramedic license. Instead of getting a lawyer and going to hearings, I decided to voluntarily surrender my South Dakota Paramedic license.

I have been working as an EMT and Paramedic for almost 8 years. I love what I do and I am very good at being a Paramedic. To the best of my knowledge, I have not done anything wrong to jeopardize my license that I so dearly worked hard to get. In the following paragraphs I will explain in detail about each of my write ups with Aberdeen Fire Rescue, my conversations with South Dakota Board of Medical and Osteopathic Examiners and ending with my final thoughts.

On August 15, 2013 I was served notice of termination from employment from Aberdeen Fire Rescue. I was served by Fire Chief Kevin VanMeter and then Battalion Chief Todd Salfrank while coming in for my normal scheduled work day. The letter stated "Dear David: This letter will serve as official notice of termination of employment with the City of Aberdeen, effective immediately. The reason for this termination is failure to successfully complete your probationary period." They stated that per there policy a probationary Firefighter cannot have more than 3 write ups during probationary period. There probationary period is the first year of employment.

My **1st** write up (don't have exact date) was served by Lieutenant Rob Senger for failing to wear proper PPE (Personal Protective Equipment) on scene. Per Aberdeen Fire Rescue policy, when arriving on scene EMS personal must have gloves worn throughout entire call. My prior experience I have worn my gloves just before I come into contact with a patient to prevent accidental and unnecessary contamination. They wanted me to have gloves worn prior to arriving on scene to avoid any delays. I explained to them that I will not make this mistake again.

My **2nd** write up was served by Lieutenant Rob Senger on July 16th 2013. My write up states: "FireFighter/Paramedic David Starner failed to follow medical protocol and failed to meet Aberdeen Fire Rescues standard of care. As noted in PCR 1203323 on 07/14/2013 The Patient condition warranted further treatment and the implementation of the chest pain protocol which was not done. Following is an written explanation that I gave to the Fire Chief Kevin VanMeter...

Key Points:

1. **Patient never complained of chest pain**
2. **Why treat a patient incorrectly**

3. Why are you forcing your medics to treat dispatch complaint and not actual patient

#1: Patient never complained of chest pain

Date: 07/14/2013

Crew: Medic 1: Driver: #15, Attendant: #76 & Truck 1: Mo and FTO Jesse Rystrom

Medic 1 dispatched for a male patient complaining of Chest Pain and heart attack. Medic 1 responding to call. Truck 1 responding to assist Medic 1. Arrived on scene to find patient sitting on edge of the bed. Patient visually appears to be without any immediate life threats, patients skin warm dry pink; respirations with good and equal chest rise and fall, patient speaking in full sentences, patient Alert and Oriented x 4 (Alert/Oriented to Person, Place, Time, and Event). I cancelled truck 1 because I had confidence in my partner (#15) and I could handle this call without occupying Truck 1 and its crew members.

Patient states that he woke up at 3 am with abdominal pain/discomfort around the belly button area. Patient state that he hasn't been able to go back to sleep. Patient also stated, the previous night, he ate a larger amount of food than normal (over eating). I was informed by the patient, that his wife called 911 because she was worried that he was having a heart attack. Patient himself stated that he never had chest pain, chest pressure, chest discomfort, and never was short of breath. Patient stated his wife advised him to take aspirin as a precautionary measure just in case he was having a heart attack. Pt state he took 2 baby aspirin and didn't take his prescribed medications because he was afraid it would upset his stomach even more.

Patient's past pertinent medical history includes, high blood pressure, pace maker. Patient state that he didn't take his high blood pressure that morning because his stomach was upset. Patient's Vital Signs: monitor shows a paced rhythm; O2 saturation 95% on room air; blood pressure 170/80, patient stated that blood pressure is normally that high when he doesn't take his medication. Patients O2 saturation remained 94% or greater, patient skin remained warm, dry and pink.

I advised the patient that he should go to the hospital to get further checked out. Initially, patient refused transport. I advised the patient that he could possibly have a sick heart due to the facts that he was complaining of abdominal pain and indigestion which indirectly could be masking him having a heart attack. Patient again denied for the second time to allow us to take him to the hospital. I reminded the patient that his wife has been up since 3 am with him and that she's really worried about his health, so why don't we take you in to the hospital to play it safe. Patient stated that he didn't know if he wanted to go to the hospital and that he feels foolish for having us there. #15 and I both reassured him that his wife did the right thing by calling us. #15 went down to get the gurney ready and also grab the clip board. I again attempted to try to get the patient to go to the hospital, reminding the patient that indigestion can be a precursor to and acute heart attack and you could die. Patients wife told him to just go in and get checked out to play it safe. Patient finally agreed to allow us to transport him to hospital.

I advised the patient and his wife before we go; I need to explain a few things to my partner before we go. When #15 came up from getting the gurney ready, I informed #15 (in front of Patient and his Wife) the patient agreed to go to hospital but before we go I need to explain a few things. At 3 am, patient woke up with stomach pain, thinking it was indigestion, at no time has he had any chest pain, chest pressure, chest discomfort or short of breath. I advised the patient that abdominal pain and indigestion can mask a heart attack and that with a paced rhythm we are unable to take a full look at his heart. #15 shook his head and said ok, the patient and his wife acknowledged what I said and said that's correct. The patient looked at me, asked me "can we go"? I replied "yes". The patient got up from his chair without assistance, walked himself down the stairs to the gurney and we transported him to the hospital without any further findings, changes or incidents.

After the call was completed and driving back to station 1, Erik said that it was too bad Dylon wasn't on this call, this would've been a great learning experience for him because you have dispatch complaint of chest pain and heart attack verses on scene patient never having chest pain and more anxiety related induced by his wife. I agreed with Erik and said this would've been a great call for Dylon.

#2: Why treat a patient incorrectly

According to my write up on 07/14/2013...

"FireFighter/Paramedic David Starner failed to follow medical protocol and failed to meet Aberdeen Fire Rescues standard of care."

****The following is Aberdeen Fire and Rescue EMS Protocols & Policies for "Routine Care":*

ROUTINE CARE

The following assessment is to be performed and information is to be obtained on all patients:

1. Assure scene safety for yourself, your fellow rescuers, and your patient.

...the scene was safe for me and my crew and my patient

2. Initial survey: General Impression:

   A. Airway with cervical spine control if appropriate – oxygen as appropriate maintaining O2 > 94%

   B. Breathing (monitor ETCO2 as indicated)

   C. Circulation with control of bleeding

   D. Disability Determination

      A = alert and conscious

V = responsive to verbal stimuli

P = responsive to painful stimuli

U = unresponsive

E = exposure

... as stated above in my explanation letter, all these steps were followed

3. Transport Decision.

...delayed due to patient refusing multiple times, eventually transported patient to his desired Hospital

4. Consider Rapid Trauma Exam or Detailed Physical Exam.

... no trauma indicated or found

5. Consider all assessment and treatments as necessary:

   A. ECG monitor (12/15 lead as indicated)

   ... patient on monitor, monitor showing paced rhythm

   B. Capnography and Pulse oximetry

   ... patient placed on pulse oximetry

   C. IV access as appropriate maintaining BP > 90

   ... patient BP remained above >90

   D. Medications per appropriate protocol

   ... no medications indicated for patient complaining of indigestion and abdominal pain

6. Detailed Physical Survey:

   A. Obtain vital signs and perform objective head-to-toe assessment.

   ... vital signs obtained and head-to-toe assessment without significant findings

   B. Obtain history:

   - Patient's name
   - Sex, age, and approximate weight
   - Chief complaint
   - Precipitating factors
   - Significant past medical history

- Allergies
- Current medications
- Private physician's name

... all above was obtained

7. Apply appropriate protocol and standing orders based on assessment.

... there are no specific protocols for indigestion and abdominal pain in Aberdeen Fire and Rescue EMS Protocols & Policies

4. Contact Medical Control as designated in protocol or if there are any problems or questions.

... no indication to contact medical control in Aberdeen Fire and Rescue EMS Protocols & Policies

9. Position patient comfortably as indicated by condition or situation.

... patient was positioned in his position of comfort

10. Reassure and calm patient. Loosen any restrictive clothing or remove as indicated.

... patient was reassured and calmed

Conclusion

I am at a loss what I failed to do correctly. I highlighted each and every portion with a brief explanation.

#3: Why are you forcing your medics to treat dispatch complaint and not the actual patient?

According to my write up on 07/14/2013...

Continued "...As noted in PCR 1203323 on 07/14/2013 The Patient condition warranted further treatment and the implementation of the chest pain protocol which was not done."

****The following is Aberdeen Fire and Rescue EMS Protocols & Policies for "Chest Pain"*

CHEST PAIN

1. Obtain and transmit 12-lead EKG, if 12-lead is unremarkable or showing an Inferior AMI, obtain a 15-lead EKG.

... patient with paced rhythm unable to perform 12/15 lead with accurate reading

2. Establish two IVs 18g or greater with care to avoid the right wrist location if possible, left arm is preferred (per cath lab).

... I did not start an IV or per protocol 2 IV's 18g or greater. Patient didn't complain of chest pain. How many paramedics have started two IV's 18g or greater with a patient complaining of chest pain?

3. Administer:

- 4 baby Aspirin chewable tablets (324 mg) p.o. if the patient is not allergic to Aspirin and does not have ulcer disease

... patient never complained of chest pain

3. If 15-lead is negative for a right ventricular AMI, administer:

- 1 Nitroglycerin spray 1/150 sublingually if systolic blood pressure is greater than 100 mmHg. May be repeated every 5 minutes until:
  - 3 sprays have been administered
  - Pain is relieved
  - Systolic blood pressure falls below 100 mgHg
  - Avoid use of Nitro in pt's that have or are suspected to have taken a phosphodiesterase inhibitor (eg, Viagra)

... ... patient never complained of chest pain

5. If 15-lead is positive for a right ventricular AMI, begin fluid administration with normal saline. Patients may require one liter or more of saline to prevent a drop in blood pressure with nitro administration. Use caution when administering sublingual nitroglycerin spray, a nitro drip is recommended in this situation.

... no 15-lead obtained due to paced rhythm

6. Consider a Nitro Drip beginning at 5 mcg/min, titrate to effect (by increasing by 5 mcg/min) while maintaining BP >100 systolic

... patient never complained of chest pain

7. For pain control, consider administering:

- Fentanyl 50-100 mcg slow IV push, this dose may be repeated as needed.

... patient never complained of chest pain

8. **If patients are < 75 years of age with a STEMI, administer a loading dose of Plavix (clopidogrel) 600 mg p.o.**

... we don't even carry Plavix

9. Treat dysrhythmias per protocols.

... patient with a paced rhythm

Conclusion:

Where did I go wrong? You want me to treat the dispatch complaint for patient complaining of chest pain and heart attack? Patient never complained of chest pain. Initially I refused to sign the write up for I felt I was being targeted by Lieutenant Rob Senger. I knew Lieutenant Rob Senger has been after me

ever sense we got into a verbal disagreement. I informed then Battalion Chief Todd Salfrank and Chief Kevin VanMeter of my fears that Lieutenant Rob Senger was "gunning" for me. They assured me that future discussions between Lieutenant Rob Senger and myself will have a witness and that I am to remember that I am a probationary firefighter and Lieutenant Rob Senger is my superior. I was also informed that if I refused to sign the write up that qualifies for immediate termination. I also had a union representative present (Mike Eliason). I was informed by my union representative that beings that I am a probationary firefighter, I don't have the right to appeal a write up. So I had no choice but to sign my write up otherwise I would have been terminated.

My ***3rd*** write up was served by Battalion Chief Huebner for failing to get to a 911 call in a timely manner. I was the driver on this call and my partner was the navigator and patient care giver. We were given the address 121 Elizabeth Drive. I was given directions by my partner how to get to the address and followed them. We went the wrong way and we were delayed getting to the call by 2 minutes. The write up stated (to the best of my memory) that all Aberdeen Fire Rescue employees are suppose to know the city and know the fastest way to get to any given address. Again I had no choice but to sign my write up.

I knew that this would be the end of my employment with Aberdeen Fire Rescue because this was my 3rd write up. They didn't terminate me right away. I went on vacation for 2 weeks to help my family. My Mother was going through chemo therapy and my Dad needed my help taking care of my Mom. When I came back from vacation on August 19th 2013 I was informed that I was terminated for the above listed reason.

On September 3, 2013 I received the following email from South Dakota Board of Medical and Osteopathic Examiners...

"Dear Mr. Starner: The South Dakota Board of Medical and Osteopathic Examiners received information that you were involuntarily terminated from the Aberdeen Fire Department for failure to successfully complete your probationary period after receiving multiple written warnings. Your response and all data collected during this inquiry are deemed confidential by the Board in accordance with SDCL 1-27-1.5(5). Please provide your written response to this matter within one week of the date of this letter. Please provide this response by email to SDBMOE@state.sd.us. Thank you for your cooperation, and I anticipate your prompt response" signed by Board investigator Ted Huss.

On September 23, 2013 I received the following email from South Dakota Board of Medical and Osteopathic Examiners...

"Dear Mr. Starner: As you are aware, I am the Investigator for the South Dakota Board of Medical and Osteopathic Examiners. You are also aware on September 3, 2013 I sent you a letter via email requesting an explanation as to your termination from the Aberdeen Fire Department. Due to your termination and other disciplinary action by the Aberdeen Fire Department, your license has been placed under investigation. Please be aware of the following:

1. ***You have the right to contest the recommendation at an administrative hearing which will be conducted in accordance with SDCL 1-26. This matter will be presented to a neutral administrative judge.***
2. ***You have the right to be represented by an attorney of your own choosing at the administrative hearing if you so desire.***
3. ***The recommendation of the administrative judge will be referred to the South Dakota Board of Medical and Osteopathic Examiners. The Board may accept, reject or modify the recommendation.***
4. ***If you participate in a hearing, you would then have the right to file an appeal to Circuit Court.***

I responded via email with the above explanations that I gave you of my write ups and termination as per requested.

On October 21, 2013 I received the following email from South Dakota Board of Medical and Osteopathic Examiners...

"Dear Mr. Starner: Please be advised that the Board member of the investigative review panel is recommending the revocation of your paramedic license. If you wish to contest this recommendation you have the following rights:

1. ***To contest the recommendation at an administrative hearing this will be conducted in accordance with SDCL 1-26. This matter will be presented to a neutral administrative judge.***
2. ***To be represented by an attorney of your own choosing at the administrative hearing if you so desire.***
3. ***The recommendation of the administrative judge will be referred to the South Dakota Board of Medical and Osteopathic Examiners. The Board may accept, reject or modify the recommendation.***
4. ***If you participate in a hearing, you would then have the right to file an appeal to Circuit Court.***

If you wish to contest this recommendation please contact William H. Golden no later than October 31, 2013, at (605) 367-5880." Signed by Board investigator Ted Huss. Cc: William H. Golden, esq. Assistant Attorney General/Litigation Division. Counsel to the South Dakota Board of Medical and Osteopathic Examiners.

On October 21, 2013 I called the Board investigator Ted Huss. I talked to him about my options concerning my State Paramedic license after the board's decision to revoke my paramedic license. He again stated that I can appeal it or get an attorney. I asked him if I am no longer living in South Dakota and don't plan on living or working as a Paramedic in South Dakota, is there any reason I need to have my South Dakota Paramedic license. He didn't give me a clear answer. I then asked him instead of getting my state Paramedic license revoked, if I could voluntarily remove my license because that would look better than having my license revoked. I also explained that I don't have the money to get an attorney. He stated that I can write a letter to him and he will present the letter to the board.

**** The following is the letter I wrote to the Board investigator Ted Huss on October 23, 2013...*

Mr. Huss,

9 AFD TERMINATION AND SDBMOE LICENSE - DAVID R STARNER JR

I would officially like to request my paramedic license for the state of South Dakota be removed and I would no longer be licensed for the state of South Dakota.

Thank you,

David Starner

On October 29, 2013 I received this email from Board investigator Ted Huss...

Mr. Starner,

Your request to withdraw licensure while under investigation will be placed on the agenda for the next Board meeting, November 13, 2013. Withdrawal while under investigation is a public board action and will be published on the Board's website and reported to the national data banks and any other entity deemed appropriate by the Board and in compliance with State and Federal law.

On November 15, 2013 I received the following email from South Dakota Board of Medical and Osteopathic Examiners...

"Dear Mr. Starner: As you aware from the Notice of Hearing you received from this office, the South Dakota Board of Medical and Osteopathic Examiners met on November 13, 2013. At the meeting they accepted your written request that you be permitted to voluntarily withdraw your South Dakota Paramedic license while under investigation.

A report of this disciplinary Board action will be submitted to the National Practitioner Data Bank and you may receive a notification from them about this activity.

The above-entitled matter having come before the South Dakota Board of Medical and Osteopathic Examiners ("Board"), and the Board having been fully advised in the premises thereof; and

As a condition of licensure, David R. Starner consents to the documents relating to this matter being provided to other state licensing authorities upon their request. NOW; THEREFORE, the Board hereby:

APPROVES the request to withdraw his licensure while under investigation and this Final Order are public records of the Board and the State of South Dakota and shall be published on the Board's website and reported to the national data banks and any other entity deemed appropriate by the Board and in compliance with State and Federal Law." Signed by Jane Phalen Board Staff.

In summary, I feel that I have done nothing wrong to warrant such a harsh penalty. I was merely a victim of an unsafe work environment which had one member out to get me. In the end I lost my job. I was fired for failing my probationary period with the Fire Department. In short, I was unfortunate to be on the wrong side of management and in the end I lost my job. South Dakota board of Medical & Osteopathic Examiners were notified I was terminated from work for failing to pass my probationary period due to multiple write ups and they were going to revoke my South Dakota Paramedic license. Instead of getting a lawyer (that I cannot afford at this time) and going to hearings, I decided to voluntarily surrender my South Dakota Paramedic license. Hind sight is 20/20. If I knew surrendering my South Dakota Paramedic license would have these types of ramifications, I would have appealed and went to a hearing to keep my South Dakota Paramedic license. I am currently in the process to renew my South Dakota Paramedic license. I have done all the steps the state has required and now I am waiting for further instructions. I anticipate that I will be going through the appeal process and also a hearing. I am confident that I will gain my South Dakota Paramedic license and be adjourned from all accusations and speculations.

In conclusion being a paramedic is all my family and I have. It took me 30 years to finally realize my calling and that was to follow in my Mothers footsteps. My Mom was an EMT and instructor for 13 years which was during my childhood years on the farm. She volunteered and ran our local ambulance in Hoffman, MN (small town less than 600 people). I am a highly skilled, resourceful, innovative and committed paramedic with an extensive experience dealing with medical and traumatic emergencies. I provide exceptional pre-hospital emergency care and services while also providing professional patient focused care. I have learned to adapt quickly to addressing my patient's needs while using a calm demeanor. I pride myself in making sure I am experienced in the newest techniques to help my patients in the field. I have a very strong knowledge about medications and the ability to apply this knowledge in a practical sense. I am a strong team player who possesses strong leadership skills. My newest passion is teaching and helping future Pre-Hospital and Hospital providers become the best they can be. I am a certified AMA ACLS and PALS instructor. I am a passionate paramedic and teacher who is loving, caring, hard working, and soon to be married and a father of 5 wonderful kids.

Thank you for taking the time to reconsider me,

David R Starner Jr

14158 130th Street. Hoffman, MN 56339

djstarner@yahoo.com

(320) 288-8707

SOUTH DAKOTA
BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

SDBMOE
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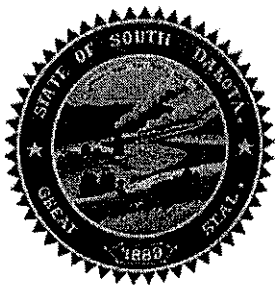

Sent Via Electronic Mail

November 26, 2012

David Starner
1416 10th Avenue SE
Aberdeen, SD 57401

David:

You indicated all "no" answers to the disclosure questions on your application for South Dakota Medical License. Since the receipt of you application, we have received information that conflicts with the answers you provided. Please submit a detailed statement to the Board explaining each of the following discrepancies and why you did not report them in your application.

- Employment verifications have been received stating:
  - You were verbally reprimanded for not following narcotic control policy.
  - You have a very difficult time accepting policy and protocols you disagree with.
  - You did not get along with other staff members and a personal relationship with a co-worker caused issues as well.

Please see the attached Affidavit and Authorization for Release of Information you signed for your application.

Sincerely,

Randi Sterling

Randi Sterling
Licensing Specialist

Send to SDBMOE, 101 N MAIN AVE STE 301, SIOUX FALLS, SD 57104

Affidavit and Authorization for Release of Information: You must attach a recent (less than 6 months old) passport quality, color photograph of yourself to this form. Take the form to a notary public and sign the form in the presence of the notary public. The notarized form then must be sent directly to this Board.

Affidavit
And
Authorization For Release of Information

I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in this application, that all statements I have made or shall make with respect thereto are true, that I am the original and lawful possessor of and person named in the various forms and credentials furnished or to be furnished with respect to my application and that all documents, forms or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

I acknowledge that I have read and understand the Application for Physician Licensure and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I authorize and request every person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me to furnish to the Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the Board or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

I hereby release, discharge and exonerate the Board, its agents or representatives and any person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by the Board.

I will immediately notify the board in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a license to practice medicine being granted to me by the board.

I understand my failure to answer questions contained in this application truthfully and completely may lead to denial, revocation, or other disciplinary sanction of my license or permit to practice medicine.

Applicant's Signature (must be signed in the presence of a notary)

STARNER
Applicant's Printed Last Name

David R JR
Applicant's Printed First Name, Middle Initial, and Suffix (e.g., Jr.)

10-17-12
Date of Signature

NOTARY

Dated 10-17-12 Signed Mary Compton

State of South Dakota County of Brown

SUBSCRIBED AND SWORN TO before me this 17 day of October 2012.

My commission expires: 3/28/2018

MARY CAMPTON NOTARY PUBLIC STATE OF SOUTH DAKOTA

(NOTARY PUBLIC SIGNATURE & SEAL)

DOC 1 1 3 9 1 5

1 EMPLOYMENT VERIFICATION EXPLANATION – DAVID R STARNER JR

November 28th 2012

Randi,

I am surprised at the allegations that have come from my previous employer about my work performance. I am having a difficult time and at a loss as to where to begin. I tried to call you Monday, November 26th 2012 to get some clarity and a place to start.

I have made several phone calls to try to clear some of this up. I talked to Ed Gregoire, (State EMS Training Coordinator), who was unaware of any problems with me and my previous employer. He took the time to look up my profile and again said that its "clear" without any infractions.

I talked to my supervisor, Rob Senger and informed him on the letter I received from you. I also forwarded a copy to him. Rob made a very good point, "Why did the City of Aberdeen hire me if these accusations where true"? Or at least the City would have made an attempt to get some clarity on these issues prior to my hiring.

I truly believe these accusations are due to my leaving First Medic Ambulance. Prior to my resignation letter, everything at work was great. I got along with everyone I worked with. I would have co-workers over for breakfast and coffee after we did our rig checks. We would get together on our days off and hang out. When I gave my resignation letter, (I have saved a copy if needed for verification and/or documentation), most of my co-workers, including my manager, Vicki Berreth, treated me very differently. We did not hang out any more. They in fact made it well known that they thought I was abandoning them. Vicki was very upset and in fact didn't talk to me until my last day at work and that was via text message (I have saved the text messages if needed for verification and/or documentation).

Randi, the following are the accusations against me that you wanted explanations for...

- Employment verifications have been received stating:

1) **<u>You were verbally reprimanded for not following narcotic control policy.</u>**
   I made one narcotic documentation error. At every shift, in the morning, we sign off the narcotics stating they are all there. The narcotics are locked up and sealed with a tag which has numbers on it. When I signed off on the narcotics, I wrote down the last number incorrectly. I put down a "5" instead of an "8". There were never any missing narcotics. Vicki explained to me the importance of taking the time to make sure I write down the correct tag numbers. I understood and haven't had a problem since. That is the only case with narcotics that I can think of.

2) **<u>You have a very difficult time accepting policy and protocols you disagree with.</u>**
I am at a loss here. No idea where this came from. In fact, First Medic asked me to rewrite and update our protocols. My work in writing the protocols didn't go unnoticed. The State of North Dakota hired me to be a part of a committee to write the State EMS protocols.

3) **<u>You did not get along with other staff members and a personal relationship with a co-worker caused issues as well.</u>**

I am speechless to say the least. As I stated above, up until the point I turned in my resignation letter, we all got along great. In fact, I considered most of my co-workers friends especially Vicki. She and I would sit for hours and just talk and hang out. But again, once I gave my notice that I am leaving First Medic, the people whom I thought were my friends, no longer wanted anything to do with me. The relationship between Vicki and I was as if we never knew each other.

I am not sure what else to say here. Please email or call me if you have any questions or if I can be of any more help in clearing this up. I am willing to get letters or support statements, or even provide telephone numbers of people you can call to verify the above accusation are in fact false. I am very concerned with any type of "black mark" on my name, and that I will do whatever it takes to get this information removed from my file as it is all false and I feel it is a defamation of my character.

Thank you for your time and consideration in this matter.

Sincerely,

David R. Starner Jr

<u>djstarner@yahoo.com</u>

626-806-0369

Nov 30, 2012

David,

Thank you for providing the detailed explanation as requested. The employment verification has now been approved on your checklist. The only item needed to complete your application for EMT- Paramedic license is approval from the EMS office.

You will need to complete the reciprocity form on the below link in order for the SD EMS office to clear your application. Once this form is completed and returned to their office as instructed they can clear the application for approval of the licensure.

http://dps.sd.gov/emergency_services/emergency_medical_services/sd_certification.aspx

If you have any questions please let us know.

Thank you,

Randi Sterling

Licensing Specialist

SD Board of Medical & Osteopathic Examiners

101 N. Main Ave., Suite 301

Sioux Falls, SD 57104

www.sdbmoe.gov

1 PROTECTION ORDER - David R Starner Jr

I am a Respondent to a Restraining Order. When I applied for South Dakota Paramedic license, I didn't disclose this fact. South Dakota found out that I am a Respondent to a restraining Order by a letter sent to them. The same woman, who has been accusing me of these untruthful allegations, is the same woman who sent a letter to South Dakota stating that I am a respondent of a Restraining order. If the Law has completely and accurately absolved me from these accusations, why am I not granted the same courtesy?

The facts are that I do have a protection order against me. In short, I had consensual sexual relationship with this woman on a weekend which latter she later told her husband that she had been sexually assaulted by me. Keep in mind; I have been completely absolved by law enforcement and by the County Attorney from these accusations. I was told by the Sheriff of Grant County that there was no truth to her allegations and that the investigation was over. I have text messages from her proving that she is not being truthful. I did not object to the Order for Protection because I simply believed that it would be the best way to let things resolve without any conflict. The Sheriff and County Attorney of Grant County did their investigation, brought in witnesses, got theirs and my testimonies, reviewed and recorded the text messages and voice message from her (messages asking me to lie about what happened that night), and in the end, they completely absolved me from all these accusations. After I was absolved from the law, I was given an Order for Protection in retaliation from her with an option to appeal. The Sheriff of Grant County told me that nothing further was going to be done with this order of protection and that this was her way to try to save her marriage. I was informed by the Sheriff of Grant County that they and the County Attorney were not going to proceed further after their investigation and that the Sheriff's department was closing its file on the case. I simply did not appear at Restraining Order hearing because I simply had no reason to ever need to see this person again.

I did not believe that an accusation by an individual woman, that is not work related, and has not been charged as an offense, was something that I need to disclose. Any woman could accuse me of sexual impropriety and the fact that she happened to go to law enforcement claiming this and Law enforcement and the county attorney after investigation dismissed it as untruthful. I was told that there was going to be no further proceeding. But due to the events of me trying to fight for my Paramedic license, I feel it's better to aid on the side of caution and be upfront and honest. I am not sure if this has any relevance to my case, or if it hurts my case, but I do not want this to come up in the future to haunt my family and I.

In short, I hope I didn't self incriminate myself by disclosing this, but I feel honesty is the best policy. Also, I hired a lawyer to appeal the restraining order and see if we can get that removed. In the end, we were not able to appeal the order because the court feels it's a waste of time beings the order expires in a few months. Please, if you have any further questions, please feel free to call or email me.

David R Starner Jr

djstarner@yahoo.com

(320) 288-8707

MARSHALL LAW OFFICES

BOX 099
BARRETT, MINNESOTA 56311

Kent D. Marshall
Lawyer

May 28, 2014

To Whom It May Concern:

RE: David Starner Jr.

I am familiar with the facts and circumstances surrounding an Harassment/Restraining Order that was filed by Jennifer M. Winningham-Floden against David Starner Jr. in Grant County, Minnesota. He did not contest this Restraining Order based upon legal advice.

The Grant County Sheriff's Department thoroughly investigated the facts surrounding Ms. Floden's claims and did not find them to be credible. There were never any charges filed.

David Starner Jr. did not commit any conduct that would warrant applying for or receiving a restraining order. However, because of the sensitive nature of the relationship between Mr. Starner and Mrs. Floden, he did not contest the Restraining Order. He did not realize that it would have such an impact on his employment.

I am confident, beyond question, that given the opportunity, Mr. Starner could prove absolutely all allegations against him to be groundless and without merit.

If any further information is needed, I would be happy to provide it at any time.

Sincerely,

Kent D. Marshall
KDM/bo

FAX (320) 528-2567 TELEPHONE (320) 528-2564 EMAIL mrshlaw@runestone.net

SOUTH DAKOTA
BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

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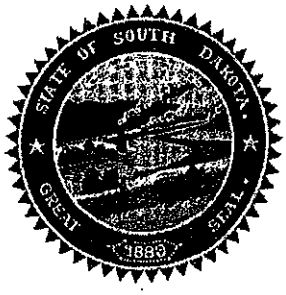

March 4, 2013

David Starner
1416 SE 10th Ave
Aberdeen, SD 57401

Dear Mr. Starner:

I am the Board Investigator for the South Dakota Board of Medical and Osteopathic Examiner's Investigative Review Panel. On your application for licensure you failed to disclose that you were the subject of two investigations of sexual assault and that you were the subject of a protection order. Due to these reasons, your license has been placed under investigation.

Please be aware of the following:

1. You have the right to contest the recommendation at an administrative hearing which will be conducted in accordance with SDCL 1-26. This matter will be presented to a neutral administrative judge.

2. You have the right to be represented by an attorney of your own choosing at the administrative hearing if you so desire.

3. The recommendation of the administrative judge will be referred to the South Dakota Board of Medical and Osteopathic Examiners. The Board may accept, reject or modify the recommendation.

4. If you participate in a hearing, you would then have the right to file an appeal to Circuit Court.

Notification that an investigation has been initiated can be disconcerting, and your first inclination may be to call the office to ask for details or discuss the matter. We respectfully request that you refrain from calling as the Board's policy for maintaining the confidentiality of all investigations prohibits the discussion of investigations over the phone. Should you have questions or concerns, please send them in writing by US mail, or you may send an email to SDBMOE@state.sd.us.

Thank you for your cooperation in this matter.

Sincerely,

Board Investigator

SOUTH DAKOTA
BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

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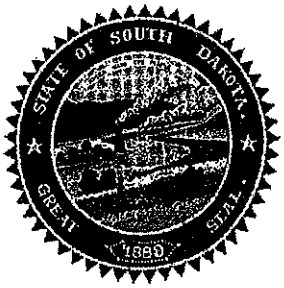

March 4, 2013

David Starner
1416 SE 10th Ave
Aberdeen, SD 57401

Dear Mr. Starner:

As you are aware, your paramedic license has been placed under investigation.

Please provide a detailed and complete explanation as to why you failed to disclose on your application that you were accused of sexual harassment on two separate incidents in Grant County and Ottertail County and the fact that you are the Respondent to a protection order.

This detailed and complete explanation should not only explain why you failed to disclose the incidents but also explain the incidents themselves.

Sincerely,

Ted Huss
Board Investigator

1 REPLY TO SDBMOE PROTECTION ORDER - David R Starner Jr

March 12, 2013

Ted Huss
Board Investigator
SD Board of Medical & Osteopathic Examiners
101 N. Main Ave., Suite 301
Sioux Falls, SD 57104

Dear Mr. Huss,

I have reviewed my License Application for SDBMOE (***License application# 12996)***. As far as I can discern, the only disclosure requirement that I may have failed to disclose on my application would have been # 13 under "required disclosures"...

> 13) ***Been accused of or been disciplined, found liable, guilty, or responsible for sexual impropriety, sexual harassment, disruptive or discriminatory behavior?***

... been accused of sexual impropriety: When I filled out this application and specifically #13 (my best guess to what I may have failed to disclose), I interpreted and believed that the accusations would have needed to have come from law enforcement or related to my work. As far as I can tell, there is no other place on the application where this would need to have been disclosed. I did not believe that an accusation by an individual woman, that is not work related, and has not been charged as an offense, was something that I needed to disclose. Any woman could accuse me of sexual impropriety and the fact that she happened to go to law enforcement claiming this. Law enforcement and the county attorney after investigation dismissed it as untruthful. I was told that there was going to be no further proceeding. Mr. Huss, I believe I was truthful and honest when I turned in my application. Below I will explain more in detail about the situation and if you have any further questions, please let me know.

I cannot find in the application that would specifically require me to disclose that I am a subject of an OFP. The facts are that I do have a protection order against me. The Sheriff of Grant County told me that nothing further was going to be done with this order of protection and that this was her way to try to save her marriage. I was informed by the Sheriff of Grant County that they and the County Attorney was not going to proceed further after their investigation and that the Sheriff's department was closing its file on the case. I simply did not appear at Restraining Order hearing because I simply had no reason to ever need to see this person again. Now that I have found that it might adversely affect my employment, I will go back into court and seek to have the Restraining Order removed.

In short, I had consensual sexual relationship with this woman on a weekend which latter she later told her husband that she had been sexually assaulted by me. Keep in mind; I have been completely absolved by law enforcement and by the County Attorney from these accusations. I was told by the Sheriff of Grant County that there was no truth to her allegations and that the investigation was over. I was never accused by anyone other than her and I have text messages from her proving that she is not being truthful. Again, I did not object to the Order for Protection because I simply believed that it would be the best way to let things resolve without any conflict. When I looked at disclosures, I didn't feel that would mean that any woman in the world could have made an accusation against me and that I would have needed to disclose the OFP. The Sheriff and County Attorney of Grant County did their investigation, brought in witnesses, got theirs and my testimonies, reviewed and recorded the text messages and voice message from her (messages asking me to lie about what happened that night), and in the end, they completely absolved me from all these accusations. After I was absolved from the law, I was given an Order for Protection with an option to appeal. As I stated before and advised by the Grant County Sheriff, that this wouldn't be on my record, nothing would come of this in the future, and I decided to let it go and not appeal it.

As far as there being 2 separate instances of sexual harassment, one in Ottertail County and the other in Grant County. I am unaware of 2 separate instances of sexual harassment. I have hired a lawyer to remove the order of protection and protect me from any further damages. My lawyer advised me there is one case on record (never charged or found guilty by the law) where I have been accused of sexual harassment not two separate cases. My lawyer stated they believe that she may have filed a Complaint in both Grant County and Ottertail County (she lives in Ottertail County). Ottertail County likely told her that the complaint had to be filed in Grant County because that is where the incident took place.

I have hired a lawyer to appeal the restraining and see if we can get that removed. If you have any further questions, or would like to speak to myself or my lawyer, please feel free to call or email me.

David Starner

SOUTH DAKOTA
BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

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September 3, 2013

David Starner
1416 10th Ave SE
Aberdeen, SD 57401

SHIPPED SEP 03 2013

SHIPPED SEP 03 2013

Dear Mr. Starner:

The South Dakota Board of Medical and Osteopathic Examiners received information that you were involuntarily terminated from the Aberdeen Fire Department for failure to successfully complete your probationary period after receiving multiple written warnings. Your response and all data collected during this inquiry are deemed confidential by the Board in accordance with SDCL 1-27-1.5(5).

Please provide your written response to this matter within one week of the date of this letter. Please provide this response by email to SDBMOE@state.sd.us. Thank you for your cooperation, and I anticipate your prompt response.

Sincerely,

Ted Huss
Board Investigator

SOUTH DAKOTA
BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

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September 23, 2013

David Starner
14158 130th St.
Hoffman, MN 56339

Dear Mr. Starner:

As you are aware, I am the Investigator for the South Dakota Board of Medical and Osteopathic Examiner's. You are also aware on September 3, 2013 I sent you a letter via email requesting an explanation as to your termination from the Aberdeen Fire Department. Due to your termination and other disciplinary action by the Aberdeen Fire Department, your license has been placed under investigation.

Please be aware of the following:

1. You have the right to contest the recommendation at an administrative hearing which will be conducted in accordance with SDCL 1-26. This matter will be presented to a neutral administrative judge.

2. You have the right to be represented by an attorney of your own choosing at the administrative hearing if you so desire.

3. The recommendation of the administrative judge will be referred to the South Dakota Board of Medical and Osteopathic Examiners. The Board may accept, reject or modify the recommendation.

4. If you participate in a hearing, you would then have the right to file an appeal to Circuit Court.

Notification that an investigation has been initiated can be disconcerting, and your first inclination may be to call the office to ask for details or discuss the matter. We respectfully request that you refrain from calling as the Board's policy for maintaining the confidentiality of all investigations prohibits the discussion of investigations over the phone. Should you have questions or concerns, please send them in writing by US mail, or you may send an email to SDBMOE@state.sd.us.

Thank you for your cooperation in this matter.

Sincerely,

Board Investigator

1 RESPONSE TO RECEIVED LETTERS FROM SDBMOE ON SEPT 3 & 23 - David R Starner Jr

David Starner

The next 10 pages are in response to September 3 & 23, 2013 email and letter I received from SDBMOE. After emailing this response to Mr. Huss, the board (SDBMOE) ultimately decided to revoke my paramedic license. Still to this day, I cannot understand what I did so wrong for the board to want to revoke my license. In short, the following 10 pages are exactly what I sent the state.

David R Starner Jr.

14158 130th Street

Hoffman, MN 56339

(320) 288-8707

djstarner@yahoo.com

Mr. Ted Huss,

I went on vacation for 2 weeks to help my family. My Mom was going through chemo therapy and my Dad needed my help helping my Mom. When I came back from my vacation, August 19th 2013, I was informed before my shift that I was fired for not passing my PHTLS course and that was basically the straw that broke the camel's back (so to speak). I was informed this by Chief Kevin VanMeter and Battalion Chief Todd Salfrank. They handed me my termination letter and wished me best of luck. At that time I was in shock and didn't know what to say. A few days later I informed chief that I did in fact have my PHTLS course and card to prove it. I never failed. That was false information. Chief said that there is nothing he can do now. I also handed him the following letter and he took it to HR director Al Norman. I have called AL multiple times and have not heard from him. There has been no further explanation concerning this letter or why I was fired even after I had proof that I had the PHTSL certification.

Mr. Huss, I am at a loss at what to do. I am not happy with how I was treated while I was working there and how I was fired. Please if you have any advice after reading this, I am open to hearing what you have to say.

The following is an explanation to my write ups...

Key Points:

1. ***Patient never complained of chest pain***
2. ***Why treat a patient incorrectly***
3. ***Why are you forcing your medics to treat dispatch complaint and not actual patient***
4. ***Double standards***
5. ***Unsafe work environment***
6. ***Defamation of character***
7. ***Libel***
8. ***Slander***

#1: Patient never complained of chest pain

Date: 07/14/2013

Crew: Medic 1: Driver: #15, Attendant: #76 & Truck 1: Mo and FTO Jesse Rystrom

Medic 1 dispatched for a male patient complaining of Chest Pain and heart attack. Medic 1 responding to call. Truck 1 responding to assist Medic 1. Arrived on scene to find patient sitting on edge of the bed. Patient visually appears to be without any immediate life threats, patients skin warm dry pink; respirations with good and equal chest rise and fall, patient speaking in full sentences, patient Alert and Oriented x 4 (Alert/Oriented to Person, Place, Time, and Event). I cancelled truck 1 because I had confidence in my partner (#15) and I could handle this call without occupying Truck 1 and its crew members.

Patient states that he woke up at 3 am with abdominal pain/discomfort around the belly button area. Patient state that he hasn't been able to go back to sleep. Patient also stated, the previous night, he ate a larger amount of food than normal (over eating). I was informed by the patient, that his wife called 911 because she was worried that he was having a heart attack. Patient himself stated that he never had chest pain, chest pressure, chest discomfort, and never was short of breath. Patient stated his wife advised him to take aspirin as a precautionary measure just in case he was having a heart attack. Pt state he took 2 baby aspirin and didn't take his prescribed medications because he was afraid it would upset his stomach even more.

Patient's past pertinent medical history includes, high blood pressure, pace maker. Patient state that he didn't take his high blood pressure that morning because his stomach was upset. Patient's Vital Signs: monitor shows a paced rhythm; O2 saturation 95% on room air; blood pressure 170/80, patient stated that blood pressure is normally that high when he doesn't take his medication. Patients O2 saturation remained 94% or greater, patient skin remained warm, dry and pink.

I advised the patient that he should go to the hospital to get further checked out. Initially, patient refused transport. I advised the patient that he could possibly have a sick heart due to the facts that he was complaining of abdominal pain and indigestion which indirectly could be masking him having a heart attack. Patient again denied for the second time to allow us to take him to the hospital. I reminded the patient that his wife has been up since 3 am with him and that she's really worried about his health, so why don't we take you in to the hospital to play it safe. Patient stated that he didn't know if he wanted to go to the hospital and that he feels foolish for having us there. #15 and I both reassured him that his wife did the right thing by calling us. #15 went down to get the gurney ready and also grab the clip board. I again attempted to try to get the patient to go to the hospital, reminding the patient that indigestion can be a precursor to and acute heart attack and you could die. Patients wife told him to just go in and get checked out to play it safe. Patient finally agreed to allow us to transport him to hospital.

I advised the patient and his wife before we go; I need to explain a few things to my partner before we go. When #15 came up from getting the gurney ready, I informed #15 (in front of Patient and his Wife) the patient agreed to go to hospital but before we go I need to explain a few things. At 3 am, patient woke up with stomach pain, thinking it was indigestion, at no time has he had any chest pain, chest pressure, chest discomfort or short of breath. I advised the patient that abdominal pain and indigestion can mask a heart attack and that with a paced rhythm we are unable to take a full look at his heart. #15 shook his head and said ok, the patient and his wife acknowledged what I said and said that's correct. The patient looked at me, asked me "can we go"? I replied "yes". The patient got up from his chair without assistance, walked himself down the stairs to the gurney and we transported him to the hospital without any further findings, changes or incidents.

After the call was completed and driving back to station 1, Erik said that it was too bad Dylon wasn't on this call, this would've been a great learning experience for him because you have dispatch complaint of chest pain and heart attack verses on scene patient never having chest pain and more anxiety related induced by his wife. I agreed with Erik and said this would've been a great call for Dylon.

#2: Why treat a patient incorrectly

According to my write up on 07/14/2013...

"FireFighter/Paramedic David Starner failed to follow medical protocol and failed to meet Aberdeen Fire Rescues standard of care."

... The following is Aberdeen Fire and Rescue EMS Protocols & Policies for "Routine Care":

The following assessment is to be performed and information is to be obtained on all patients:

1. Assure scene safety for yourself, your fellow rescuers, and your patient.

...the scene was safe for me and my crew and my patient

2. Initial survey: General Impression:

   A. Airway with cervical spine control if appropriate – oxygen as appropriate maintaining O2 > 94%

   B. Breathing (monitor ETCO2 as indicated)

   C. Circulation with control of bleeding

   D. Disability Determination

A = alert and conscious

V = responsive to verbal stimuli

P = responsive to painful stimuli

U = unresponsive

E = exposure

... as stated above in my explanation letter, all these steps were followed

3. Transport Decision.

...delayed due to patient refusing multiple times, eventually transported patient to his desired Hospital

4. Consider Rapid Trauma Exam or Detailed Physical Exam.

... no trauma indicated or found

5. Consider all assessment and treatments as necessary:

   A. ECG monitor (12/15 lead as indicated)

   ... patient on monitor, monitor showing paced rhythm

   B. Capnography and Pulse oximetry

   ... patient placed on pulse oximetry

   C. IV access as appropriate maintaining BP > 90

   ... patient BP remained above >90

   D. Medications per appropriate protocol

   ... no medications indicated for patient complaining of indigestion and abdominal pain

6. Detailed Physical Survey:

   A. Obtain vital signs and perform objective head-to-toe assessment.

   ... vital signs obtained and head-to-toe assessment without significant findings

B. Obtain history:

- Patient's name
- Sex, age, and approximate weight
- Chief complaint
- Precipitating factors
- Significant past medical history
- Allergies
- Current medications
- Private physician's name

... all above was obtained

7. Apply appropriate protocol and standing orders based on assessment.

... there are no specific protocols for indigestion and abdominal pain in Aberdeen Fire and Rescue EMS Protocols & Policies

9. Contact Medical Control as designated in protocol or if there are any problems or questions.

... no indication to contact medical control in Aberdeen Fire and Rescue EMS Protocols & Policies

9. Position patient comfortably as indicated by condition or situation.

... patient was positioned in his position of comfort

10. Reassure and calm patient. Loosen any restrictive clothing or remove as indicated.

... patient was reassured and calmed

Conclusion

I am at a loss what I failed to do correctly. I highlighted each and every portion with a brief explanation.

#3: Why are you forcing your medics to treat dispatch complaint and not the actual patient?

According to my write up on 07/14/2013...

Continued "...As noted in PCR 1203323 on 07/14/2013 The Patient condition warranted further treatment and the implementation of the chest pain protocol which was not done."

...The following is Aberdeen Fire and Rescue EMS Protocols & Policies for "Chest Pain"

1. Obtain and transmit 12-lead EKG, if 12-lead is unremarkable or showing an Inferior AMI, obtain a 15-lead EKG.

... patient with paced rhythm unable to perform 12/15 lead with accurate reading

2. Establish two IVs 18g or greater with care to avoid the right wrist location if possible, left arm is preferred (per cath lab).

... I did not start an IV or per protocol 2 IV's 18g or greater. Patient didn't complain of chest pain. How many paramedics have started two IV's 18g or greater with a patient complaining of chest pain?

3. Administer:

- 4 baby Aspirin chewable tablets (324 mg) p.o. if the patient is not allergic to Aspirin and does not have ulcer disease

... patient never complained of chest pain

3. If 15-lead is negative for a right ventricular AMI, administer:

- 1 Nitroglycerin spray 1/150 sublingually if systolic blood pressure is greater than 100 mmHg. May be repeated every 5 minutes until:
  - 3 sprays have been administered
  - Pain is relieved
  - Systolic blood pressure falls below 100 mgHg
  - Avoid use of Nitro in pt's that have or are suspected to have taken a phosphodiesterase inhibitor (eg, Viagra)

... ... patient never complained of chest pain

5. If 15-lead is positive for a right ventricular AMI, begin fluid administration with normal saline. Patients may require one liter or more of saline to prevent a drop in blood pressure with nitro administration. Use caution when administering sublingual nitroglycerin spray, a nitro drip is recommended in this situation.

... no 15-lead obtained due to paced rhythm

6. Consider a Nitro Drip beginning at 5 mcg/min, titrate to effect (by increasing by 5 mcg/min) while maintaining BP >100 systolic

... patient never complained of chest pain

7. For pain control consider administering:

- Fentanyl 50-100 mcg slow IV push, this dose may be repeated as needed.

... patient never complained of chest pain

8. **If patients are < 75 years of age with a STEMI, administer a loading dose of Plavix (clopidogrel) 600 mg p.o.**

... we don't even carry Plavix

9. Treat dysrhythmias per protocols.

... patient with a paced rhythm

Conclusion:

Where did I go wrong? You want me to treat the dispatch complaint for patient complaining of chest pain and heart attack? Patient never complained of chest pain.

#4: Double standards

a. Let's pretend my patient was complaining of chest pain, accordingly to protocol, we are to start 2 large bore IV's. How many chest pain calls have medic started 2 large bore IV's? You take 100 past chest pain calls and most of all those calls the medic wouldn't have started 2 large bore IV's. So how come I am singled out and written up? Why do I keep getting harassed even though I am doing my job correctly? Why is EMS coordinator Rob Senger documenting false accusations against me? Why hasn't Rob Senger not written up anyone else for not starting two IV's 18ga or greater on chest pain patients? Why am I singled out? I have talked to other Aberdeen Fire and Rescue FireFighter/Paramedics to find out if they have started two IV's 18ga or greater. Every single Paramedic I talked to stated they haven't or if they have, they did it once. Why haven't they been written up by EMS coordinator Rob Senger?

b. FTO Jesse Rystrom is able to break protocol without any ramification? On 07-16-2013 approx 1230, Medic 1(David Starner, Dylon, and FTO Jesse Rystrom) had a call for a Motor Vehicle Accident (6th ave west by Perkins). Patient with Altered Level of Consciousness. Patient was not cooperating. Patient was initially secured full spinal axial immobilization onto a long board. FTO Jesse Rystrom loosened the bottom 2 "spider" straps that were securing the lower body. The patient now was able to move his whole body from side to side nullifying the objective to protect the patient spine. According to

Aberdeen Fire and Rescue EMS Protocols & Policies for "Trauma: Indications for Spinal Immobilization" (page 55) under Blunt trauma, patient with Altered LOC requires Immobilize and Rapid Transport. No indications for clearing or partially clearing spinal immobilization for an Altered LOC patient. FTO Jesse Rystrom had Dylon write the report indicating Dylon was the primary medic providing care. Why can FTO Jesse Rystrom write me up for not following a certain protocol but yet he can justify jeopardizing an Altered LOC patient spine which clearly shows he failed to follow Aberdeen Fire and Rescue EMS Protocols & Policies? How come EMS coordinator Rob Senger didn't write FTO Jesse Rystrom up for failing to follow protocol?

c. My previous write up for not wearing appropriate PPE's? Why isn't there a specific incident or PCR number? Why again am I singled out and written up? I have shown picture and video evidence of other Aberdeen Fire and Rescue not following proper PPE's but yet no one else was written up. How is that fair?

#5: Unsafe work environment

Why do I have to spend so much time defending myself? Why can't I be allowed to work without being afraid to be picked on?

#5: Defamation of Character

Any intentional false communication, either written or spoken, that harms a person's reputation; decreases the respect, regard, or confidence in which a person is held; or induces disparaging, hostile, or disagreeable opinions or feelings against a person.

Defamation may be a criminal or civil charge. It encompasses both written statements, known as LIBEL, and spoken statements, called slander.

#6: Libel

to publish in print (including pictures), writing or broadcast through radio, television or film, an untruth about another which will do harm to that person or his/her reputation, by tending to bring the target into ridicule, hatred, scorn or contempt of others. Libel is the written or broadcast form of defamation, distinguished from slander which is oral defamation.

#7: Slander

oral defamation, in which someone tells one or more persons an untruth about another which untruth will harm the reputation of the person defamed.

SOUTH DAKOTA
BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

SDBMOE
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SIOUX FALLS, SD 57104
SDBMOE@STATE.SD.US
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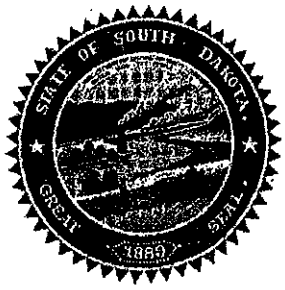

October 21, 2013

David Starner
14158 130th St.
Hoffman, MN 56339

Dear Mr. Starner:

Please be advised that the Board member of the investigative review panel is recommending the revocation of your paramedic license.

If you wish to contest this recommendation you have the following rights:

1. To contest the recommendation at an administrative hearing this will be conducted in accordance with SDCL 1-26. This matter will be presented to a neutral administrative judge.

2. To be represented by an attorney of your own choosing at the administrative hearing if you so desire.

3. The recommendation of the administrative judge will be referred to the Board of Medical and Osteopathic Examiners. The Board may accept, reject or modify the recommendation.

4. If you participate in an administrative hearing, you would then have the right to file an appeal to Circuit Court.

If you wish to contest this recommendation please contact William H. Golden no later than October 31, 2013, at (605) 367-5880.

Sincerely,

Ted Huss
Board Investigator

Cc: William H. Golden, esq.
Assistant Attorney General/Litigation Division
Counsel to the South Dakota Board of Medical and Osteopathic Examiners

1 EXPLANATION FOR OCT 21 LETTER FROM SDBMOE - David R Starner Jr

David R Starner Jr.

After I sent a detailed explanation to SDBMOE, I received the previous letter on October 21, 2013 from SDBMOE. I was shocked that after a thorough explanation that the board still decided to revoke my paramedic license. I didn't do anything wrong to warrant such a harsh penalty from SDBMOE to lose my South Dakota Paramedic license. During this time I was in talk via email with Ted Huss (Board Investigator) about my options. This is where I asked him if I voluntarily surrender my Paramedic license, if there would be any future problems with me getting work elsewhere as a Paramedic. I didn't get a clear answer from him. I was left with a decision to go to the hearing, hire a lawyer that I cannot afford or voluntarily surrender my South Dakota Paramedic license. I was afraid that if the South Dakota revoked my paramedic license (as stated in the letter of October 21, 2013) that I wouldn't get jobs elsewhere. So I thought it best if I surrendered my license instead of having it revoked (wow big mistake, hind sight is 20/20). I went ahead and requested that SDBMOE would accept my resignation of my South Dakota Paramedic license. The next page is the official letter I sent to SDBMOE.

**** I do have all emails that were exchanged with Mr. Huss.

David R Starner Jr.

14158 130th Street

Hoffman, MN 56339

(320) 288-8707

djstarner@yahoo.com

Mr. Huss,

I would officially like to request my paramedic license for the state of South Dakota be removed and I would no longer be licensed for the state of South Dakota.

Thank you,

David Starner

SOUTH DAKOTA
BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

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HTTP://WWW.SDBMOE.GOV

Via electronic and regular mail

November 1, 2013

David Starner
14158 130th St.
Hoffman, MN 56339
djstarner@yahoo.com

Dear Mr. Starner:

The board office is in receipt of your request to withdraw your South Dakota paramedic license. As you know, your paramedic license was placed under investigation, and you requested withdrawal of your license while under investigation. You were also informed that the withdrawal while under investigation is a public action of the Board and would be posted on the Board website and reportable to the national data banks and other entities as required.

Your request will be presented to the South Dakota Board of Medical and Osteopathic Examiners at the Board meeting on Wednesday, November 13, 2013. The meeting will begin at 9:00 am, and will be held in the conference center of the CNA Surety Building. Enclosed please find directions and parking instructions for the Board meeting.

Also enclosed please find a Notice of Hearing. You have the right to attend this Board meeting if you wish to do so, and to have an attorney accompany you to the meeting if you so desire; however, this is not a requirement.

After the meeting I will send you a letter with the final decision of the Board and certified copies of any documents.

I request that you please contact this office at SDBMOE@state.sd.us no later than November 8th if you plan to attend the Board meeting.

Sincerely,

Jane Phalen

Jane Phalen
Board Staff

Enclosure

SOUTH DAKOTA BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

* *

IN THE MATTER OF THE
REQUEST FOR WITHDRAWAL OF
THE SOUTH DAKOTA PARAMEDIC
LICENSE WHILE UNDER
INVESTIATION

NOTICE OF HEARING

RE: DAVID R. STARNER

* *

Please take notice that a contested case hearing has been scheduled before the South Dakota Board of Medical and Osteopathic Examiners in the above captioned matter. The hearing will take place on November 13, 2013, in the conference center of the CNA Surety Building, 101 S. Reid St., Sioux Falls, SD 57104, beginning at 9:00 am.

Dated this 1 day of November, 2013.

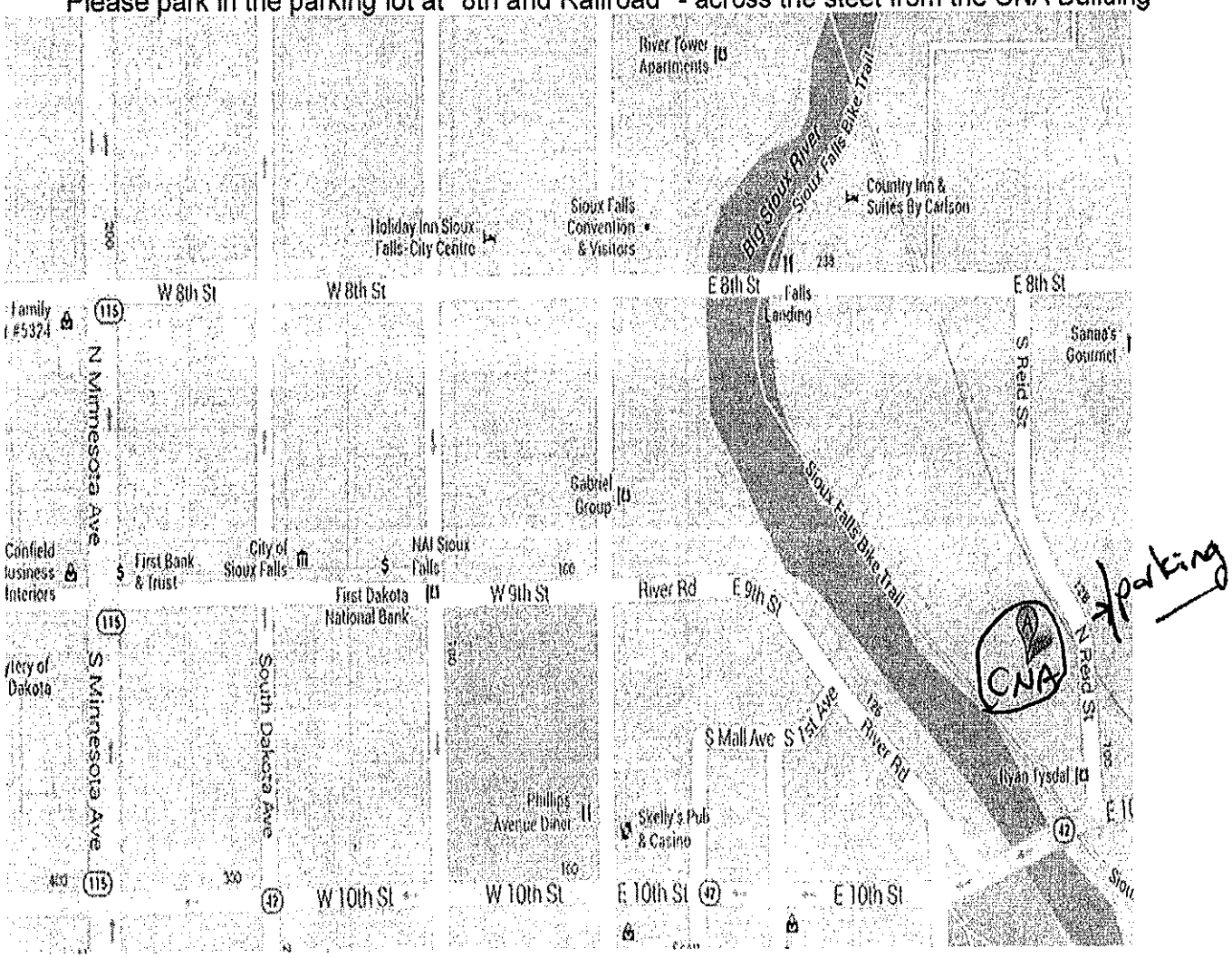
William H. Golden, esq.
Assistant Attorney General/Civil Litigation Division
317 N. Main Ave.
Sioux Falls, SD 57104
Attorney for the South Dakota Board of
Medical and Osteopathic Examiners
(605) 367-5880

SDBMOE Board Meeting Directions to CNA Surety Building at 101 S. Reid St.

Directions from Airport (see map)

1.) Take Minnesota Ave to West 8th St.
2.) Turn east onto West. 8th St. and continue over the Big Sioux bridge. (Please be aware that there is road construction on 8th Street going over the bridge.)
3.) Turn south onto S. Reid St.
4.) CNA Surety is marked with the "A" below.

Please park in the parking lot at "8th and Railroad" - across the steet from the CNA Building



Is It Working Time?

The Fair Labor Standards Act states that all nonexempt employees must be compensated for *all* hours worked or performed under the control of and for the benefit of the employer.

The Workweek Defined

- A regularly recurring period of 168 hours (seven consecutive 24-hour periods) as defined by the employer
- Does not have to coincide with a traditional calendar week
- May be different for different employees

Rules for Determining Time Worked

1. **Meal/rest periods**
   - If an employee meal period is to be an unpaid period, the employee must be given a minimum of 30 consecutive uninterrupted minutes.
   - All rest periods and breaks must be paid time, although a break of 30 minutes or more could potentially be unpaid.

   State laws determine whether or not meal periods and breaks are required.

2. **Travel time**
   - Home-to-work travel is not working time.
   - Drive time for locations within a 50-mile radius is not working time.
   - Drive time for locations outside a 50-mile radius is working time.

     — On a trip that includes an overnight stay:

     - If the employee is driving, all travel time is paid time.
     - If the employee is traveling within his or her normally scheduled work hours, all travel time is paid time.
     - If the employee is traveling outside his or her normally scheduled work hours, all travel time in transit as a passenger does not have to be paid time.

3. **On-call time**

   need to pay for just being on call

   - Time in which the employee spends responding to a page while otherwise off the clock is working time.
   - Time in which the employee is on call is working time if his or her activities have been significantly restricted.
   - Time in which the employee is on call is not working time if the activities have not been significantly restricted, such as simply being required to keep a cell phone or pager with him or her and to be potentially available as needed.

4. **Waiting time**
   - Engaged to be waiting (is working time)
   - Waiting to be engaged (is not working time)

5. **Meetings and training sessions are considered work time *unless***
   - They are not held during regular working hours, *and*
   - Attendance is voluntary, *and*
   - They are not directly related to the employee's current job, *and*
   - The employee performed no productive work for the employer.

6. **Preliminary or postliminary activities — paid if required**
   - Changing clothes
   - Cleaning up

7. **Medical attention**
   - On employer's premises is work time
   - During regular hours at employer's direction is work time
   - Mandatory medical exams or drug/alcohol testing is work time, whenever it occurs.

SOUTH DAKOTA
BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

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SIOUX FALLS, SD 57104
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P 605-367-7781 F 605-367-7786
HTTP://WWW.SDBMOE.GOV

Via electronic and regular mail

November 15, 2013

David R. Starner
14158 130th St.
Hoffman, MN 56339
djstarner@yahoo.com

Dear Mr. Starner:

As you aware from the Notice of Hearing you received from this office, the South Dakota Board of Medical and Osteopathic Examiners met on November 13, 2013. At the meeting they accepted your written request that you be permitted to voluntarily withdraw your South Dakota Paramedic license while under investigation.

A report of this disciplinary Board action will be submitted to the National Practitioner Data Bank and you may receive a notification from them about this activity.

A certified copy of the Final Order is enclosed. This is intended as service to you, and is provided for your records.

Sincerely,

Jane Phalen
Board Staff

Enclosure

THE SOUTH DAKOTA BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

****

Re: David R. Starner, EMT Paramedic FINAL ORDER

****

The above-entitled matter having come before the South Dakota Board of Medical and Osteopathic Examiners ("Board"), and the Board having been fully advised in the premises thereof; and

As a condition of licensure, David R. Starner consents to the documents relating to this matter being provided to other state licensing authorities upon their request. NOW; THEREFORE, the Board hereby:

APPROVES the request to withdraw his licensure while under investigation and this Final Order, and directs that the withdrawal while under investigation and this Final Order are public records of the Board and the State of South Dakota and shall be published on the Board's website and reported to the national data banks and any other entity deemed appropriate by the Board and in compliance with State and Federal law.

By: _____ Date: 11/13/13
South Dakota Board of Medical and Osteopathic Examiners

STATE OF SOUTH DAKOTA } S.S.
MINNEHAHA COUNTY
I hereby certify that the foregoing instrument is a true and correct copy of the original as the same appears on the record in my office.
Executive Secretary
By MBH by JTP
Date 11-15-13

EMERGENCY CALL-IN PAY POLICY:

An emergency call-back is defined as an unscheduled request made by an appropriate management official, for an employee to return to work due to unforeseen or emergency work after leaving the building or work location at the end of his or her regular shift, and before the beginning of the next regularly scheduled shift.

The maintenance department supervisor will develop a rotational "call-in" list for the department. The document will be shared with all departments, ensuring information accuracy for call-in's is present. Maintenance will have a true rotation whereby all maintenance personnel are included on the list. Individuals assigned to the list must be available within 60 minutes of call-in time. All individuals assigned to the call-in must follow all other requirements associated with employee behavior as identified in this manual.

The emergency call-back policy states that an employee shall be paid the applicable straight-time or overtime rate for the actual hours worked, or a minimum of 3 hours regular straight-time base pay, whichever is greater, on the occasion that it is necessary to call in hourly employees without notice outside of their regular shift hours to handle emergency repairs, equipment failures, or other production problems. If an individual is called back on multiple occasions on the same day, the total actual hours worked, or a minimum of 3 hours regular straight-time pay applies. Supervisors who call in an employee under this policy should notify the Payroll Department for payroll administrative purposes. Employees exempt from overtime, part-time employees, and temporary employees are not eligible for call-in pay. Instead, they will be paid based on applicable law.

Starner Exhibit Index

(Applicant Exhibits A-E, L-N were marked but not utilized)

F. Certificate of Completion EMT-P to Paramedic

G. Continuing Education hours Heart Failure course

H. Continuing Education hours STEMI Care

I. Continuing Education hours Sudden Cardiac Death

J. Certificate of Completion PHTLS

K. 03/27/14 Ringdahl letter of recommendation

O. Starner compilation of documents

BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

December 2014

By Margaret B. Hansen and Randi Sterling

LICENSING: Ensure only qualified professionals are licensed and allowed to practice.

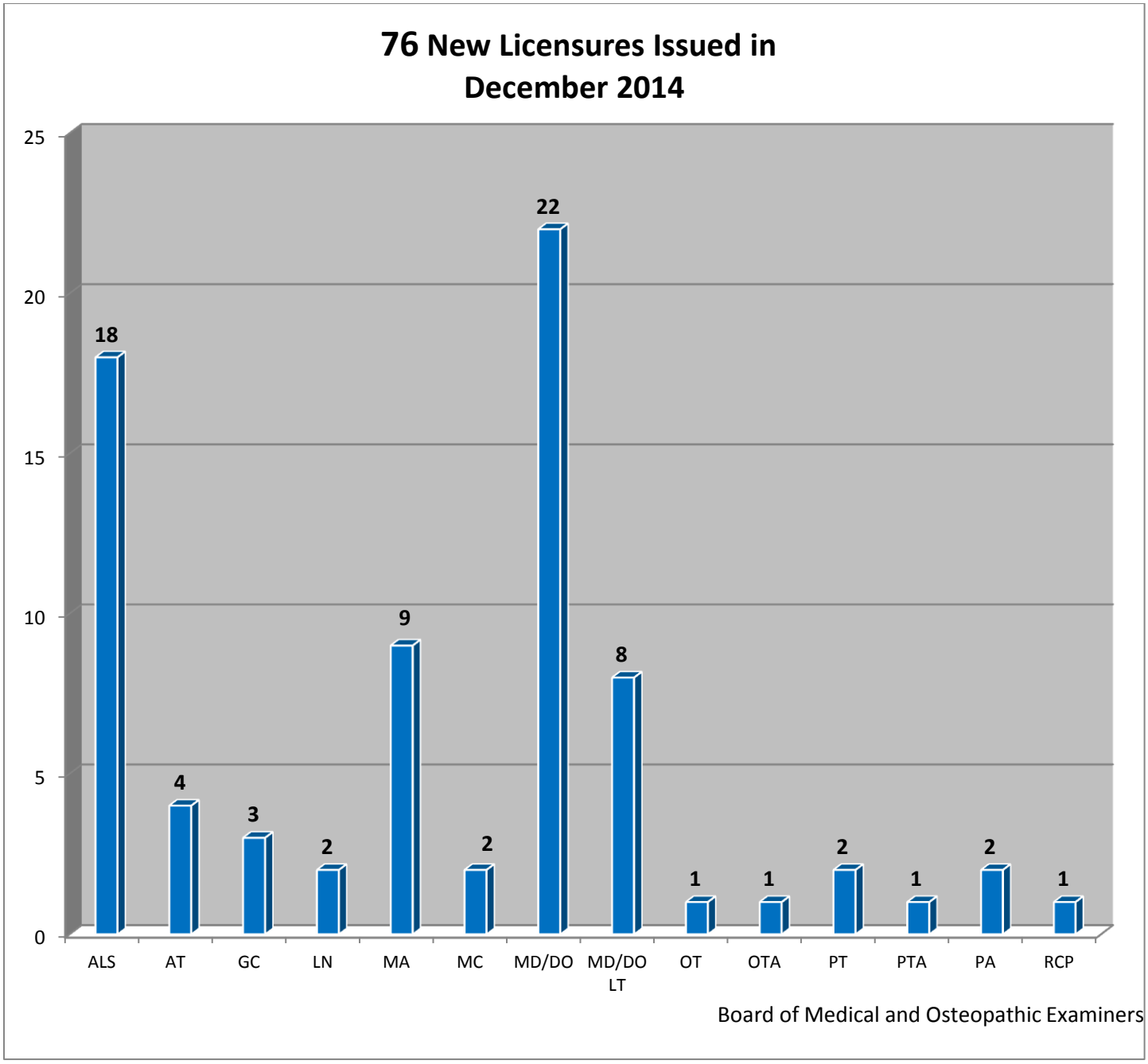
Current/Past Events:

- **Thursday, December 4, 2014, Regular Board Meeting Summary**
  - Board Members Present: Kevin Bjordahl, MD; Walter Carlson, MD; David Erickson, MD; Laurie Landeen, MD; Brent Lindbloom, DO; Jeffrey Murray, MD
  - Board Members Absent: Ms. Deb Bowman; Dr. Mary Carpenter
  - Board Staff Present: Margaret Hansen, PA-C; Mr. Tyler Klatt; Ms. Jane Phalen
  - Counsel Present: Steven Blair, Board; William H. Golden, Staff
- Dr. Carlson, Vice President of the Board, called the meeting to order and a quorum was established.
- The Board approved the following:
  - Minutes of the September 11, 2014 meeting
  - New Licenses, Permits, Certificates, and Registrations issued: September 1 through November 30, 2014
  - Executive Summary and Financial Report
  - Revised Code of Ethics Administrative Rules:
  - Genetic Counselor (ARSD 20:82:03): staff authorized to proceed
  - Licensed Nutritionist/Dietetics (ARSD 20:81:03): staff authorized to proceed
  - Occupational Therapy (ARSD 20:64:05): staff authorized to proceed
  - Petition for Declaratory Ruling to vacate ARSD 44:20:04:01(Universal Precautions): staff authorized to proceed
  - Proposed Administrative Rules (ARSD 20:47:07:01 and 02): Best Practices: staff authorized to proceed
  - Proposed Administrative Rules (ARSD 20:78:05:09 and 10): Conflict of Interest: staff authorized to proceed
  - Contested Case Hearings:
  - Jessica M. Thurman, PA: Consent Agreement with Letter of Concern (Carlson abstain)
  - Elizabeth Daggett, Paramedic: Withdrawal of license while under investigation
  - Kerry Blackham, DO: modify Findings of Fact and Conclusions of Law to mirror restrictions imposed on his medical license in Utah and issuance of a restricted South Dakota medical license with Dr. Blackham's agreement to participate in SD HPAP and comply with all Utah requirements. All required primary source verifications must first be received and reviewed. (Bowman absent)
  - Winn H. Gregory, MD: Stipulation and Agreement (Bowman absent)
  - Scharazard Gray, MD: Stipulation and Agreement (Bowman absent)
  - Roger L. Carter, MD: Agreement to Voluntarily Surrender South Dakota Medical License #1729 (Landeen Abstain)
- **Information was provided for discussion on the following:**
  - Medical License Renewal Cycle
  - Midwest Health Medical Management Services, LLC (SD HPAP) – Maria Eining
  - Advisory Committee Meeting Reports
  - Proposed Administrative Rule (ARSD 20:66:02): Physical Therapist Continuing Education

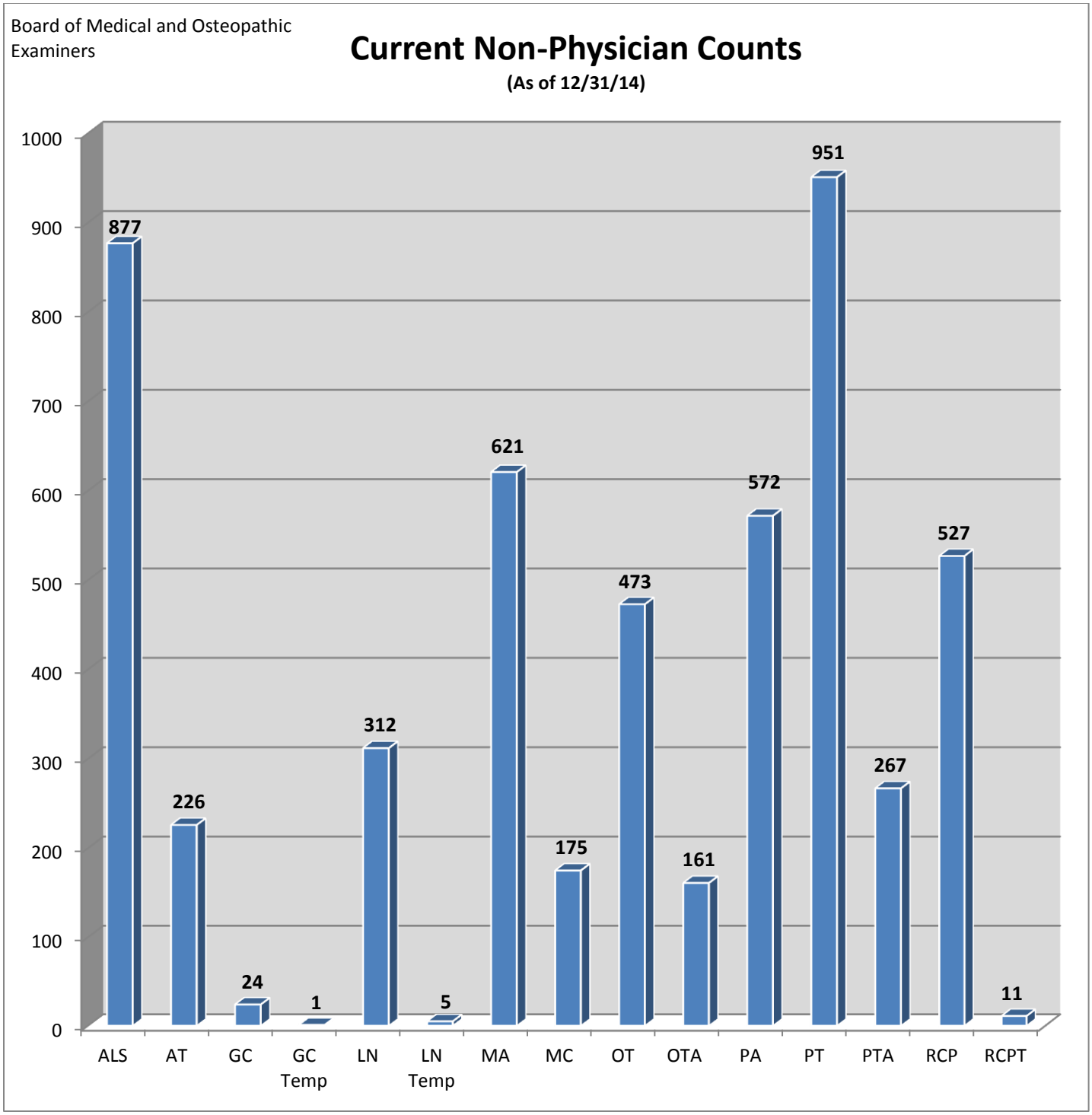
- Executive Director Report
- Monthly Statistical Reports for September, October, and November 2014
- 2015 Legislative Update: process and procedure for Boards and Board members
- SDBMOE Articles for South Dakota Medicine
- Board member information at quarterly meetings (frequently asked questions)
- Complaint and Investigation Docket
- Standard of Competency Docket
- 2015 and 2016 dates for Federation of State Medical Boards Annual Meetings

- **The next meeting is Wednesday, March 11, 2015**

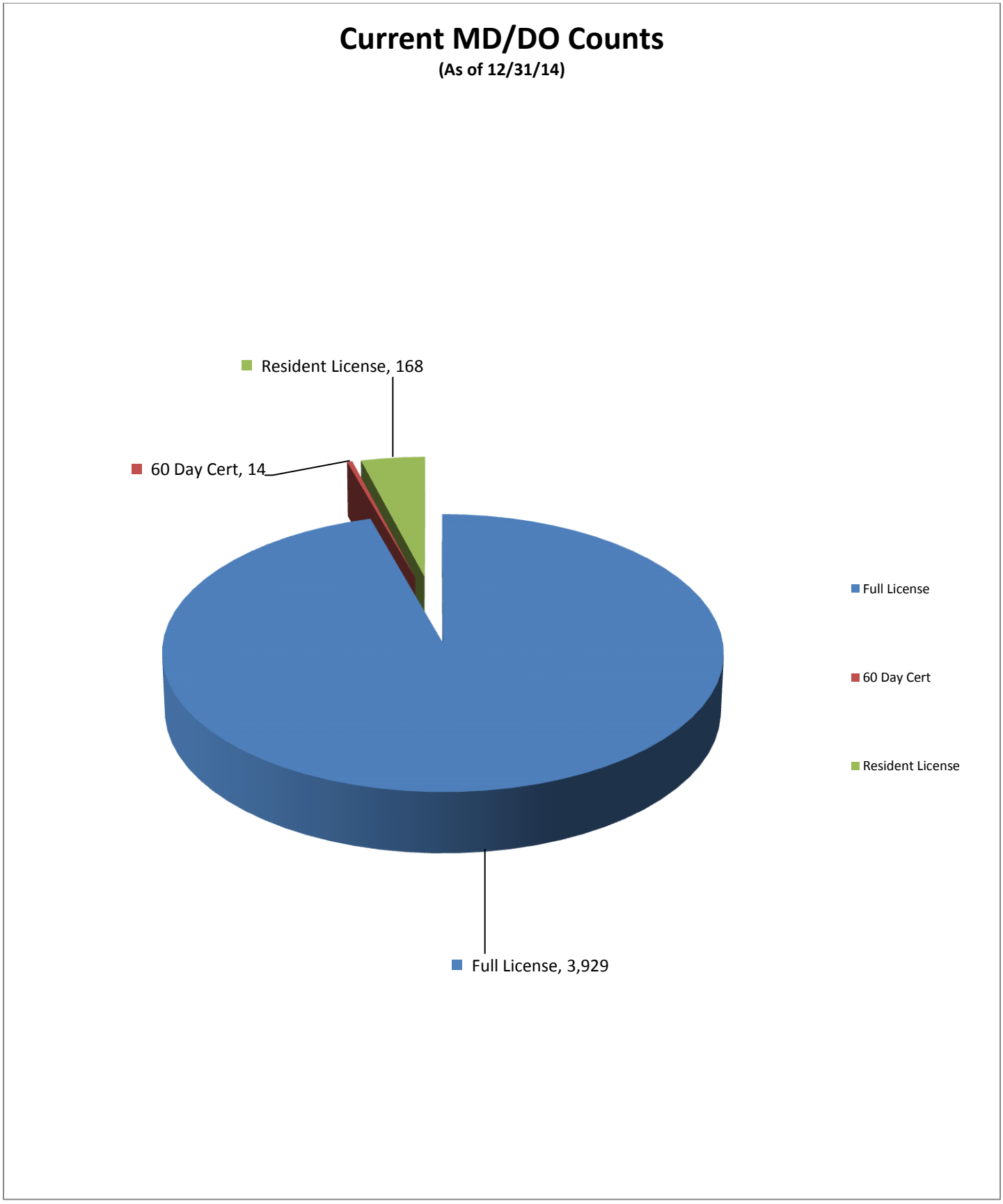
Statistics



ALS – Advanced Life Support (EMT)
AT – Athletic Trainer
GC – Genetic Counselor
LN – Licensed Nutritionist
MA – Medical Assistant
MC – Medical Corporation
MD/DO – Medical License
MD/DO LT – Physician Locums Tenens
OT – Occupational Therapist
OTA – Occupational Therapist Assistant
PT – Physical Therapist
PTA – Physical Therapist Assistant
PA – Physician Assistant
RCP – Respiratory Therapy



ALS – Advanced Life Support (EMT)
AT – Athletic Trainer
GC – Genetic Counselor
LN – Licensed Nutritionist
MA – Medical Assistant
MC – Medical Corporation
OT – Occupational Therapist
OTA – Occupational Therapy Assistant
PA – Physician Assistant
PT – Physical Therapist
PTA – Physical Therapist Assistant
RCP – Respirator Care Practitioner


Current MD/DO Counts
(As of 12/31/14)
Resident License, 168
60 Day Cert, 14
Full License, 3,929
Full License
60 Day Cert
Resident License

INVESTIGATIONS: Ensure complaints and issues are properly investigated and resolved.

Issues

Complaints:

Summary of new applications

1.) New Licenses were issued

a. 76 new licenses issued

b. 19 complex applications resolved or closed

Statistics

Investigations and Complaints
(As of12/31/14)

Category	New	On-going	Resolved
Complex Applications	14	30	19
Complaints/ Investigations	21	32	20
Competency (Malpractice cases)	0	289	0

Reinstatement and Renewal Applications
(As of 12/31/2014)

Category	New	On-going	Completed
Reinstatement and Renewal Applications	5	14	6

OUTREACH: Make life easier for our customers.

Education

The Executive Director and Board staff continues to meet and do outreach to the medical school, residency programs, healthcare recruiters, clinic managers, health system administrators, state regulatory boards and associations as well as with the SDBMOE licensees.

Outreach Efforts:

Outreach Activities

(Totals reflect activities from first to last day of month)

Activity	Organization	# Participants	Topic Covered
Training	Academic Program (Residency) Directors & Coordinators. Healthcare Systems Recruiter. Board & Advisory Members	150	Licensing discussion
Phone/General Email	Licensees/ Applicants	2102	General questions
In-Office Assistance	Licensees/ Applicants	87	Renewal and general questions

Upcoming Events:

- **2015 Meeting Dates**
  - March 11 & 12, June 11, September 10 and December 3
- **2016 Meeting Dates**
  - March 3 & 4, June 2, September 8 and December 1

BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

February 2015

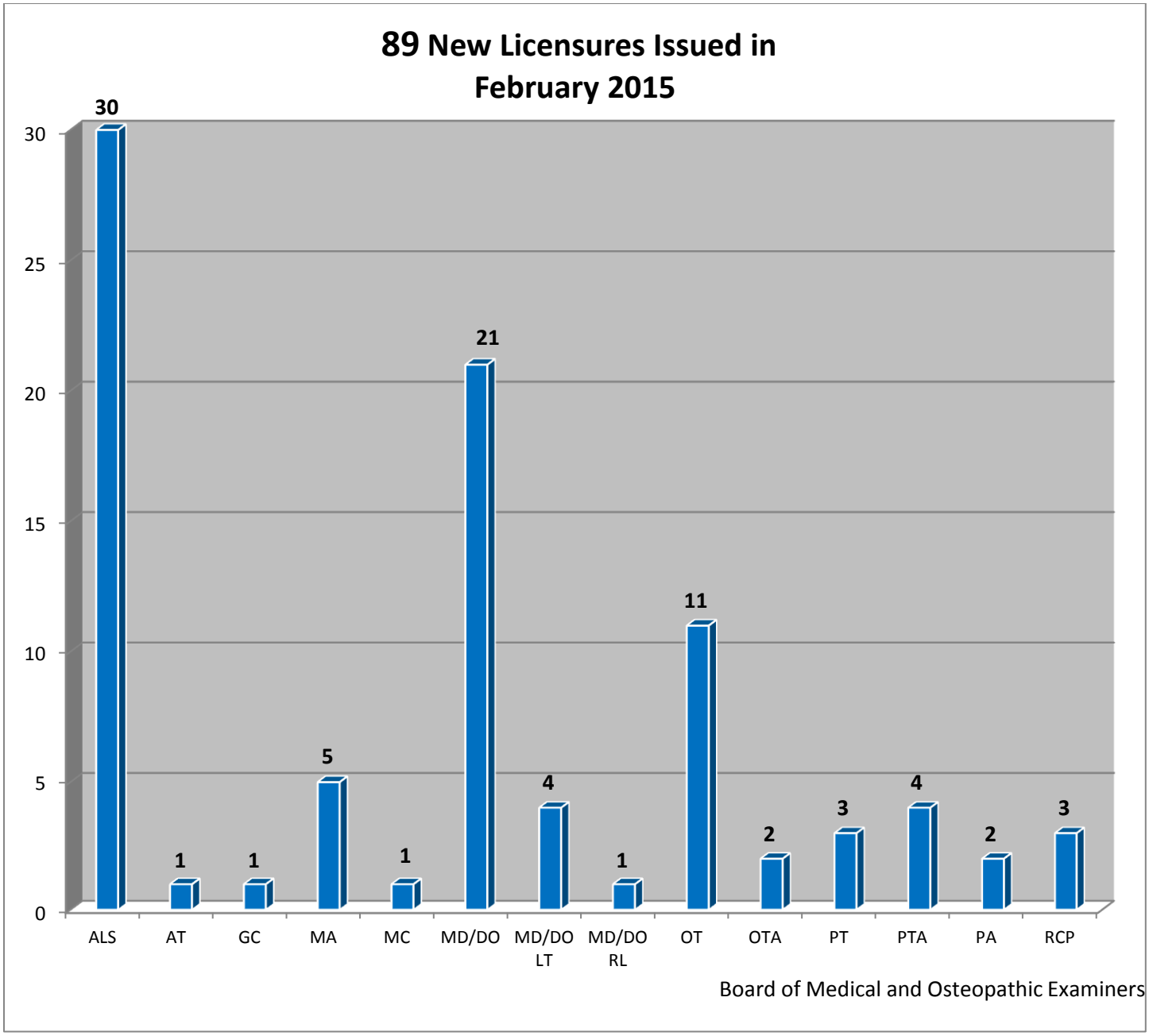
By Margaret B. Hansen and Randi Sterling

LICENSING: Ensure only qualified professionals are licensed and allowed to practice.

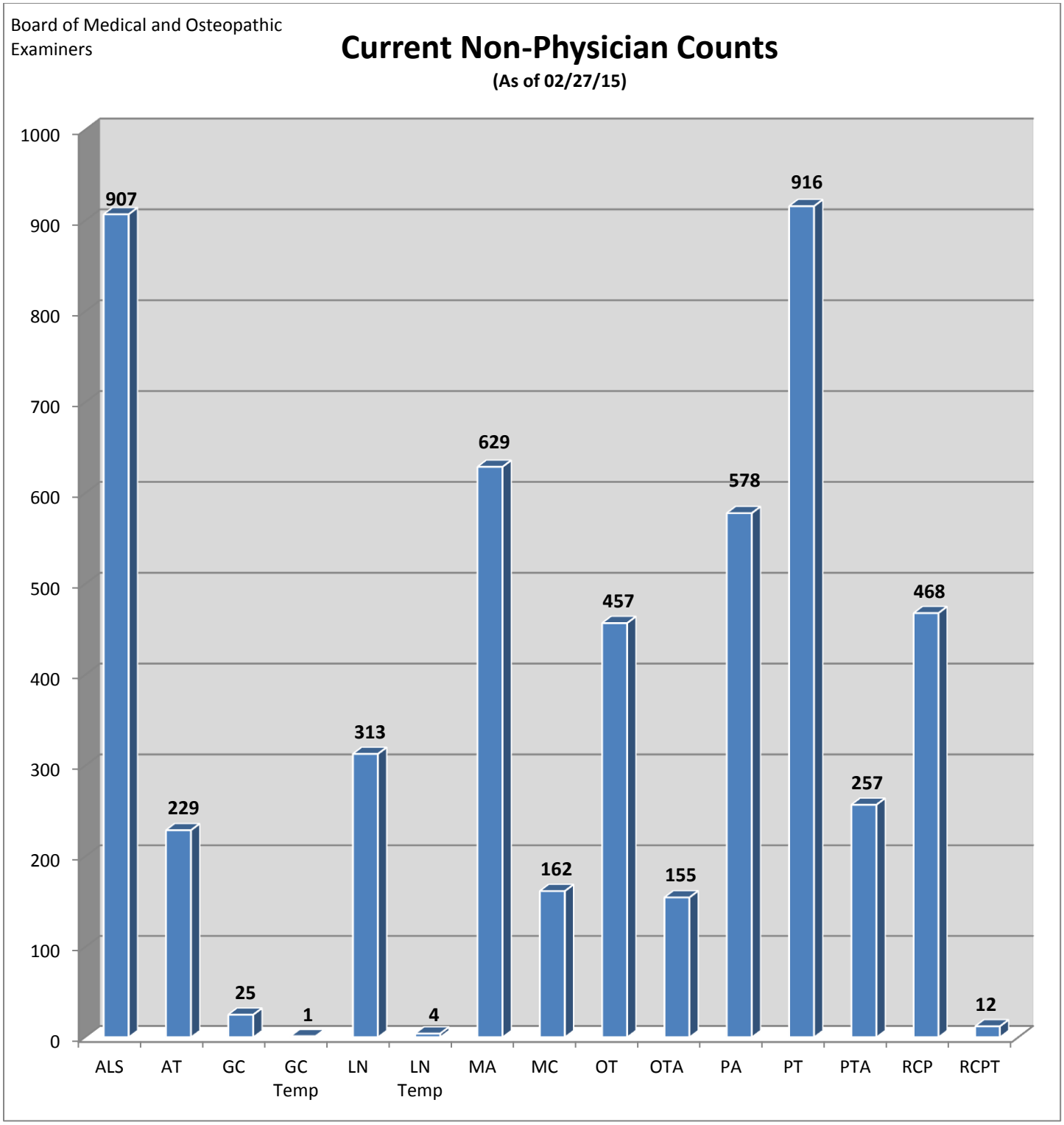
Current/Past Events:
SB 63 passed unanimously out of the House Health and Human Services Committee and will now move to a House vote possibly on Tuesday March 2.

The physician license renewal period will end March 1, 2015. As of February 27th: 3,668 licenses have been renewed and approximately 260 have yet to renew. The non-renewed 260 number would also include those who would not be renewing due to retirement or other reasons.

Statistics



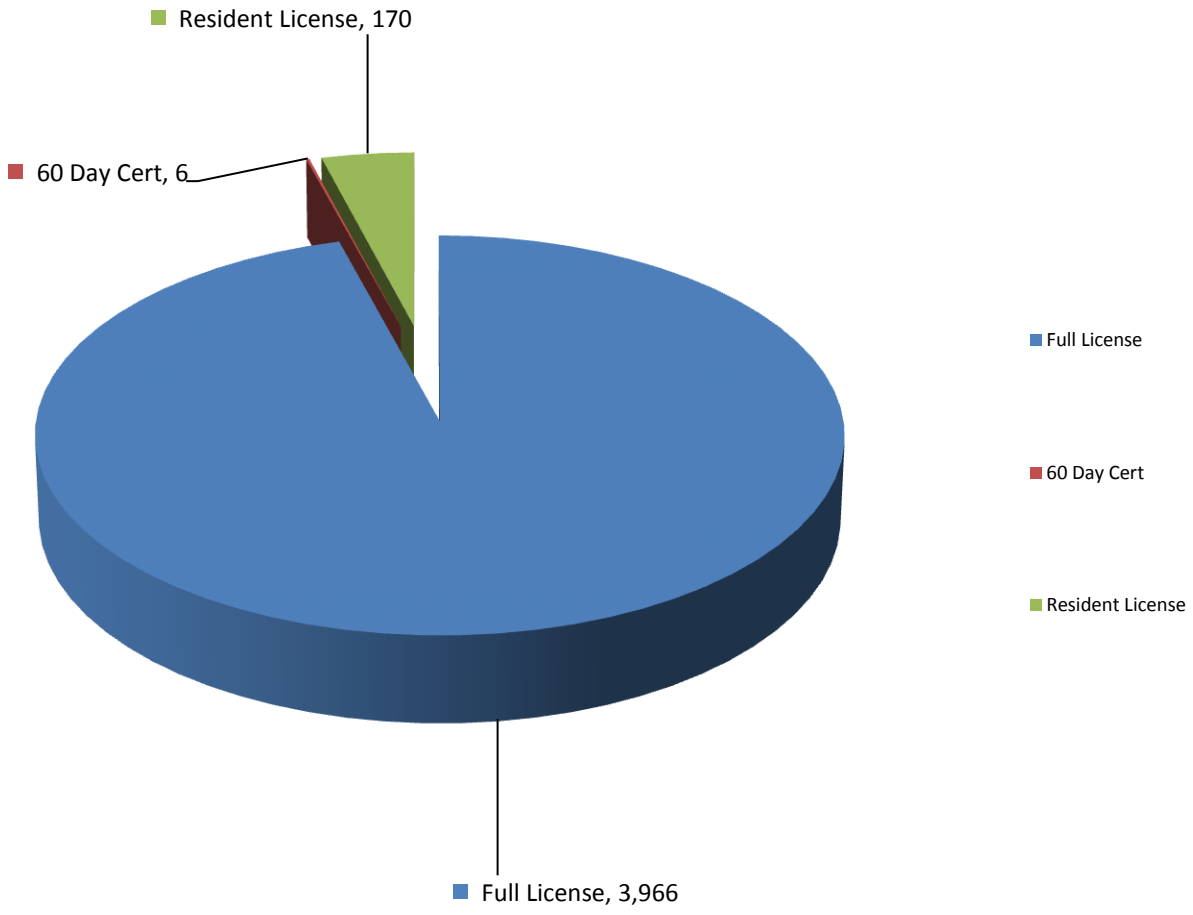
ALS – Advanced Life Support (EMT)
AT – Athletic Trainer
Genetic Counselor
MA – Medical Assistant
MC – Medical Corporation
MD/DO – Medical License
MD/DO LT – Physician Locums Tenens
MD/DO RL – Resident License
OT – Occupational Therapist
OTA – Occupational Therapist Assistant
PT – Physical Therapist
PTA – Physical Therapist Assistant
PA – Physician Assistant
RCP – Respiratory Therapy



ALS – Advanced Life Support (EMT)
AT – Athletic Trainer
GC – Genetic Counselor
LN – Licensed Nutritionist
MA – Medical Assistant
MC – Medical Corporation
OT – Occupational Therapist
OTA – Occupational Therapy Assistant
PA – Physician Assistant
PT – Physical Therapist
PTA – Physical Therapist Assistant
RCP – Respirator Care Practitioner

Current MD/DO Counts

(As of 02/27/15)



INVESTIGATIONS: Ensure complaints and issues are properly investigated and resolved.

Issues

Complaints:

Summary of new applications

1.) New Licenses were issued

a. 89 new licenses issued

b. 15 complex applications resolved or closed

Statistics

Investigations and Complaints
(As of 2/27/2015)

Category	New	On-going	Resolved
Complex Applications	20	50	15
Complaints/ Investigations	24	46	11
Competency (Malpractice cases)	0	291	0

Reinstatement and Renewal Applications
(As of 02/27/2015)

Category	New	On-going	Completed
Reinstatement and Renewal Applications	3	12	0

OUTREACH: Make life easier for our customers.

Education

The Executive Director and Board staff continues to meet and do outreach to the medical school, residency programs, healthcare recruiters, clinic managers, health system administrators, state regulatory boards and associations as well as with the SDBMOE licensees.

Outreach Efforts:

Outreach Activities

(Totals reflect activities from first to last day of month)

Activity	Organization	# Participants	Topic Covered
Training	Academic Program (Residency) Directors & Coordinators. Healthcare Systems Recruiter. Board & Advisory Members	150	Licensing discussion
Phone/General Email	Licensees/ Applicants	3025	General questions
In-Office Assistance	Licensees/ Applicants	98	Renewal and general questions

Upcoming Events:

- **2015 Meeting Dates**
  - March 11, June 11, September 10 and December 3
- **2016 Meeting Dates**
  - March 3 & 4, June 2, September 8 and December 1

BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

January 2015

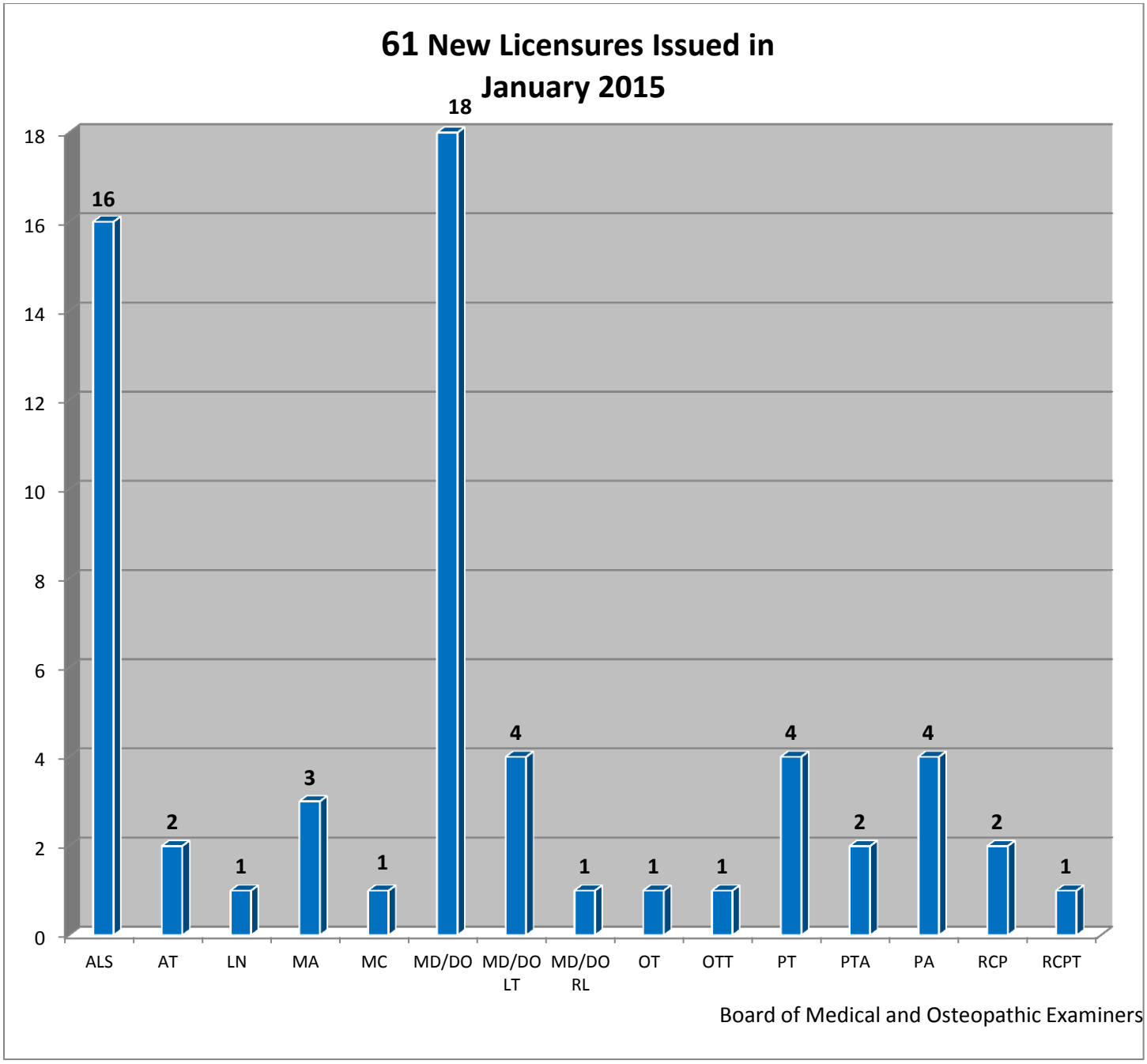
By Margaret B. Hansen and Randi Sterling

LICENSING: Ensure only qualified professionals are licensed and allowed to practice.

Current/Past Events:
The Board has SB 63 which passed unanimously out of the Senate Health and Human Services Committee and went to the full Senate on January 29, where it was passed 24 to 10. Now this bill will move on to the House Committee.

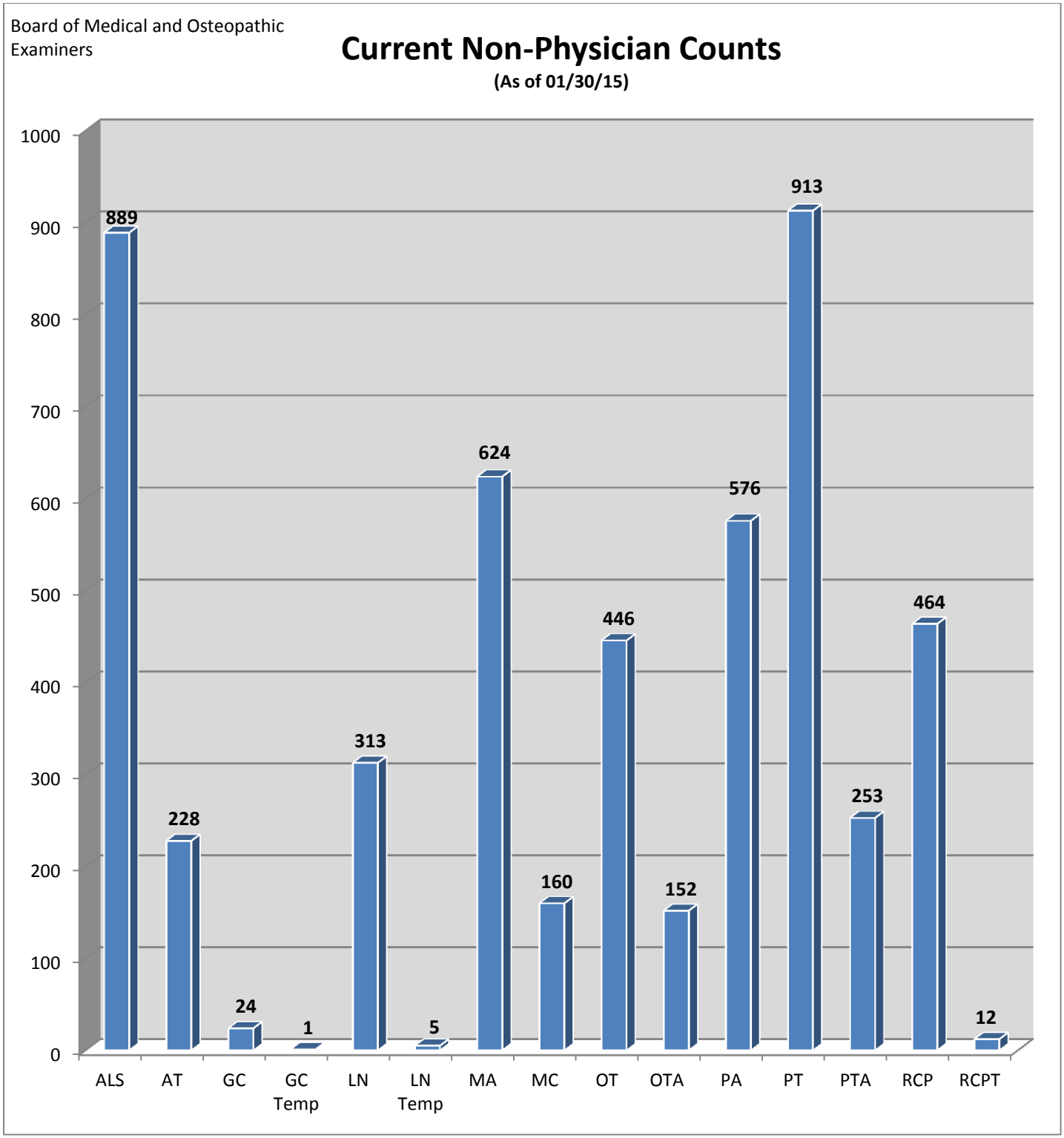
The physician license renewal period is ongoing until March 1, 2015.

Statistics



ALS – Advanced Life Support (EMT)
AT – Athletic Trainer
LN – Licensed Nutritionist
MA – Medical Assistant
MC – Medical Corporation
MD/DO – Medical License
MD/DO LT – Physician Locums Tenens
MD/DO RL – Resident License

OT – Occupational Therapist
OTT – Occupational Therapist Temp Permit
PT – Physical Therapist
PTA – Physical Therapist Assistant
PA – Physician Assistant
RCP – Respiratory Therapy
RCPT – Respiratory Therapy Temp Permit



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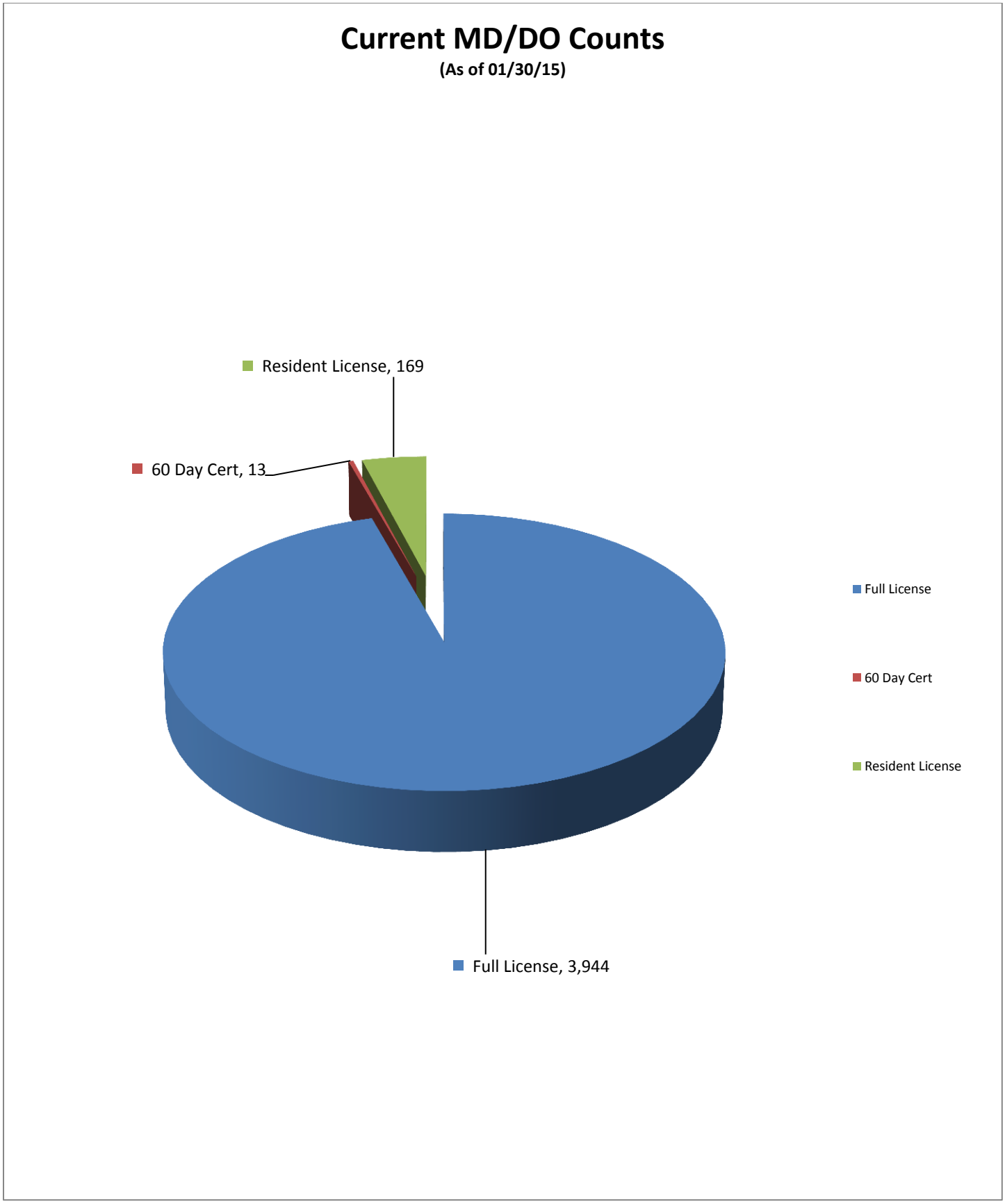
Current MD/DO Counts
(As of 01/30/15)
Resident License, 169
60 Day Cert, 13
Full License, 3,944
Full License
60 Day Cert
Resident License

INVESTIGATIONS: Ensure complaints and issues are properly investigated and resolved.

Issues

Complaints:

Summary of new applications

1.) New Licenses were issued

a. 61 new licenses issued

b. 5 complex applications resolved or closed

Statistics

Investigations and Complaints
(As of 01/30/2015)

Category	New	On-going	Resolved
Complex Applications	20	44	5
Complaints/ Investigations	18	42	8
Competency (Malpractice cases)	0	291	0

Reinstatement and Renewal Applications
(As of 01/30/2015)

Category	New	On-going	Completed
Reinstatement and Renewal Applications	1	12	3

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Education

The Executive Director and Board staff continues to meet and do outreach to the medical school, residency programs, healthcare recruiters, clinic managers, health system administrators, state regulatory boards and associations as well as with the SDBMOE licensees.

Outreach Efforts:

Outreach Activities

(Totals reflect activities from first to last day of month)

Activity	Organization	# Participants	Topic Covered
Training	Academic Program (Residency) Directors & Coordinators. Healthcare Systems Recruiter. Board & Advisory Members	125	Licensing discussion
Phone/General Email	Licensees/ Applicants	2325	General questions
In-Office Assistance	Licensees/ Applicants	72	Renewal and general questions

Upcoming Events:

- **2015 Meeting Dates**
  - March 11, June 11, September 10 and December 3
- **2016 Meeting Dates**
  - March 3 & 4, June 2, September 8 and December 1

SPECIAL COMMITTEE ON STRATEGIC POSITIONING

Report on FSMB Strategic Plan Recommendations 2015-2020

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FEDERATION OF STATE MEDICAL BOARDS
SPECIAL COMMITTEE ON STRATEGIC POSITIONING

Report on FSMB Strategic Plan Recommendations
2015-2020

Introduction

The Federation of State Medical Boards' (FSMB) Special Committee on Strategic Positioning was convened in August 2014 and charged with reviewing the FSMB's current strategic plan and developing the strategic direction of the FSMB over the next 5 years. The Committee was asked to identify possible areas of modification of the current strategic plan and to develop new strategic planning recommendations, taking into account emerging trends and changes in the environment for medical regulation over the last 5 years.

During the course of its work, including two face-to-face meetings in Washington, D.C., the committee discussed the current medical regulatory environment in the United States and internationally, highlighted key trends, and identified challenges and opportunities for the FSMB in this environment. The group closely examined the FSMB's current Strategic Plan and major initiatives and operational priorities and discussed potential adjustments to the plan, given key trends and developments of the last five years.

Included in this report are summaries of key observations made during the committee's strategic planning sessions, a list of suggested strategic priorities that emerged during discussions, and draft-language recommendations for an updated 2015-2020 Strategic Plan.

Environmental Trends

During discussions, participants identified a list of emerging trends in medical regulation -- and the health care environment in general – that the FSMB should consider as it updates its Strategic Plan. While many factors of significance were identified, several emerged as particularly noteworthy. These included:

- **Rapid change in the practice of medicine and the health care delivery system overall** – ranging from workforce and demographic shifts to the growth of telemedicine to ramifications of the Affordable Care Act. The fluidity of the current environment is a reality that will continue for the foreseeable future and will require flexibility and responsiveness in strategic outlook.

- **A new, coalition-and-partnership oriented environment for policy making and advocacy**. The importance of developing partnerships, alliances, and co-branding opportunities continues to grow, and the FSMB should be proactively engaged with other organizations as it pursues its agenda.

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- **The importance of FSMB's role in advocating for state-based regulation and in serving and supporting state medical boards**. In the current policy-making environment, which includes new questions about the role and authority of federal vs. state agencies in regulatory matters, the FSMB has a vital role to play in articulating the value of state-based regulation. As state medical boards continue to face budget cuts and access to resources, the FSMB's role in providing education, data and other support services is more important than ever.

- **The growth of internationalism and the global interconnection of regulatory agencies**. Health care issues and policies increasingly cross national borders; international aspects of health care delivery, including the licensing of International Medical Graduates, can impact state medical boards directly. In this new environment, the FSMB should place stronger emphasis on working with international partners and should adopt an international view in its advocacy for best practices.

- **The increasing volume of health-care-related data and new technology platforms for the improved use of data**. "Big Data" has emerged as a powerful factor across sectors, as technology improves our ability to gather and analyze information. The FSMB's data and research capabilities have increased significantly in recent years and it is operating in an environment in which both are considered highly valuable assets. The FSMB should seek opportunities to leverage its data and expand its research parameters in pursuit of its mission and goals.

Other environmental factors identified by the committee that can impact medical regulation and should be taken into account as strategic goals are established included:

- The growing focus on **team-based care in medicine** and changes in traditional **scope-of-practice boundaries** in health care overall.

- An increasingly **polarized political environment** in Washington, D.C. and in state governments.

- The rise of more **empowered health care consumers**, who have higher expectations for their medical care and play a larger role in health care decision making.

- The nation's **opioid prescribing crisis**.

Challenges and Opportunities

The committee identified several challenges and opportunities that impact the FSMB's future, including:

Challenges

- An increased push by special interest groups for some form of national licensure, including support for proposed legislation in Congress.

- The growing focus on team-based health care, which is shaking up traditional scope of practice boundaries and introducing new questions about regulatory authority. (Note: team-based care was also identified as bringing potential opportunities – see below).

- Recent adverse court actions and actions by federal agencies, which have the potential to dilute state regulatory authority.

- Continuing economic pressure faced by states, which in turn threatens budgets and the operating effectiveness of state medical boards.

Opportunities

- The growing focus on team-based health care, which opens doors to new relationships with peer organizations in other sectors and the creation of new synergies to ensure patient safety and competent delivery of care.

- Health plans' interest in working in new ways with organizations such as the FSMB as the Affordable Care Act brings new mandates for them.

- The emergence of other new potential partners in health care, interested in working with the FSMB as the policy environment becomes more complex.

- The FSMB's growth in recent years as a major health care stakeholder, highlighted by its expanded advocacy role in Washington, D.C. ; the unique national "bully pulpit" it occupies as the voice of state medical boards.

- The FSMB's new data capabilities, which can open doors to assist federal agencies in addressing targeted issues such as opioid pill mills and fraud and abuse in health care.

- A growing level of interest and support in the new Interstate Compact for Medical Licensure, which offers a national infrastructure for sharing data about physician licensure and discipline while retaining state-based regulation.

- The willingness of international regulatory agencies to begin working more closely together and to coordinate activities in ways that benefit U.S. patient safety and medical competence.

Key Trends among State Medical Boards

The committee also identified environmental trends of particular importance in the state medical board community, including:

- State board budgetary pressures and staffing levels.

- A growing shift by state boards towards the use of remedial programs for physicians as an alternative to traditional forms of discipline.

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- A more "policy-proactive" stance by state boards, which are increasingly attempting to identify emerging issues of importance to physicians and patients and to address these issues earlier, with innovative policy solutions.
- The increase of Continuing Medical Education (CME) offerings from state boards.
- Growth in the use of electronic communications and online processes for medical regulation.
- Increasing transparency by boards in their use of data, providing consumers more detailed information about the backgrounds of their licensees.
- The increase in collection of demographic data by state boards.

Several public policy issues were identified as having a high impact on state medical boards. These include:

- Opioid abuse
- Telemedicine/license portability
- Reporting issues/sharing and use of physician data

FSMB Strategic Positioning Survey Findings

Observations from the Committee's discussions closely tracked results from the FSMB's Strategic Positioning Survey, sent to staff and elected representatives of state medical boards earlier in 2014 in an effort to identify the short-term and long-term needs of the state medical regulatory community.

Key findings of the survey indicated that:

- Boards frequently use the FSMB as a source of information.
- Boards increasingly deal with and are challenged by a politically charged and legislatively complex environment.
- Boards consider emerging technologies (i.e., telemedicine) to be an important topic that will impact their future.
- Boards identify education and providing information as important services from the FSMB.

Committee Recommendations

In assessing the current FSMB Strategic Plan's focus, relevance and effectiveness in view of these factors, the committee agreed that in general, the overall structure and focus of the plan remains essentially on target, with a moderate degree of revision needed. The committee did not advise major shifts in strategy. New strategic directions and imperatives – adopted in response to a changing medical regulatory environment -- should be included as appropriate, along with changes in wording and adjustments to the tone and degree of emphasis placed on various elements.

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To better align the plan with emerging trends and developments, and to more effectively position the FSMB for success between 2015 and 2020, the committee made these overarching recommendations:

- **Continue to articulate <u>general</u> goals, which in turn can guide the FSMB's more detailed yearly tactical action plan**. Retain the Strategic Plan's basic structure, focusing on a few carefully selected strategic goals and keeping the wording of these goals general enough to allow for flexibility in tactics as the environment changes from year to year.

- **Introduce several new key areas of strategic focus to reflect the changing health care environment**. These include a new emphasis on education, internationalism, research, and the development and use of data.

- **Place a stronger emphasis on several components of the current plan to indicate their new importance**. These include placing a stronger emphasis on partnerships and coalition building, and on providing resources and support for state medical boards.

- **Expand the language of the strategic goals for clarity, strengthening the use of active vs. passive voice and creating a more dynamic statement of the FSMB's strategic vision**.

- **Eliminate or modify the current graphic representation of the strategic goals**, which displays the goals in six linked grey circles, to create a more effective and reader-friendly presentation.

- **Remove "Values" as a formal component of the Strategic Plan and incorporate these instead as a tool to be used for internal purposes** – that is, to help guide FSMB staff and elected leadership as it carries on the work of the organization.

- **Create more distinction between the vision and mission statements**. The committee recommended making adjustments to the vision and mission statements, creating a stronger sense of envisioned future for the vision statement and slightly expanding the mission statement.

- **Strive for simplicity of language overall**. The committee discussed the importance of avoiding unneeded language and keeping the vision, mission and strategic goals as concise as possible to ensure they are clear and understandable by all audiences.

RECOMMENDED STRATEGIC PLAN REVISIONS

VISION Recommendations

The Committee recommends making slight adjustments to the Vision Statement in order to create more of a visionary tone and sense of path forward, emphasize leadership, and include references to patient safety and health care quality.

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Proposed Revised Vision: *The FSMB is an innovative leader, helping state medical boards shape the future of medical regulation by protecting the public and promoting quality health care.*

MISSION Recommendations

The Committee recommends broadening the mission statement to more accurately reflect what the FSMB does; adding "voice of state medical boards," "education, assessment, research and advocacy," "services and initiatives," "regulatory best practices," and "patient safety." The Committee also recommends changing the term "excellence in medical practice" to "quality health care," as this is a more accurate representation of the scope of the FSMB's work.

Proposed Revised Mission: *The FSMB serves as the voice for state medical boards, supporting them through education, assessment, research and advocacy while providing services and initiatives that promote patient safety, quality health care and regulatory best practices.*

VALUES Recommendations

The Committee recommends removing "Values" as a formal component of the Strategic Plan and incorporating it instead as a tool to be used for internal purposes – that is, to help guide FSMB staff and elected leadership as they carry on the work of the organization.

STRATEGIC GOALS Recommendations

The Committee recommends retaining most of the current goals, but making adjustments of wording and emphasis, including simplifying headings, editing for consistency, and using active voice vs. passive voice. The Committee also recommends:

- Strengthening the language of the goals to indicate the FSMB's commitment to serving state medical boards
- Expanding the current "Information Resource" goal to include the terms "data and research"
- Strengthening references to patient safety and quality care
- Adding other new terms of emphasis into the language of the goals in keeping with overarching recommendations made earlier in this report

Proposed Revised Strategic Goals

- ***State Medical Board Support****: Serve state medical boards by promoting best practices and providing policies, advocacy, and other resources that add to their effectiveness.*

- ***Advocacy and Policy Leadership****: Strengthen the viability of state-based medical regulation in a changing, globally-connected health care environment.*

- ***Collaboration****: Strengthen participation and engagement among state medical boards and expand collaborative relationships with national and international organizations.*

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- ***Education**: Provide educational tools and resources that enhance the quality of medical regulation and raise public awareness of the vital role of state medical boards.*

- ***Data and Research Services**: Expand the FSMB's data-sharing and research capabilities while providing valuable information to state medical boards, the public and other stakeholders.*

- ***Organizational Strength and Excellence**: Enhance the FSMB's organizational vitality and adaptability in an environment of change and strengthen its financial resources in support of its mission.*

Addition of an "About the FSMB" section

The Committee recommends adding a preamble to the Strategic Plan, titled "About the FSMB," which will help clarify for public audiences the FSMB's structure and scope of its work.

Proposed Preamble to the Strategic Plan

The Federation of State Medical Boards represents the 70 state medical and osteopathic regulatory boards -- commonly referred to as state medical boards -- within the United States, its territories and the District of Columbia. It supports its member boards as they fulfill their mandate of protecting the public's health, safety and welfare through the proper licensing, disciplining, and regulation of physicians and, in most jurisdictions, other health care professionals.

For comparison, the current 2010-2015 Strategic Plan and the proposed 2015-2020 Strategic Plan can be found behind **Attachments A and B**, respectively.

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Attachment A

Attachment A: Current 2010-2015 Strategic Plan

Vision

The Federation of State Medical Boards is the leader in medical regulation, serving as an innovative catalyst for effective policy and standards.

Mission

The FSMB leads by promoting excellence in medical practice, licensure, and regulation as the national resource and voice on behalf of state medical boards in their protection of the public.

Values

The FSMB, an organization of state medical boards, embraces these equally important values:

- Public Protection: Promotes public health, safety and welfare through its Member Boards.
- Leadership: Demonstrates innovation, cooperation and responsiveness.
- Integrity: Incorporates honesty, ethical behavior, reliability and transparency in all its operations and services.
- Excellence: Promotes and maintains high standards of performance and a commitment to continuous improvement, efficiency and effectiveness.
- Commitment to Service: Provides support and high quality service to its Member Boards.

Strategic Goals:

- **Advocacy and Policy Leader:** Strive to enhance the role of state medical and osteopathic boards in an evolving health care environment.
- **Consistent Standards**: Effectively lead, assist and support state medical and osteopathic boards to develop and use standards, language, definitions and tools.
- **Information Resource**: Be recognized by the public and policymakers as a valued informational and educational resource for medical licensure and regulation.
- **Organizational Improvement**: Enhance our organizational vitality and nimbleness, broaden our financial resources, and provide a technology platform adequate for the evolving needs of FSMB.
- **Partnerships**: Engender greater participation and engagement among our member boards and more effective relationships with national and international organizations as a trusted and reliable partner.
- **Support for State Medical Boards**: Offer relevant policy, programs, education and services to state medical and osteopathic boards that result in improved quality and safety of patient care through effective and fair medical regulation and discipline.

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Attachment B

Attachment B: Proposed 2015-2020 Strategic Plan

About the FSMB

The Federation of State Medical Boards represents the 70 state medical and osteopathic regulatory boards -- commonly referred to as state medical boards -- within the United States, its territories and the District of Columbia. It supports its member boards as they fulfill their mandate of protecting the public's health, safety and welfare through the proper licensing, disciplining, and regulation of physicians and, in most jurisdictions, other health care professionals.

Vision

The FSMB is an innovative leader, helping state medical boards shape the future of medical regulation by protecting the public and promoting quality health care.

Mission

The FSMB serves as the voice for state medical boards, supporting them through education, assessment, research and advocacy while providing services and initiatives that promote patient safety, quality health care and regulatory best practices.

Strategic Goals

- **State Medical Board Support**: Serve state medical boards by promoting best practices and providing policies, advocacy, and other resources that add to their effectiveness.
- **Advocacy and Policy Leadership**: Strengthen the viability of state-based medical regulation in a changing, globally-connected health care environment.
- **Collaboration**: Strengthen participation and engagement among state medical boards and expand collaborative relationships with national and international organizations.
- **Education**: Provide educational tools and resources that enhance the quality of medical regulation and raise public awareness of the vital role of state medical boards.
- **Data and Research Services**: Expand the FSMB's data-sharing and research capabilities while providing valuable information to state medical boards, the public and other stakeholders.
- **Organizational Strength and Excellence**: Enhance the FSMB's organizational vitality and adaptability in an environment of change and strengthen its financial resources in support of its mission.

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SOUTH DAKOTA
BOARD OF MEDICAL & OSTEOPATHIC EXAMINERS
sdbmoe.gov

SDBMOE Board News

By Margaret B. Hansen, PA-C, MPAS; and Tyler Klatt, MPA

The Interstate Medical Licensure Compact: What Physicians Should Know

What is the Interstate Medical Licensure Compact?

The compact would be a new pathway to expedite and simplify physician licensing for those seeking to practice medicine in multiple states. The compact would strengthen public protection because it would help states share investigative and disciplinary information.

The proposal could:

- Increase health care access for underserved or rural areas; and
- Allow medical expert consult by telemedicine technologies.

Is the Interstate Compact a national license?

No. Each license to practice medicine will be issued by a state medical board and physicians must be licensed in the state where the patient is located. A licensed obtained through the expedited procedure will provide the same

Can a physician ineligible to participate in the Compact still obtain multiple licenses?

Yes. Physicians who are ineligible for the expedited licensure process facilitated by the Interstate Compact may seek additional licenses in those states where they desire to practice and will apply through the respective traditional licensure processes.

Who is eligible to seek licensure through the Compact process?

To be eligible, a physician would have to possess a full and unrestricted license in a member state, be board certified in a medical specialty and have no history of being disciplined, penalized or punished by a court, a medical licensing agency or the Drug Enforcement Administration. Initial surveys estimate that nearly 80 percent of the physician population licensed in the U.S. would be eligible for expedited licensure.

How do I apply for expedited licensure?

An eligible physician would designate a member state as the state of principal licensure and select the other member states in which a medical license is desired. The state of principal licensure will verify the physician's eligibility and provide credential information to the Interstate Commission. The Interstate Commission will collect applicable fees and transmit the physician's information and licensure fees to the additional states. Upon receipt in the additional states, the physician would be granted a license.

What state can serve as the state of principal licensure?

The physician must possess a full and unrestricted license to practice medicine in the state of principal licensure, and the state must be:

- The state of primary residence for the physician, or
- The state where at least 25 percent of the practice of medicine occurs, or
- The location of the physician's employer, or
- If no state qualifies, the state designated as state of residence for purpose of federal income tax.

How long will it take for me to be licensed in other states?

The compact will substantially reduce the time it takes to receive multiple licenses. As soon as eligibility is verified and fees are transferred, additionally selected states will issue a full and unrestricted license to the physician.

Will the Compact be used for renewing licenses?

As long as a physician remains eligible for the Compact, expedited licenses granted by a member state will be renewed through a process created by the Interstate Commission.

Where can I learn more about the Interstate Compact?

http://www.fsmb.org/state-medical-boards/interstate-model-compact/

Support from the U.S. Senate

In a letter sent Jan. 9 to the Federation of State Medical Boards (FSMB), a bipartisan group of 16 U.S. senators applauded the progress being made by the state medical boards in the development of an Interstate Medical Licensure Compact.

In the letter, the senators noted that the proposed compact system retains important patient-protection advantages of the current state-based medical licensing process. "We agree that allowing states to share information while allowing each state to retain jurisdiction over physicians who choose to practice in the state is in the best interest of both physicians and patients," the letter said. The senators noted that the new expedited licensure system would help ensure telemedicine is practiced in a "safe and accountable manner."

The letter was signed by: John Thune (R-SD), Michael Enzi (R-WY), Lamar Alexander (R-TN), John Barrasso (R-WY), Roy Blunt (R-MO), John Boozman (R-AR), Tom Carper (D-DE), Tom Coburn (R-OK), Thad Cochran (R-MS), Al Franken (D-MN), James Inhofe (R-OK), Johnny Isakson (R-GA), Tim Johnson (D-SD), Amy Klobuchar (D-MN), John D. Rockefeller IV (D-WV), and Mark Warner (D-VA).

REFERENCES

Adapted from multiple sources including the FSMB FAQ documents by Margaret B. Hansen, PA-C, MPAS, and Tyler J. Klatt, MPA.

SDBMOE Board News is a monthly bulletin from the South Dakota Board of Medical and Osteopathic Examiners. For more information, contact the Board at SDBMOE@state.sd.us or write to SDBMOE, 101 N. Main Avenue, Suite 301, Sioux Falls, SD 57104.