IN THE SUPREME COURT
OF THE
STATE OF SOUTH DAKOTA

Appeal No. 27491

STEVEN J. WIPF,

Plaintiff and Appellee,

VS.

TERRY ALTSTIEL, M.D. and **REGIONAL HEALTH PHYSICIANS, INC.**,

Defendants and Appellants

Appeal from the Circuit Court
Fourth Judicial Circuit
Lawrence County
Hon. Michelle Percy, Circuit Court Judge

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Table of Contents

Page

Table of Contents ii

Table of Authorities iv

Preliminary Statement 1

Jurisdictional Statement 1

Statement of Issues 2

Statement of the Case 2

Statement of the Facts 4

1. The case is about whether Altstiel perforated Wipf's small bowel during an operation, and then failed to find the perforations. 4

2. Wipf wants discovery to answer a question he posed to Altstiel's expert, but which is unrelated to the opinions the expert is offering for Altstiel. 6

3. The circuit court ordered Altstiel to produce the medical records of nonparty patients. 9

Argument 10

1. The standard of review is *de novo*. 10

2. The treatment records of nonparty patients are privileged. 10

A. Privileged information is not discoverable. 11

B. Nonparty medical records are privileged under the clear language of the statute. 11

C. South Dakota has consistently expanded protection of medical information.....14

1. Unlike most privileges, which are strictly construed to expand disclosure, the physician-patient privilege is liberally construed to expand protection. 16

2. This Court has recognized the importance of physicians asserting the privilege on behalf of their patients. 19

3. The South Dakota legislature has consistently expanded the protections of the physician-patient privilege. 20

3. Redacting medical records is not an exception to the physician-patient privilege and, even when redacted, the contents of the records create a risk of identification. 25

A. Redaction is not an enumerated exception and does not defeat the privilege.....26

B. Those courts that have permitted discovery make the ruling dependent upon the risk of identification.....30

C. This Court should adopt the rule prohibiting production of nonparty medical records, even if they are redacted.....33

Conclusion 35

Request for Oral Argument 35

Certificate of Compliance 36

Certificate of Service 37

Appendix 38

Table of Authorities

Page

Cases

Bertelsen v. Allstate Ins. Co.,
2011 S.D. 13, 796 N.W.2d 685 16

Dakota, Minnesota & E. R.R. Corp. v. Acuity,
2009 S.D. 69, 771 N.W.2d 623 ..... 11, 16

Hogg v. First Nat. Bank of Aberdeen,
386 N.W.2d 921 (S.D. 1986) 24

Hogue v. Massa,
123 N.W.2d 131 (S.D. 1963) 15, 16, 17

In re Columbia Valley Regional Medical Center,
41 S.W.3d 797 (Tex. App. 2001) 2, 27, 28, 29

In re Golder's Estate,
158 N.W. 734 (S.D. 1916) 15, 16, 17

In re W. River Elec. Ass'n, Inc.,
2004 S.D. 11, 675 N.W.2d 222 29

Maynard v. Heeren,
1997 S.D. 60, 563 N.W.2d 830 ..... 10, 17, 18, 29

Northlake Med. Or., LLC v. Queen,
634 S.E.2d 486 (Ga. Ct. App. 1996) 14

Parkson v. Central Dupage Hosp.,
435 N.E.2d 140 (Ill. App. 1982) 28, 29, 30

Roe v. Planned Parenthood Southwest Ohio Region,
912 N.E.2d 61 (Ohio 2009) 2, 26, 27, 29

Rudnick v. Superior Court,
523 P.2d 643 (Cal. 1974) 32, 33

Schaffer v. Spicer,
215 N.W.2d 134 (S.D. 1974) ..... passim

Shamburger v. Behrens,
380 N.W.2d 659 (S.D. 1986) 12

Staley v. Northern Utah Healthcare Corp.,
230 P.3d 1007 (Utah 2010) ..... passim

State v. Catch the Bear,
352 N.W.2d 640 (S.D. 1984) 24

State v. Means,
268 N.W.2d 802 (S.D. 1978) 24

Wheeldon v. Madison,
374 N.W.2d 367 (S.D. 1985) 21

Statutes

42 U.S.C. § 1320d 14

SDCL § 15-26A-3 1

SDCL § 15-26A-66 36

SDCL § 15-6-26 ..... 11, 18

SDCL § 19-13-11 ..... 21, 22, 23

SDCL § 19-19-501 11

SDCL § 19-19-503 ..... 2, 12, 13

SDCL § 19-2-13 24

SDCL § 19-2-3 ..... 18, 21, 22, 23

SDCL § 19-2-6 20

SDCL § 36-4-30 15

Other Authorities

SL 2001 Ch. 103 (H.B. 1002) 21, 22

Preliminary Statement

Appellants will refer to themselves as "Altstiel." Appellants will refer to Appellees as "Wipf."

Appellants will refer to the Record on Appeal as "R.," followed by the page number(s) assigned by the Lawrence County Clerk of Courts. Appellants will refer to the hearing transcript as "HT:," followed by the page number(s). Appellants will refer to materials in their Appendix by "Appellants' Appx." followed by the page number(s).

Jurisdictional Statement

This is an interlocutory appeal from an order of the circuit court dated June 23, 2015. (R. 200-01; Appellants' Appx. 1-2) This Court entered an Order Granting Petition for Allowance of Appeal from Intermediate Order on August 7, 2015. This Court has jurisdiction pursuant to SDCL § 15-26A-3(6).

Statement of Issues

> Whether, in a civil action alleging medical malpractice, the defendant physician may be compelled to produce treatment records of his nonparty patients, so long as identifying information is redacted.

The circuit court ordered Altstiel to produce redacted treatment records of all of his patients undergoing laproscopic hernia repair over a five-year period.

- SDCL § 19-19-503.
- *Roe v. Planned Parenthood Southwest Ohio Region*, 912 N.E.2d 61 (Ohio 2009).
- *In re Columbia Valley Regional Medical Center*, 41 S.W.3d 797 (Tex. App. 2001).
- *Staley v. Northern Utah Healthcare Corp.*, 230 P.3d 1007 (Utah 2010).

Statement of the Case

This is an intermediate appeal from an order by the Fourth Judicial Circuit, Lawrence County, the Honorable Michelle Percy presiding.

Wipf sued Altstiel for alleged medical malpractice. This appeal arises from a discovery order compelling Altstiel to provide Wipf with medical records from each of Altstiel's patients who underwent laproscopic hernia repair surgery from 2009 through 2013.

Wipf served discovery requests asking for medical records from Altstiel's other patients. (R: 138-40; Appellants' Appx. 3-5)

Altstiel responded by objecting on various grounds, including that the requested records are protected under the physician-patient privilege. (R: 138-40; Appellants' Appx. 3-5)

Wipf moved for an order compelling Altstiel to produce the requested medical records. The circuit court heard argument on Wipf's Motion to Compel on June 15, 2015, and granted the motion without explanation. (HT: 18:22-19:4) On June 23, the circuit court entered an order granting Wipf's motion to compel and ordering Altstiel to produce the medical records of nonparty patients (R. 200-201; Appellant's Appx. 1-2). Wipf served Notice of Entry on June 24 (R. 202-03).

On July 7, 2015, Altstiel petitioned for permissive appeal, which this Court granted on August 7, 2015.

Altstiel asserted several objections to the discovery, but most of them fall within the circuit court's discretion. Therefore, Altstiel confines this appeal to the legal issue of whether the circuit court erred in denying his objection based upon the physician-patient privilege.

Statement of the Facts

While Altstiel is not appealing the circuit court's relevance determination, this Court needs to know why Wipf wants the nonparty records to give context to the privilege dispute.

1. The case is about whether Altstiel perforated Wipf's small bowel during an operation, and then failed to find the perforations.

On Friday April 22, 2011, Altstiel performed a laparoscopic hernia repair on Wipf at the Spearfish Regional Surgery Center. Laparoscopic hernia repair is a technique to fix tears or openings in the abdominal wall using small incisions, laparoscopes (small telescopes inserted into the abdomen) and a patch (screen or mesh) to reinforce the abdominal wall. The surgery ended around 10:00 a.m., and Wipf was discharged home at about 4:00 p.m. Wipf was advised to call his physician in the event of any unusual pain or fever.

The next day, Wipf called Spearfish Regional Surgery Center complaining of pain in his upper back, a fever, and that he had not had a bowel movement since before the laparoscopy. The physician

assistant on-call told Wipf to go to the emergency room. Wipf lives in Sturgis, so he went to Sturgis Regional Hospital. Wipf said his primary complaint was pain, but admitted that he had not been taking his pain medications because he did not like to rely on them. The E.R. doctor noted that Wipf had no temperature, and no blockage in his bowel. The E.R. doctor gave Wipf some additional pain medication, instructed him to take the pain medication as directed for at least a couple of days, and told him to come back if things got worse.

Wipf went back to the emergency room three nights later, Tuesday night. He complained of nausea, and that he had not had a bowel movement since before the surgery. The E.R. doctor admitted Wipf to the hospital for observation. Wipf was in the Sturgis hospital through Thursday morning, when they performed a CT scan of his abdomen.

The CT scan revealed fluid and air in the abdomen, and a nearby opening in the mid-small bowel. Based on these findings, Sturgis Regional Hospital transferred Wipf to Rapid City Regional Hospital to undergo surgery with Dr. Larry Wehrkamp. Dr.

Wehrkamp found two perforations in the small bowel that measured about two centimeters in size.

Wipf's malpractice claim turns on two issues. First, did the the bowel perforations exist at the time Altstiel completed his surgery? Second, if so, was Altstiel negligent in not finding them?

Altstiel maintains that the perforations did not exist at the time he finished the surgery. Altstiel testified that, before closing the surgery, he inspected the bowel for injury and there was none. He also maintains that Wipf's symptoms after the surgery show that the perforations did not exist until days after the surgery. Wipf, on the other hand, claims that Altstiel's operative report does not say that he inspected the bowel, and therefore he did not, and that is why Altstiel missed the perforations that he would have seen had he inspected the bowel.

2. Wipf wants discovery to answer a question he posed to Altstiel's expert, but which is unrelated to the opinions the expert is offering for Altstiel.

Wipf claims Altstiel's expert, Dr. Donald Wingert, testified that Altstiel's other surgeries are relevant. That is true, if at all,

only because Wipf got Dr. Wingert to make *legal* errors in his testimony, and then led him around by those errors.

Wipf asked Dr. Wingert, over objection, to define the term "standard of care." Dr. Wingert said it meant not making "a gross error in judgment or treatment." (Deposition of Dr. Donald Wingert, 12:10-15; R. 145) Obviously, that is not a legally correct definition. But, it gets worse.

Forty pages later, Wipf takes that erroneous definition and turns it into the legal threshold for duty and breach.

> Q Doctor, earlier you talked about, in order to be held responsible, a doctor needs to commit gross error. Is that correct?
>
> A Yes.
>
> Q And what does "gross error" mean to you?
>
> A Be incompetent to do the case he's doing or to willingly commit something that will injure a patient purposefully.

(Wingert Deposition, 52:25-53:7; R. 155-56) So now, rather than simply discussing the care that Altstiel provided Wipf, the entire discussion shifts to how one would determine whether a physician

was competent to do the procedure at all. But Wipf has never alleged that Altstiel is incompetent to perform laparoscopic hernia repair.

Dr. Wingert understands the real issue. He testified that "a doctor should be held responsible if they do something to the patient that's negligent," but not simply because "bad things happen during surgery." (Wingert Deposition, 53:16-25; R. 156) Dr. Wingert believes Altstiel provided good care to Wipf, and he testified at length about why he believes that. But having stumbled into the general competence issue, Dr. Wingert was roped into discussing complication rates, morbidity, and mortality.

And that is Wipf's argument: Dr. Wingert's testimony renders a physician's surgical history relevant to his general competence to perform a given procedure. But Wipf has never alleged that Altstiel is incompetent to perform laparoscopic hernia repairs; therefore, the entire line is irrelevant. This case is about whether Altstiel's care of Wipf was appropriate. Dr. Wingert's legal errors do not change the issues in this case.

3. The circuit court ordered Altstiel to produce the medical records of nonparty patients.

Following briefing and oral argument, the circuit court ordered Altstiel to produce the following:

> Defendants shall provide to Plaintiff copies of all the medical records (beginning with the operative note and including all medical reports or notes generated for the next 30 days that in any way related to care for, or recovery from, the laparoscopic hernia repair surgery) for each patient on which Dr. Terry L. Altstiel performed laparoscopic hernia repair surgery during the years 2009 through 2013;

(Appellants' Appx. 1) The circuit court further ordered Altstiel to redact certain information from the records.

> IT IS FURTHER ORDERED that Defendants shall redact from these records the personal identifiers for each patient, including the patient's name, address, phone number, date of birth, and social security number, prior to disclosing these records to Plaintiff;

(Appellants' Appx. 1-2)

Because the circuit court's Order compels production of all treatment records for 30 days following the surgery, it will require production of such records as operative reports, discharge summaries, follow-up clinic visits, or possible follow-up hospitalization records. To provide an idea of what such records

might include, examples from Wipf's medical records are included at Appellants' Appx. 6 to 13.

Argument

1. The standard of review is *de novo*.

This Court reviews the issue of whether redacting medical records removes them from the physician-patient privilege *de novo*. *Maynard v. Heeren*, 1997 S.D. 60, ¶ 5, 563 N.W.2d 830, 833 (While discovery rulings are typically reviewed for abuse of discretion, "whether the trial court's order violated the psychologist-patient confidentiality privilege . . . raises a question of statutory interpretation requiring *de novo* review.").

2. The treatment records of nonparty patients are privileged.

Medical records are protected by the physician-patient privilege. While there is a patient-litigant exception to the privilege, there is no exception for the medical records of nonparties. Courts in other jurisdictions have split on the question of whether redacting identifying information from medical records makes them

discoverable, but none of those rulings would support the circuit court's order compelling medical records in this case.

A. Privileged information is not discoverable.

Wipf may obtain discovery of information only if it is "not privileged." SDCL § 15-6-26(b)(1). Statutes and court rules—not the common law—determine the scope of privileges in South Dakota. SDCL § 19-19-501. Altstiel must show there is a statutory privilege to his nonparty patients' treatment records. *Dakota, Minnesota & E. R.R. Corp. v. Acuity*, 2009 S.D. 69, ¶ 48, 771 N.W.2d 623, 636. If he does, then Wipf must show that an exception or waiver applies. *See Id.* at ¶ 51, 637 ("The party asserting a claim of waiver has the burden of establishing a waiver of a privilege.").

B. Nonparty medical records are privileged under the clear language of the statute.

Patients hold a privilege over their medical information, and have the right to control its use or dissemination.

> A patient has a privilege to refuse to disclose and to prevent any other person from disclosing confidential communications made for the purpose of diagnosis or treatment of his physical, mental, or emotional condition, including alcohol or drug addiction, among

> himself, physician, or psychotherapist, and persons who are participating in the diagnosis or treatment under the direction of the physician or psychotherapist, including members of the patient's family.

SDCL § 19-19-503(b).[1] Altstiel may claim the privilege on behalf of his patients. SDCL § 19-19-503(c). While the privilege uses the word "communication," this Court has ruled that medical records are privileged from discovery under SDCL § 19-19-503. *Shamburger v. Behrens*, 380 N.W.2d 659, 662 (S.D. 1986). Having established the privilege, the burden shifts to Wipf to prove a waiver or exception. *Schaffer v. Spicer*, 215 N.W.2d 134, 137 (S.D. 1974).

Altstiel cannot waive the privilege because he is not the holder of the privilege. The statute provides that the "*patient* has a privilege to refuse to disclose and to prevent any other person from disclosing confidential communications." SDCL § 19-19-503(b) (emphasis added.) The privilege "is to be liberally construed in favor of the patient[, and] . . . it must clearly appear there is an intention to waive, and a court will not run to such a conclusion." *Schaffer*, 215 N.W.2d at 137. Indeed, in *Schaffer*, this Court held that the

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[1] At the time of the original objections and motion to compel, the privilege was found at SDCL § 19-13-7.

privilege "imposes a duty upon a physician or other healing practitioner to keep confidential or privileged, information gained while in professional attendance of a patient," and held that failure to do so might be actionable. *Id.*, at 136.

There are exceptions to the privilege, but they are limited in number, expressly provided by statute, and inapplicable here. The only exceptions are

> (1) Information relating to proceedings to hospitalize the patient for mental illness;
>
> (2) Information related to court ordered physical, mental, or emotional examinations; and,
>
> (3) The patient-litigant exception, for information relevant to the *patient's* claim or defense or, information relevant to a deceased patient's medical condition when any party relies upon that condition as an element of a claim or defense.

SDCL § 19-19-503(d) (emphasis added). None of these exceptions authorize discovery of nonparty medical records.

The physician-patient privileges prohibits the production of treatment records for Altstiel's nonparty patients. None of the exceptions to that privilege apply to Wipf's requests or the circuit court's order.

C. South Dakota has consistently expanded protection of medical information.

The development of the physician-patient privilege in South Dakota provides an important backdrop to the issues in this appeal. Medical confidentiality has been enshrined in the American Medical Association's Principles of Medical Ethics[2] and codified as federal law. Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. 1. No. 104-191, 110 Stat. 1936 (1996). HIPAA is designed to "ensure the integrity and confidentiality of patients' information and protect against unauthorized uses or disclosures of the information." *Northlake Med. Or., LLC v. Queen*, 634 S.E.2d 486, 489 (Ga. Ct. App. 1996); *see also* 42 U.S.C. § 1320d-2(d)(2)(A) & (B)(ii) (2000).

The strong public policy supporting confidentiality is reflected in this Court's recognition that a patient may bring a civil action against a physician for violation of the duty of confidentiality, *see Schaffer*, 215 N.W.2d at 136, and South Dakota law regulating the practice of medicine, which includes to "willfully betray a

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[2] Available at http://www.ama-assn.org/ama/pub/category/2512.htrnl.

professional confidence" as unprofessional conduct that can lead to discipline, including loss of one's medical license. *See* SDCL § 36-4-30(4).

The physician-patient privilege has been recognized in South Dakota since at least 1877. *See Hogue v. Massa*, 123 N.W.2d 131,133 (S.D. 1963) (*citing* § 499(3) of the Territorial Revised Code); *State v. Schroeder*, 524 N.W.2d 837, 841 n.4 (N.D. 1994). The Territorial Code Commission declared that "[t]here are particular relations in which it is the policy of the law to encourage confidence and to preserve it inviolate," and provided that "[a] physician or surgeon cannot, without the consent of his patient, be examined in a civil action as to any information acquired in attending the patient which was necessary to enable him to prescribe or act for the patient." *Hogue*, 123 N.W.2d at 133. Following statehood, South Dakota adopted an identical provision in section 538(3) of South Dakota's Code of Civil Procedure. *See In re Golder's Estate* (*Johnson v. Shaver*), 158 N.W. 734,735 (S.D. 1916).

1. Unlike most privileges, which are strictly construed to expand disclosure, the physician-patient privilege is liberally construed to expand protection.

Generally, "[s]tatutory privileges 'are to be strictly construed to avoid suppressing otherwise competent evidence.'" *Bertelsen v. Allstate Ins. Co.*, 2011 S.D. 13, ¶ 44, 796 N.W.2d 685, 700 (*quoting Dakota, Minn. & E. R.R. Corp. v. Acuity*, 2009 S.D. 69, ¶ 57, 771 N.W.2d 623, 639. However, that is not true of the physician-patient privilege.

In 1916, this Court observed that the medical privilege statute in section 538(3) was expressly limited to civil actions, and held that the privilege "should be strictly construed and held to apply only where the clear wording of the statute requires such a holding." *In re Golder's Estate* (*Johnson v. Shaver*), 158 N.W. 734,735 (S.D. 1916).

In 1963, this Court reversed itself. *Hogue*, 123 N.W.2d at 132. The *Hogue* case was an action for medical negligence brought by a patient and his wife against the husband's physician. The issue presented in the intermediate appeal was whether the defendant

could depose the plaintiff's subsequent physician regarding his care and treatment of the plaintiff, or whether such information was protected from discovery by the medical privilege reclassified as SDCL 1960 Supp. 36.0101(3). *See id.* at 133-34.

In conducting its analysis, this Court first recognized that the medical privilege "expresses a long-standing public policy to encourage uninhibited communication between a physician and his patient." *Id.* at 133. Next, this Court overruled its holding in *Golder's Estate*, that the medical privilege should be strictly construed. Referring to a previously overlooked provision of the civil code requiring it to be "liberally construed with a view to effect its objects and promote justice," this Court explained that, "[i]n obedience to this legislative mandate it is our duty to effectuate the purposes of the statute. In other words, it [the medical privilege] is to be liberally construed in favor of the patient." *Hogue*, 123 N.W.2d at 134.

In 1997, this Court ruled that, even if the privilege is waived, circuit courts must take care to ensure that the use and dissemination of the information is limited. In *Maynard v. Heeren*,

1997 S.D. 60, 563 N.W.2d 830, the Court held that the two waiver statutes for the privilege (SDCL §§ 19-2-3 and 19-13-11) created a statutory "patient-litigant" exception to the medical privilege that gives the party seeking disclosure an absolute right of access to privileged material pursuant to those statutes. *See id.* at 835. But, this Court went on to explain that trial courts should use procedures that were in place to protect a patient-litigant from disclosure of particular records or communications that may not be relevant:

> While the access may be absolute, this does not limit the sound discretion of the trial court in placing reasonable restrictions upon dissemination and use of the sought-after material. The party seeking to oppose discovery has the right to an *in camera* hearing to determine whether the material is relevant. The party seeking to invoke the privilege may file a motion for protective order under SDCL 15-6-26(c) or objections to discovery pursuant to SDCL 15-6-33(b) and 15-6-34(b).

Id. at 835-36.

This Court has routinely applied the statutory privilege liberally, and its exceptions strictly, so as to give the utmost protection to treatment records.

2. This Court has recognized the importance of physicians asserting the privilege on behalf of their patients.

In 1974, this Court was presented with a claim brought by a patient against one of her physicians for breaching the privilege. *See Schaffer*, 215 N.W.2d at 134. Betty Schaffer and her recently divorced husband, Virgil, were embroiled in a child custody dispute. *See id.* at 136. In an attempt to demonstrate why the children should remain with him, Virgil filed an affidavit provided by Betty's psychiatrist, Edward Spicer, "going into extensive detail and divulging much information that he received from the physician-patient relationship while consulting and treating Betty ..." *Id.* Betty then brought an action against her psychiatrist for violation of the medical privilege. *See id.*

First, this Court held that a claim against a physician for violation of the medical privilege was authorized under South Dakota law:

> The above statute imposes a duty upon a physician or other healing practitioner to keep confidential or privileged, information gained while in professional attendance of a patient. If a practitioner of the healing

> art breaches that duty by making any unauthorized disclosure of confidential information he may be liable to the patient for resulting damages.

Id. (footnote omitted). Next, this Court addressed the psychiatrist's assertion that Betty had waived the medical privilege pursuant to SDCL § 19-2-6, which provided for a waiver of a legal privilege when the holder of the privilege testified as to any particular communication. *See Schaffer*, 215 N.W.2d at 137-38.

Rejecting that contention, this Court expressly reaffirmed the principles that the medical privilege should be liberally construed in favor of the patient, that a waiver of the privilege would not be recognized unless clearly established that the patient intended to waive it, and that the burden of establishing such an intention was on the party asserting waiver. *See id.* at 137 (*quoting Hogue*, 123 N.W.2d at 133-34).

3. The South Dakota legislature has consistently expanded the protections of the physician-patient privilege.

"The physician-patient privilege has no common law basis. 2 Weinstein's Evidence § 504[01] at 504-8. The privilege is created and

controlled by statute or court rule." *Wheeldon v. Madison*, 374 N.W.2d 367, 376 (S.D. 1985).

In 2001, the Legislature amended SDCL §§ 19-13-11 and 19-2-3 to broaden the protection of potentially sensitive medical information. *See* SL 2001 Ch. 103 (H.B. 1002) ("An Act to revise certain provisions regarding the waiver of a patient's privilege on communications with a physician or psychotherapist"). The 2001 amendment to SDCL § 19-13-11 clarified that, rather than there being "no privilege" where the patient's condition is an element of a legal claim or defense, such privilege existed but was "waived" in those circumstances in the manner prescribed by the Legislature. *See id.* at § 1 (amending SDCL § 19-13-11).

The 2001 amendment to SDCL § 19-2-3 provided substantial additional protections for privileged medical information by mandating that "the waiver of the privilege shall be *narrow in scope*, closely tailored to the time period or subject matter of the claim."

> If any party or holder of the privilege objects to the discovery of the privileged communication on grounds that disclosure of the communication would subject the party to annoyance, embarrassment, oppression, or undue burden or expense and that the disclosure of the

> privileged communication is not likely to lead to the discovery of relevant evidence, the court shall conduct an *in camera* review of the privileged communication to determine whether the communication is discoverable.

Id. at § 2 (amending SDCL § 19-2-3) (emphasis supplied).

Although the plain language of these amended statutes speaks for itself, the legislative history confirms that the legislature was concerned not only about giving patients notice and an opportunity to object before confidential information is disclosed to an opposing party, but also about protecting medical providers from claims that the privilege was violated by releasing such information without prior knowledge or consent.[3]

In 2003, SDCL § 19-13-11 was amended to correspond with the requirements of SDCL § 19-2-3 that a patient-litigant waives the medial privilege only "at trial or for the purpose of discovery under chapter 15-6," where medical information is relevant to a claim or defense. *See* SL 2003 Ch. 121 (H.B. 1086) ("An Act to revise the

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[3] See House Health and Human Services Committee Hearing on H.B. 1002 (January 31, 2001); Senate Health and Human Services Committee Hearing on H.B. 1002 (February 12,2001), available at http://legis.state.sd.us/sessionsI2001/1002.htm. This bill passed the Senate unanimously (33-0) and passed the House on a vote of 64 to 3. Governor Janklow signed the bill on February 21, 2001.

exception for a patient's privilege on confidential communications with physicians and psychotherapists"). Again, the language of the statute is clear, but the testimony before the House and Senate Judiciary Committees shows that the purpose of the amendment was to bring SDCL § 19-13-11 into accord with SDCL § 19-2-3.[4]

In 2010, this Court promulgated a new rule to further strengthen the physician-patient privilege. SL 2011, ch 231 adopted Supreme Court Rule 10-07, which provided that, even when the physician-patient privilege is waived under the patient-litigant exception, that waiver is limited to only the immediate action for which it was waived.

> The production of a record of a health care provider, whether in litigation or in contemplation of litigation, does not waive any privilege which exists with respect to the record, other than for the use in which it is produced. Any person or entity receiving such a record may not reproduce, distribute, or use it for any purpose other than for which it is produced.

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[4] See House Judiciary Committee Hearing on H.B. 1086 (January 29, 2003); Senate Judiciary Committee Hearing on H.B. 1086 (February 7, 2003), available at http://legis.state.sd.us/sessions/2003/1086.htm. According to the testimony, this bill had its origins in a recommendation by the State Bar Association's evidence committee. It was passed unanimously by both the House (69-0) and the Senate (35-0), and signed by Governor Rounds on February 21, 2003.

> This rule does not bar any person or entity from complying with any court order, or state or federal law or regulation authorizing disclosure of information that otherwise would be protected by this rule.

SDCL § 19-2-13. That limitation is a departure from, and expands the protection of, the general rule regarding waivers of privileges.

Generally, once a privilege is waived, it is waived forever. *See Hogg v. First Nat. Bank of Aberdeen*, 386 N.W.2d 921, 926 (S.D. 1986) (noting that "authority exists for the proposition that once a privilege is waived, it cannot be regained"); *State v. Catch the Bear*, 352 N.W.2d 640, 647 (S.D. 1984); *State v. Means*, 268 N.W.2d 802, 813 (S.D. 1978) ("The right of privilege is personal to the client, and after an effectual waiver the privilege disappears and the barrier is removed."). However, that is not true for the physician-patient privilege. The waiver of the privilege is limited to the action at issue, and then the privilege reattaches to that information.

So, not only does the clear language of the privilege statute protect the medical records of Altstiel's nonparty patients, but South Dakota's judiciary and legislature have demonstrated a clear unwillingness to reduce the protections of the statutes.

3. Redacting medical records is not an exception to the physician-patient privilege and, even when redacted, the contents of the records create a risk of identification.

Wipf urged, and the circuit court agreed, that the physician-patient privilege to nonparty treatment records is overcome by redacting identifying information. This is an issue of first impression in South Dakota.[5] Courts in other jurisdictions have reached inconsistent conclusions, which tend to fall into one of two groups. One group, strictly applying the language of physician-patient privilege statutes, holds that redaction does not meet an exception. The other group, looking to legislative intent outside the language of the statutes, holds that so long as there is no way to identify the patient from the record, then the privilege does not apply.

---

[5] While this Court has examined issues related to use of other-party medical records before, those cases all involved co-plaintiffs, who had expressly waived the privilege for each other's cases. *See, e.g.*, *Martinmaas v. Engelmann*, 2000 S.D. 85, 612 N.W.2d 600 (multiple plaintiffs suing a physician for sexual assault), and *St. John v. Peterson*, 2011 S.D. 58, 804 N.W.2d 71 (multiple plaintiffs bringing malpractice actions, and seeking consolidation). The Court has not previously addressed the effect of redaction upon the privilege.

South Dakota's adherence to statutory privileges and exceptions, and its history of protecting and expanding the scope of the physician-patient privilege, should lead this Court to adopt the first approach. But, even if this Court were to adopt the second approach, it should vacate the circuit court's order because of the presence of the risk of identification in this case.

A. Redaction is not an enumerated exception and does not defeat the privilege.

Several courts have applied clear language of privilege statues, and found no exception for redaction.

In *Roe v. Planned Parenthood Southwest Ohio Region*, 912 N.E.2d 61 (Ohio 2009), parents of a 14-year-old girl who obtained an abortion without their knowledge or consent sued Planned Parenthood. Plaintiffs sought redacted medical records of other minor patients of Planned Parenthood. The court held that the medical records were privileged, and that redacting the medical records would not change the privilege.

> The confidential abuse reports and medical records at issue are privileged from disclosure per R.C. 2317.02 and former 2151.421(H)(1). Redaction of personal identifying information does not remove the privileged

> status of the records. Therefore, the reports and medical records are not subject to discovery pursuant to Civ.R. 26(B)(1).

Roe, 912 N.E.2d at 64. The *Roe* court addressed, and rejected, the very argument made by Wipf in this case—that redaction defeats the privilege. The court noted that redaction is a tool for safeguarding information in documents that are otherwise discoverable. It does not eliminate privileges.

> Redaction of personal information, however, does not divest the privileged status of the confidential records. Redaction is merely a tool that a court may use to safeguard the personal, identifying information within confidential records that have become subject to disclosure either by waiver or by an exception.

Roe, 912 N.E.2d at 71.[6] *Roe* found the issue straight-forward—the statute said that plaintiffs were not entitled to look at someone else's medical records, and the trial court could not change the law by changing the medical records.

In *In re Columbia Valley Regional Medical Center*, 41 S.W.3d 797 (Tex. App. 2001), plaintiff brought a medical malpractice case

---

[6] Redaction would be appropriate, for example, to deal with the issues discussed in *Meynard v. Heeren*. The records are discoverable because the privilege is waived, but there might be particular parts of the record that are subject to protection because they are irrelevant, or would tend to oppress or humiliate.

arising out of a birth injury. Plaintiff sought medical records of other patients treated by an obstetrical nurse. The court held that the plain language of the statute creates a privilege, and that redaction does not change that privilege or bring records within an exception to the statute. The *Columbia Valley* court noted there was no question that "the medical records of the nonparties in the underlying litigation are privileged." *Id.* at 799. The court then rejected the argument that redaction changed the privileged nature of the documents.

> Additionally, the redaction of only identifying information does not address the concerns regarding portions of the nonparty medical records relating to diagnosis, evaluation, or treatment. The rule does not limit confidentiality to cover only the identity of the patient. Allowing production of information regarding diagnosis, evaluation or treatment, would expand the scope of discovery of nonparty medical records, running afoul of the plain language of the privilege statutes.
>
> We conclude, therefore, redaction of identifying information from nonparty medical records does not defeat the medical records privilege.

Id. at 800.

In *Parkson v. Central Dupage Hosp.*, 435 N.E.2d 140 (Ill. App. 1982), plaintiffs alleged medical malpractice and drug product

liability from injuries caused by taking a certain drug. Plaintiffs sought the adverse drug reaction reports of other patients who had received the drug. The court held those records were covered by the physician-patient privilege, and redaction did not change that. *Id.* at 143.

Like the courts in *Roe*, *Columbia Valley*, and *Parkson*, this Court applies the plain-meaning rule to statutory construction. *Maynard v. Heeren*, 1997 S.D. 60, ¶ 13, 563 N.W.2d 830, 835 ("When a statute's language is clear, certain and unambiguous, our interpretation is confined to declaring its meaning as plainly expressed."); *In re W. River Elec. Ass'n, Inc.*, 2004 S.D. 11, ¶ 15, 675 N.W.2d 222, 226 ("[I]f the words and phrases in the statute have plain meaning and effect, we should simply declare their meaning and not resort to statutory construction."). The language of the privilege is clear, and the list of exceptions is clear. This Court should hold that nonparty treatment records are privileged, and none of the exceptions to privilege include redaction.

B. Those courts that have permitted discovery make the ruling dependent upon the risk of identification.

The *Parkson* court ruled that nonparty medical records are privileged, whether redacted or not. *Parkson*, 435 N.E.2d at 143. But the court also commented on a common element in the cases that have permitted discovery—the risk of patient identification. First, *Parkson* noted that the types of records involved in that case made it "questionable at best" that patients would remain unidentified:

> The patients' admit and discharge summaries arguably contain histories of the patients' prior and present medical conditions, information that in the cumulative can make the possibility of recognition very high. As the patients disclosed this information with an expectation of privacy, their rights to confidentiality should be protected.

Id. at 144 (internal citation omitted). The court determined that the risk of identification was too high. Those courts that have permitted discovery have gone through the same process, but found identification unlikely.

For example, in *Staley v. Northern Utah Healthcare Corp.*, 230 P.3d 1007 (Utah 2010), the plaintiff claimed the defendant hospital was understaffed, causing her nurse to fail to monitor her

blood pressure, which resulted in kidney damage. Plaintiff sought limited and redacted records of other patients cared for by her nurse on the night in question.

Staley permitted disclosure of sufficiently redacted records, noting that "an underlying premise to upholding redaction and limited review is that *patient identification will be impossible*." *Id.* at 1012 (emphasis added). The court held that redaction does not create a general exception to the physician-patient privilege, but rather, "[w]hether and under what circumstances redaction can make good on its promise of anonymity depends on the circumstances of each case." *Id.*

Because redaction must eliminate the risk of identification, there can be no general rule permitting disclosure of redacted treatment records. "Although redaction will serve to protect the identity of the patients in this case, we also note that in some cases the prospect of preserving anonymity through redaction may be too uncertain to permit the production of redacted records." *Id.* at 1012-13. Because of that, "[c]ourts must be cautious when analyzing the information so as to determine the appropriate method and level of

redaction, *if any at all*, which would be sufficient to avoid offending the physician-patient privilege." *Id.* at 1013 (emphasis added).

The *Staley* court decided that redaction would be sufficient because Salt Lake County had 900,000 people, the hospital in question was one of several hospitals in the area, and the request was limited to the acuity records of a few patients. *Id.* Conversely, Spearfish is a community of 11,000 people.[7] It has two places for surgery—Spearfish Regional Hospital and Spearfish Regional Surgery Center. The circuit court ordered Altstiel to produce all records, without knowing what the records are or what they contain, for all patients, without knowing anything about the commonality or uniqueness of their conditions.

Wipf relies heavily upon *Rudnick v. Superior Court*, 523 P.2d 643 (Cal. 1974). In *Rudnick*, plaintiff sued a drug manufacturer for injuries allegedly caused by drug reactions. Plaintiff sought disclosure of adverse drug reports that doctors had provided to the defendant drug manufacturer. The *Rudnick* opinion addresses

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[7] United States Census Bureau data at http://quickfacts.census.gov/qfd/states/46/4660020.html.

whether these drug reaction reports are covered by the physician-patient privilege. In a footnote, the court added *dictum* suggesting that, if the trial court found the reports to be privileged, it could consider ordering redaction to avoid application of the privilege, so long as the information could not be linked to a patient. *Id.* at 650, n. 13.

Rudnick is distinguishable from this case because drug interaction reports, which were sent in from all over the country, are not the equivalent of 30 days of treatment records for hundreds of patients in the Black Hills. And South Dakota is different than California. As a small state with several rural medical centers, it is significantly more difficult to protect patient privacy.

C. This Court should adopt the rule prohibiting production of nonparty medical records, even if they are redacted.

The rule prohibiting production of nonparty medical records, regardless of redaction, fits the history of the physician-patient privilege in South Dakota. South Dakota has consistently increased protections for patient privacy; we have not reduced it. Unlike other

privileges, this Court applies this statutory privilege liberally, to broaden protection of patient privacy. The plain meaning of the privilege statute is, unless an exception applies, only the patient may permit disclosure of his or her treatment records.

In a state of this size, permitting disclosure with redaction creates the risk of having different rules for different judicial circuits. *Staley* relied on the number of hospitals and the population of Salt Lake County, Utah in allowing disclosure with redaction. *Staley*, 230 P.3d at 1013. So, would records discoverable in Sioux Falls or Rapid City not be discoverable in Philip or Tyndall?

Another complication is that disclosure of redacted records requires increasing disclosure of patient information. In this case, Wipf wants the records to establish two things: references to inspecting the bowel in the operative reports, and evidence of other perforations for determining Altstiel's complication rate. But, in either case, Altstiel must be permitted to explain those medical records. He must be allowed to explain why he noted examining the bowel in one record. He must be allowed to explain how another patient was different than Wipf. All of these explanations require

that Altstiel dive further into the symptoms, anatomy, and care provided to nonparties, which increases the risk of identification. The "disclosure with redaction" approach is dangerous and unworkable in our small state.

Conclusion

This Court applies statutes according to their plain meaning, and liberally construes the physician-patient privilege for the protection of medical information. Under the plain meaning of the privilege, nonparty medical records are privileged, even if they are redacted.

The Court should reverse the decision of the circuit court compelling production of Altstiel's nonparty medical records, vacate the Order Granting Plaintiff's Second Motion to Compel (R. 200-201), and remand with instructions to deny Plaintiff's Second Motion to Compel (R. 134-35).

Request for Oral Argument

Appellants respectfully request the Court grant oral argument on the issues presented in the appeal.

Respectfully submitted October 9, 2015.

BANGS, MCCULLEN, BUTLER,
FOYE & SIMMONS, L.L.P.

BY: */s/ Jeffrey G. Hurd*
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Certificate of Compliance

This brief is submitted under SDCL § 15-26A-66(b). I certify that the brief complies with the type volume limitation. In reliance upon the document properties provided by Microsoft Word, in which this brief was prepared, the brief contains 7012 words and 37568 characters, including the table of contents, table of cases, jurisdictional statement, statement of legal issues, and any certificates of counsel, but excluding any addendum materials.

Certificate of Service

The undersigned hereby certifies that he electronically filed a copy of this legal document with the South Dakota Supreme Court and that the original and two copies of the same were filed by serving them upon:

Ms. Shirley A. Jameson-Fergel
South Dakota Supreme Court
500 East Capitol Avenue
Pierre, SD 57501-5070

A true and correct copy of *Appellants' Brief* was provided by electronic means to:

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Attorneys for Appellee

which addresses are the last addresses of the addressees know to the subscriber.

Dated this 9th day of December 2015.

Jeffrey G. Hurd
Jeffrey G. Hurd

Appendix

Page

1. Order Granting Plaintiff's Second Motion to Compel..... 1

2. Defendants' Response to Plaintiff's Third Set of Requests for Production of Documents..... 3

3. Report of Operation 6

4. Discharge Summary 8

5. Emergency Department Admission 10

6. Follow up Clinic Visit 13

STATE OF SOUTH DAKOTA	)	IN CIRCUIT COURT
	) SS	
COUNTY OF LAWRENCE	)	FOURTH JUDICIAL CIRCUIT

STEVEN J. WIPF, Plaintiff, vs. TERRY L. ALTSTIEL, M.D., and REGIONAL HEALTH PHYSICIANS, INC., a South Dakota corporation, Defendants.	)	Civ. No. 13-131 **ORDER GRANTING PLAINTIFF'S SECOND MOTION TO COMPEL**

This matter having come on for hearing before the Honorable Michelle K. Percy on June 15, 2015, in regard to Plaintiff's Second Motion to Compel, and Plaintiff appearing by and through his attorney, Brad J. Lee, and the Defendants appearing by and through their attorney, Jeffrey G. Hurd, and the Court having reviewed the briefing, heard arguments of counsel, been fully advised on the matter, and considering the same, it is hereby:

ORDERED that Plaintiff's Second Motion to Compel is hereby granted. Defendants shall provide to Plaintiff copies of all the medical records (beginning with the operative note and including all medical reports or notes generated for the next 30 days that in any way related to care for, or recovery from, the laparoscopic hernia repair surgery) for each patient on which Dr. Terry L. Altstiel performed laparoscopic hernia repair surgery during the years 2009 through 2013;

IT IS FURTHER ORDERED that Defendants shall redact from these records the personal identifiers for each patient, including the patient's name,

address, phone number, date of birth, and social security number, prior to disclosing these records to Plaintiff;

IT IS FURTHER ORDERED that Defendants shall provide to Plaintiff the above-referenced documents within 60 days of the date of this Order.

Dated this 23 day of June, 2015.

BY THE COURT:

Michelle K. Percy
Circuit Court Judge

ATTEST: Carol Latuseck
CLERK OF COURT

(SEAL) (Deputy)

STATE OF SOUTH DAKOTA
Fourth Judicial Circuit Court
I hereby certify that the foregoing instrument is a true and correct copy of the original as the same appears on file in my office on this date:

JUN 23 2015

Carol Latuseck
Lawrence County Clerk of Courts
By: Carol Latuseck

FILED

JUN 23 2015

SOUTH DAKOTA UNIFIED JUDICIAL SYSTEM
4TH CIRCUIT CLERK OF COURT

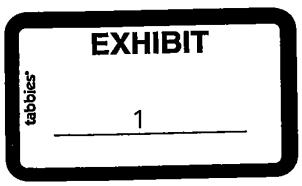
By_____

Filed: 6/24/2015 2:55:08 PM CST Lawrence County, South Dakota 40CIV13000131

STATE OF SOUTH DAKOTA	)	IN CIRCUIT COURT
	) SS	
COUNTY OF LAWRENCE	)	FOURTH JUDICIAL CIRCUIT
STEVEN J. WIPF,	)	Civil No. 13-131
Plaintiff,	)	
vs.	)	**DEFENDANTS' RESPONSE TO PLAINTIFF'S THIRD SET OF REQUESTS FOR PRODUCTION OF DOCUMENTS**
TERRY L. ALTSTIEL, M.D., and REGIONAL HEALTH PHYSICIANS, INC., a South Dakota corporation.	)	
Defendants.	)	

Defendants respond to Plaintiff's Third Set of Requests for Production of Documents as follows:

Defendants provide the following responses based upon information currently known, and without prejudice to their right to produce information subsequently obtained. Therefore, any other discovery responses asserted by any party to this action, any documents produced by any party in this action, any affidavits submitted by any witness in this action, and any statements made during any deposition taken in this action will be deemed as supplements to these Answers at the time that such responses, documents, affidavits, or depositions are provided to you.



Requests for Production

REQUEST NO. 1: Please provide copies of all the medical records (beginning with the operative note and including all medical reports or notes generated for the next 30 days that in any way related to care for, or recovery from, the laparoscopic hernia repair surgery) for each patient (Plaintiff has no objection to Defendants redacting the name and all other personal identifiers related to the patients. Further, Plaintiff has no objection to consulting with counsel regarding an appropriate protective order under which this information may be exchanged.) on which Dr. Terry L. Altstiel performed laparoscopic hernia repair surgery during the years 2009 through 2013.

Response: **Defendants object to the Request as beyond the scope of SDCL § 15-6-26(b). The information sought is not relevant to the subject matter involved in the pending action, nor does the information sought appear reasonably calculated to lead to the discovery of admissible evidence. We understand that Plaintiff seeks the information because he asked a defense expert "how many bad outcomes in a laparoscopic surgery do there need to be before a doctor should be held accountable? What percentage?" Defendants have not asked the expert to render such an opinion. Nor would such an opinion be admissible or relevant to whether Defendant Altstiel met the standard of care in this case. Plaintiff may not make such an opinion relevant simply by asking the question at a deposition.**

Defendants object to the Request because it is unduly burdensome and expensive, taking into account the needs of the case. SDCL § 15-6-26(b)(1)(A)(iii). Plaintiff is requesting that Defendants find, copy, and redact perhaps hundreds of patient records, and thousands of pages of medical records, for the limited purpose of evaluating an inadmissible non-opinion of an adverse expert. And the requested medical records cannot reasonably be de-identified so as to comply with 45 C.F.R. § 164.514(a), et seq., without excessive burden and expense.

Defendants object to the Request as seeking information that is privileged under SDCL § 19-13-7, and removal of personal identifying information does not overcome the privilege.

Dated this 8th day of April, 2015.

BANGS, McCULLEN, BUTLER,
FOYE & SIMMONS, L.L.P.

By: _____
Daniel F. Duffy
Jeffrey G. Hurd
333 West Boulevard, Ste. 400
P.O. Box 2670
Rapid City, SD 57709-2670
(605) 343-1040

Attorneys for Defendants
Terry L. Altstiel, M.D., and
Regional Health Physicians, Inc.

SPEARFISH REGIONAL SURGERY CENTER
1316 10TH STREET
SPEARFISH, SD 57783
605-642-3113

PATIENT NAME:	WIPF,STEVEN JOSEPH
DOB:	05/23/1965
PATIENT ADDRESS:	STURGIS, SD
ATTENDING:	ALTSTIEL,TERRY MD
DICTATED BY:	ALTSTIEL,TERRY MD
LOCATION:	SROUT
MEDICAL RECORD #:	SR003057
ACCOUNT #:	SR00037507

REPORT OF OPERATION

DATE OF PROCEDURE:
April 22, 2011

SURGEON:
Terry L. Altstiel, MD

POSTOPERATIVE DIAGNOSES:
1. Recurrent abdominal incisional hernia.
2. GERD (Gastroesophageal reflux disease) with dysphagia.

POSTOPERATIVE DIAGNOSES:
1. Symptomatic cholelithiasis.
2. Extensive intraabdominal adhesions.
3. Hiatal hernia.

PROCEDURES:
1. Laparoscopic mesh repair recurrent abdominal incisional hernia with extensive lysis of adhesions.
2. EGD (Esophagogastroduodenoscopy).

TECHNIQUE:
The patient was placed in the supine position under general anesthesia and prepped and draped in the usual fashion. Ioban drape was placed onto the surface of the skin for later marking. Entry into the peritoneal cavity was through a 5-mm port in the left upper quadrant using the step system technique. Pneumoperitoneum was created, a 5-mm port placed and camera positioned. An additional 5-mm port and a 10-mm port were placed in the left lower quadrant. The patient had extensive adhesions. A failed Marlex mesh hernia repair with the mesh curled and entrapping bowel, etc., were all found. A rather extensive recurrent hernia was appreciated as well. After takedown of adhesions we were able to discern the defect well. This was marked out on the surface of the skin on the Ioban drape. A composite Parietex mesh was chosen for the repair using the 6 x 8-inch oval. This was laid on the surface of the Ioban and marked out circumferentially for puncture sites and positioning of the mesh. The mesh itself was then marked to orient it once inside the abdomen. Following this, the mesh was soaked in antibiotic solution, rolled into a tube and introduced through the 10-mm port. Inside the abdomen it was unrolled and the previously placed Gore-Tex mesh at each mark was then retrieved for each respective puncture site and brought through to the surface of the skin with a strong fascial bridge using the suture retrieval device as usual. Each sutures equally placed around the mesh were used to anchor the mesh and after this, the tacking device (absorbable Tacker) was used to protect remainder of the defects between the stitches. This covered the defect very nicely and after irrigation with antibiotic solution, good hemostasis was assured and the pneumoperitoneum was evacuated and all ports removed. After irrigation of the subcutaneum, the port sites were closed with a stapling device and the puncture sites with

SPEARFISH REGIONAL SURGERY CENTER
1316 10TH STREET
SPEARFISH, SD 57783
605-642-3113

REPORT OF OPERATION

PATIENT NAME:	WIPF,STEVEN JOSEPH
DOB:	05/23/1965
PATIENT ADDRESS:	STURGIS, SD
ATTENDING:	ALTSTIEL,TERRY MD
DICTATED BY:	ALTSTIEL,TERRY MD
LOCATION:	SROUT
MEDICAL RECORD #:	SR003057
ACCOUNT #:	SR00037507

Steri-Strips using tincture of benzoin.

EGD was then undertaken introducing the scope and advancing down the esophagus without difficulty. The GE junction was essentially anatomic with a small sliding hiatal hernia. No stricture or reflux changes were seen. The stomach was normal. Duodenum was normal. The scope was withdrawn without difficulty. The patient tolerated the procedures well.

DRAFT COPY UNLESS ELECTRONICALLY SIGNED BY AUTHOR(S) OF DOCUMENT.

[redacted]

_____ Date:_____ Time:_____

ALTSTIEL, TERRY MD/TJD D: 04/22/11 1011 T: 04/22/11 1303

Physician

cc: LEWIS, CHARLES DO
ALTSTIEL, TERRY MD
LEWIS,CHARLES DO
ALTSTIEL,TERRY MD
(C:LEWIS,CHARLES DO ; ALTSTE ; LEWICH ~ ALTSTE) 0422-0224

WIPF, STEVEN JOSEPH (id #267852, dob: 05/23/1965)

RAPID CITY REGIONAL HOSPITAL
353 FAIRMONT BLVD
RAPID CITY, SD 57701
(605) 719-1000

DISCHARGE SUMMARY

PATIENT NAME:	WIPF,STEVEN J
DOB:	05/23/1965
PATIENT ADDRESS:	STURGIS, SD
ATTENDING:	WEHRKAMP,LARRY MD
DICTATED BY:	TIEMAN,TERRI PA-C
LOCATION:	RCSNW
MEDICAL RECORD #:	RC359118
ACCOUNT #:	RC34347278
DATE OF ADMISSION:	10/13/11
DATE OF DISCHARGE:	10/18/11

DATE OF ADMISSION:
October 13, 2011

DATE OF DISCHARGE:
October 18, 2011

ADMISSION DIAGNOSIS:
Large ventral incisional hernia.

DISCHARGE DIAGNOSIS:
Status post ventral hernia repair with component separation surgery.

HISTORY AND HOSPITAL COURSE:
Mr. Wipf is a 46-year-old male who unfortunately had a long hospital course in the past where he did have an enterocutaneous fistula and a significant abdominal wound for some time. He did eventually have a wound VAC and healed very nicely and the fistula resolved. However, he did develop a large ventral incisional hernia as expected. His wound has been healed up for long enough now that we felt it would be an appropriate time to fix this hernia. We did discuss with him that due to the size of the hernia, we really felt that a component separation technique would be necessary and he agreed to this.

On October 13, 2011, he was admitted to the hospital and underwent hernia repair using component separation technique. He tolerated the procedure well. Initially, we went slow with his diet and did have him on IV fluids and PCA for pain. As he improved, we were able to advance his diet, stop his IV fluids and transition him over to oral pain medication. He tolerated all of this well without any postoperative complications. He did have JP (Jackson-Pratt) drains in place, one on the right and one on the left, which we did indicate to him that he would likely be discharged home with due to the high amount of serous fluid present after component separation surgery. On October 18, 2011, patient was doing very well and was anxious for discharge home. He was discharged with the following instructions.

DISCHARGE INSTRUCTIONS:
1. Discharged to home.
2. Diet regular.
3. Activity as tolerated
4. No lifting more than 10 pounds for the next 4 weeks.
5. No driving while taking pain pills.
6. JP (Jackson-Pratt) care as instructed by the nursing staff. Empty and record JP output as instructed by nursing.

WIPF, STEVEN JOSEPH (id #267852, dob: 05/23/1965)

RAPID CITY REGIONAL HOSPITAL
353 FAIRMONT BLVD
RAPID CITY, SD 57701
(605) 719-1000

DISCHARGE SUMMARY

PATIENT NAME:	WIPF,STEVEN J
DOB:	05/23/1965
PATIENT ADDRESS:	STURGIS, SD
ATTENDING:	WEHRKAMP,LARRY MD
DICTATED BY:	TIEMAN,TERRI PA-C
LOCATION:	RC8NW
MEDICAL RECORD #:	RC359118
ACCOUNT #:	RC34347278
DATE OF ADMISSION:	10/13/11
DATE OF DISCHARGE:	10/18/11

7. Wear abdominal binder when out of bed.
8. Follow up with Dr. Wehrkamp on Monday, October 24, 2011, at 10:30 a.m.

DISCHARGE MEDICATIONS:
1. Resume all home medications at the usual dosages.
2. Percocet 5/325 one to two q.4h. as needed for pain.
3. If constipation occurs, may take stool softeners daily. However, currently patient is having diarrhea and he should not use Colace while having loose stools. He understands all of the above and feels ready to go home.

FINAL DIAGNOSIS:
Status post ventral hernia repair with component separation surgery.

DRAFT COPY UNLESS ELECTRONICALLY SIGNED BY AUTHOR(S) OF DOCUMENT.

_____ Date:_____ Time:_____
TIEMAN, TERRI PA-C/WKH D: 10/18/11 1018 T: 10/20/11 0826

WEHRKAMP, LARRY MD
Physician

cc:
TIEMAN, TERRI PA-C
LEWIS,CHARLES DO
WEHRKAMP,LARRY MD

ADDENDUM_HEADER

STURGIS
REGIONAL HOSPITAL
949 HARMON STREET
STURGIS, SD 57785
(605) 720-2400

EMERGENCY DEPARTMENT ADMISSION

PATIENT NAME:	WIPF,STEVEN JOSEPH
DOB:	05/23/1965
PATIENT ADDRESS:	STURGIS, SD
ATTENDING:	HOGUE,MICHAEL MD
DICTATED BY:	HOGUE,MICHAEL MD
LOCATION:	STMAC
MEDICAL RECORD #:	ST106211
ACCOUNT #:	ST02291904
ED DATE OF SERVICE:	04/26/11

DATE OF SERVICE:
April 26, 2011

HISTORY OF PRESENT ILLNESS:
The patient is 45-year-old male who presents to the emergency room with abdominal pain and dehydration. His history is that on Friday of last week he had an incisional hernia repair by Dr. Altstiel. He had a mesh repair of a recurrent abdominal incision. He has had previous cholecystectomy. He has had previous appendectomy and he had a previous tonsillectomy. He apparently developed a recurrent incision in this hernia and had extensive adhesions, so lysis of the adhesions was performed and he had a mesh placed. He has multiple puncture wounds across his abdomen from apparently laparoscopic repair of this incisional hernia.

He says he has had persistent problems with abdominal discomfort and nausea and inability to eat since that time. He says he has had small bowel movements. He also says that he has been passing gas. He stopped taking the Vicodin. He said it really did not help that much and he said all it was make his stomach more constipated and because of that he did not necessarily want to take it. He describes significant pain. He says it is probably an 8 on a scale of 10. He denies any chest pain or shortness of breath. He does feel dry and he just cannot keep anything down.

PAST MEDICAL HISTORY:
Positive as stated for previous cholecystectomy. He has had an appendectomy. He has had a tonsillectomy, hernia repair before and now this recurrent repair. He has otherwise no chronic medical history. No significant hospitalizations, no major medical problems.

CURRENT MEDICATIONS:
He has been taking hydrocodone 10/325, but he has been holding off on these. He has also had a prescription for tramadol.

ALLERGIES:
The patient is allergic to CODEINE.

PRIMARY CARE PHYSICIAN:
Dr. Lewis.

PHYSICAL EXAMINATION:
GENERAL: He is a well-developed, well-nourished 45-year-old male who is in moderate distress secondary to abdominal distention and pain.
VITAL SIGNS: His temperature is 98.5, his pulse is 100, respirations are 20, blood pressure is 144/85.
HEENT: Head is normocephalic. Eyes negative. Ears negative. Mouth and oropharynx shows he has very dry mucous membranes and is clearly dehydrated.

NECK: Supple, no nodes.
CHEST: Clear. There are no rales, wheezes or rhonchi.
CARDIAC: Shows a regular rate and rhythm. There is no murmur or extrasystoles.
ABDOMEN: Soft, it is distended. It is tense, primarily laterally to the umbilicus on the left side. There is some inflammation here and there is a small amount of fluid oozing. He does have bowel sounds but they are hypoactive. Difficult to examine secondary to the distention in the discomfort.
EXTREMITIES: Show normal strength and range of motion.

RADIOLOGY FINDINGS:
Flat and upright of the abdomen is performed and is compared to films taken. Over the weekend on the 23rd when he presented to the emergency room. It shows basically some similar distention in the small bowel with no focal obvious point of obstruction noted. Otherwise, nonremarkable.

LABORATORY FINDINGS:
White count on him is slightly elevated at 10,400 with upper limits of normal being 9600. He has 76% neutrophils, 10% lymphocytes. His hemoglobin is 11.6. His hematocrit is 34.5. His platelet count is 284,000. His sodium is 136, potassium is 3.7. Urinalysis is performed and a specific gravity is 1.020, which is much better than I expected based on his mucous membranes.

ASSESSMENT:
Abdominal pain and distention and dehydration post-hernia repair.

PLAN:
The patient is afebrile and his white count is actually very minimally elevated. It is surprisingly better than I thought it would be based on his look. However, he does still appear to be quite dry and he is fairly uncomfortable. I am going to put him in overnight on short stay observation. I am going to start him on IV fluids. He is not in any significant pain, especially when he is lying down, so I am going to hold off on any pain medications and will used Tylenol as needed. I will have the nurses notify me if he spikes a temperature. In the meantime, we are just going to give him IV fluids and hydrate him overnight and see if we can get a good idea of how responds to the fluids. Will check his CBC, electrolytes and specific gravity once again in the morning.

CONDITION AT THE TIME OF ADMISSION:
Stable.

DRAFT COPY UNLESS ELECTRONICALLY SIGNED BY AUTHOR(S) OF DOCUMENT.

<Electronically signed by MICHAEL HOGUE MD> 04/27/11 0656
_____ Date: _____ Time:
HOGUE, MICHAEL MD/CK1

STURGIS
REGIONAL HOSPITAL
949 HARMON STREET
STURGIS, SD 57785
(605) 720-2400

PATIENT NAME:	WIPF,STEVEN JOSEPH
DOB:	05/23/1965
PATIENT ADDRESS:	STURGIS, SD
ATTENDING:	HOGUE,MICHAEL MD
DICTATED BY:	HOGUE,MICHAEL MD
LOCATION:	STMAC
MEDICAL RECORD #:	ST106211
ACCOUNT #:	ST02291904
ED DATE OF SERVICE:	04/26/11

EMERGENCY DEPARTMENT ADMISSION
04/27/11

D: 04/27/11 0039 T: 04/27/11 0615

Physician

cc:
HOGUE, MICHAEL MD
(C: - HOGUMI)

WIPF, STEVEN JOSEPH (id #267852, dob: 05/23/1965)

- Colon Surgery - 05/2011 - bowel resection
- Laparoscopic incisional hernia repair - 04/22/2011

Patient's Pharmacies

COUNTY DRUG (ERX): 1111 LAZELLE ST, STURGIS SD 57785, Ph (605) 347-2466, Fax (605) 347-3380

Family History

Reviewed family history (as of 04/06/2011) without changes
Mother - Cancer, type
- stomach

Social History

Reviewed Social History & made changes
General Adult and Health Maintenance Screening Tests
Do you use tobacco?: Y.
If not currently, did you ever use tobacco?: Y.
Smoking Status: Current every day smoker.
Smoker (1/2 PPD)
Chewing tobacco: none.
Pipe: None.
Cigars: None.
Tobacco-years of use: 25.
Chest X-ray: 08/06/2008

ROS

None recorded.

Vitals

Ht: 6 ft 1 in **Wt: 250 lbs** **BMI: 33**
Body Surface Area: 2.42 m²

Physical Exam

None recorded.

Assessment / Plan

None recorded.
Return to Office
None recorded.

Encounter Sign-Off
Encounter signed-off by Larry Wehrkamp, MD, 06/25/2012.

Encounter performed and documented by Larry Wehrkamp, MD
Encounter reviewed & signed by Larry Wehrkamp, MD on 06/25/2012 at 10:05am

IN THE SUPREME COURT OF THE STATE OF SOUTH DAKOTA

APPEAL NO. 27491

STEVEN J. WIPF,

Plaintiff and Appellee,

vs.

TERRY ALTSTIEL, M.D., and
REGIONAL HEALTH PHYSICIANS, INC.,

Defendants and Appellants.

APPELLEE BRIEF

Appeal from the Circuit Court, Fourth Judicial Circuit
Lawrence County, South Dakota

Honorable Michelle Percy, Circuit Court Judge

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PERMISSION FOR DISCRETIONARY APPEAL GRANTED: AUGUST 7, 2015

TABLE OF CONTENTS

TABLE OF AUTHORITIES ii

PRELIMINARY STATEMENT 1

JURISDICTIONAL STATEMENT 1

STATEMENT OF THE ISSUES 1

STATEMENT OF THE CASE 1

STATEMENT OF FACTS 2

1. THE MEDICAL ERRORS LEADING TO THIS LITIGATION 2
2. ALTSTIEL'S EXPERT'S TESTIMONY. 3
3. THE PLAINTIFF'S DISCOVERY REQUEST. 5

ARGUMENT AND AUTHORITIES 6

1. INTERPRETING SOUTH DAKOTA'S PHYSICIAN-PATIENT PRIVILEGE STATUTE TO APPLY TO COMPLETELY REDACTED MEDICAL RECORDS WOULD LEAD TO UNREASONABLE RESULTS AND VIOLATE PUBLIC POLICY. 7
2. THE MAJORITY OF COURTS ALLOW DISCOVERY OF MEDICAL RECORDS WITH REDACTED PERSONAL IDENTIFIERS 11
3. THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 DOES NOT PROHIBIT DISCLOSURE OF NON-PARTY MEDICAL RECORDS WHEN THE PERSONAL IDENTIFIERS ARE REDACTED. 14
   a. Medical records do not constitute "individually identifiable health information" unless the records identify the individual. 14
   b. HIPAA preempts State privilege laws that offer protection to de-identified medical records. 15

CONCLUSION 16

REQUEST FOR ORAL ARGUMENT 17

CERTIFICATE OF COMPLIANCE 17

TABLE OF AUTHORITIES

CASES

Andrews v. Ridco,
2015 S.D. 24, 863 N.W.2d 540 …… 9

Baptist Mem. Hosp. v. Johnson,
754 So.2d 1165 (Miss. 2000) ……... 12

Bayne v. Provost,
359 F.Supp.2d 234 (N.D.N.Y. 2005)..…….. 16

Bennett v. Fieser,
152 F.R.D. 641 (D. Kans. 1994) …….. 12

Binder v. Superior Court,
242 Cal.Rptr 231, 196 Cal.App.3d 893 (Cal. Ct. App. 1987) ……. 12

Burke v. Ability Ins. Co.,
291 F.R.D. 343 (D.S.D. 2013) ……. 9

Cmty. Hosp. Ass'n v. District Court,
570 P.2d 243, 194 Colo. 98 (1977) ……. 12

Hyman v. Jewish Chronic Disease Hosp.,
15 N.Y.2d 317, 258 N.Y.S.2d 397, 206 N.E.2d 338 (1965) ……... 12

In re Estate of Howe,
2004 S.D. 118, 689 N.W.2d 22 …..……. 7

In re Rezulin Products Liab. Litig.,
178 R. Supp. 2d 412 (S.D.N.Y. 2001) ……. 1, 11, 12

In re Zyprexa Products Liab. Litig.,
254 F.R.D. 50 (E.D.N.Y. 2008), No. 04-MD-1596,
2008 WL 4682311 (E.D.N.Y. Oct. 21, 2008)…….. 15

Martinmaas v. Engelmann,
2000 S.D. 85, 612 N.W.2d 600 …… 7

Nw. Mem'l Hosp. v. Ashcroft,
362 F.3d 923 (7th Cir. 2004) …… 16

Osterman v. Ehrenworth,
256 A.2d 123, 106 N.J.Super. 515 (N.J. Super. 1969) …… 12

Parkson v. Central DuPage Hosp.,
105 Ill.App.3d 850, 61 Ill.Dec 651, 435 N.E.2d 140 (Ill. App. 1982) … 12

Patsy Schmidt, as Personal Representative of the Estate of Betty Bolstad v. Terry L. Altstiel, M.D., and Regional Health Physicians, Inc.,
Civ. 13-193 (S.D. Fourth Jud. Cir.)……. 14

People in Interest of D. K.,
245 N.W.2d 644 ……... 8

Rogen v. Monson,
2000 S.D. 51, 609 N.W.2d 456……. 16

Rudnick v. Superior Court,
523 P.2d 643, 114 Cal.Rptr. 603, 11 Cal.3d 924 (1974)…….. 1, 11, 12

Sparagon v. Native Am. Publishers, Inc.,
1996 S.D. 3, 542 N.W.2d 125…….. 7, 8

State ex rel. Benoit v. Randall,
431 S.W.2d 107 (Mo. 1968) ……. 12

Terre Haute Regional Hosp., Inc. v. Trueblood,
600 N.E.2d 1358 (Ind. 1992) ……... 12

Ventimiglia v. Moffitt,
502 So.2d 14 (Fla. App. 1986) …… 12

Ziegler v. Superior Court,
656 P.2d 1251, 134 Ariz. 390 (Ariz. App. 1982) …… 12

STATUTES

45 C.F.R. § 160.103 …… 1, 14, 15
45 C.F.R. § 164.512.……..... 1, 15
45 C.F.R. §164.512(e)(1)(i) ……. 15
45 C.F.R. § 164.512(e)(1)(ii) …….. 16
45 C.F.R. § 164.514(a) …… 6
SDCL 15-6-26(b)……. 5
SDCL 15-6-26(b)(1)(A)(iii) …… 5
SDCL 19-13-7 ……. 6
SDCL 19-19-503 ……. 1
SDCL 19-19-503(b)…….. 8, 9, 10, 13
SDCL 15-26A-3(6) …….. 1

OTHER AUTHORITIES

https://www.abos.org/certification/part-ii-exam.aspx 10

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) 6, 7, 14, 15, 16

PRELIMINARY STATEMENT

Appellee with refer to himself as "Wipf." Appellee with refer to Appellants as "Altstiel."

Appellee will refer to the Record on Appeal as "R.," followed by the page number(s) assigned by the Lawrence Count Clerk of Courts. Appellee will refer to the hearing transcript as "HT:," followed by the page number(s). Appellee will refer to materials in his Appendix by "Appellee's Appx.," followed by the page number(s).

JURISDICTIONAL STATEMENT

This is an interlocutory appeal form an order of the circuit court dated June 23, 2015. (R. 200-01; Appellants' Appx. 1-2.) This Court entered an Order Granting Petition for Allowance of Appeal from Intermediate Order on August 7, 2015. This Court has jurisdiction pursuant to SDCL 15-26A-3(6).

STATEMENT OF THE ISSUES

> Whether, in a civil action alleging medical malpractice, the defendant physician may be compelled to produce treatment records of his nonparty patients, so long as identifying information is redacted.

The circuit court ordered Altstiel to produce redacted treatment records of all of his patients undergoing laparoscopic hernia repair over a five-year period.

- *Rudnick v. Superior Court*, 523 P.2d 643 (Cal. 1974).
- *In re Rezulin Products Liab. Litig.*, 178 F. Supp. 2d 412 (S.D.N.Y. 2001).
- SDCL 19-19-503.
- 45 C.F.R. § 160.103.
- 45 C.F.R. § 164.512.

STATEMENT OF THE CASE

This is an intermediate appeal from an order by the Fourth Judicial Circuit, Lawrence County, the Honorable Michelle Percy presiding.

Wipf sued Altstiel for medical malpractice after Dr. Altstiel performed a laparoscopic hernia repair and perforated Wipf's bowel. It was discovered that shortly after Dr. Altstiel perforated Wipf's bowel, he performed a similar laparoscopic hernia repair on Betty Bolstad and also perforated her bowel causing her death. Donald Wingert, M.D., Altstiel's retained expert, testified that in order to opine whether Dr. Altstiel violated the standard of care he needed to know the results of Dr. Altstiel's prior 200 or 300 laparoscopic procedures. As a result, Wipf requested this information from Altstiel and the circuit court ordered it be produced.

STATEMENT OF FACTS

1. THE MEDICAL ERRORS LEADING TO THIS LITIGATION.

On Friday April 22, 2011, Steven Wipf presented at the Spearfish Regional Surgery Center to undergo a laparoscopic ventral hernia repair.[1] Terry Altstiel, M.D., performed the procedure. In summary, Dr. Altstiel indicated in his operative report that he removed the adhesions surrounding the hernia, applied mesh to the defective area, and then removed the equipment and closed the port sites. Notably, at no point did Dr. Altstiel indicate he "ran the bowel" or inspected the bowel, to make sure that there were not any perforations along the bowel.

A CT scan ultimately revealed "a very large fluid and air collection seen within the ventral abdomen." The report stated: "There appears to be a direct fistula with the mid small bowel along the posterior aspect of this large collection." Based on these findings Mr. Wipf was transferred to Rapid City Regional Hospital to undergo immediate

[1] Laparoscopic hernia repair is a technique to fix tears or openings in the abdominal wall using small incisions, laparoscopes (small telescopes inserted into the abdomen) and a patch (screen or mesh) to reinforce the abdominal wall.

surgery with Dr. Larry Wehrkamp. Dr. Wehrkamp began performing surgery to remove fecal matter and pus from Wipf's abdomen and then discovered the cause of the infection: two perforations in the small bowel that measured about two centimeters in size.

Wipf filed a medical malpractice action in on March 8, 2013. Wipf alleged that Dr. Altstiel perforated his small bowel during a routine hernia surgery, resulting in an infection that caused him significant personal injuries. Wipf maintains Dr. Altstiel was negligent in failing to recognize the perforation in his intestine by "running the bowel" or otherwise checking for perforations.

2. ALTSTIEL'S EXPERT'S TESTIMONY.

Altstiel hired Donald Wingert, M.D., to offer the opinion that Altstiel's laparoscopic surgery on Wipf and ensuing care did not violate any medical standard of care. According to the testimony of Altstiel's own expert, Dr. Wingert, the records that Wipf requested, and the circuit court ordered produced, are relevant and necessary in order to determine whether Altstiel was exercising an acceptable standard of care when he performed surgery on Wipf:

> Q So, if a doctor cuts a patient's bowel during a surgical procedure and cuts another patient's bowel three months later, that's acceptable to you because he had 400 that didn't have evidence of leaks?
>
> MR. DUFFY: Object to the form of the question as to "cut their bowel."
>
> THE WITNESS: Well, I mean I hate to sound like a baseball adage; but it's sort of a batting average. You know, a guy can get hot and raise his average from 250 to 300. I would still look at the guy in the broad spectrum of *his practice*.

Now, sure, if he had done great for 20 years and all of a sudden he's having this, this, this, this, this, and this, I don't know. Has he lost the edge or something? Maybe. But, I've just got to put it in a context.

(Appellee's Appx. 1: Wingert Dep. 54:19-55:9 (emphasis added).)

The acceptable standard of care then, according to Altstiel's expert, must be established by reviewing the care exercised by Altstiel in Wipf's surgery, along with the resulting outcome, in context with the care observed in the performance of Altstiel's related surgeries throughout his practice:

A If somebody has a 20-percent leak rate, there's a problem. What do I expect to have happen out of something like this? Somewhere less than five percent, certainly.

If somebody has done a thousand of these and, you know, had 50 leaks, there's a problem. If somebody has done a thousand and has had two leaks, I don't think there's a problem.

(Appellee's Appx. 1: Wingert Dep. 54:11-18.)

Dr. Wingert further explained why he needed to know and understand Altstiel's complication rate in order to offer opinions in this case:

Q No. What I'm asking is: Did Dr. Altstiel do anything wrong in the handling of his patient, Mr. Wipf, during this procedure?

A I do not believe so, no.

(Appellee's Appx. 2: Wingert Dep. 71:5-8.)

Q Okay. Then what do you mean by -- what does the plaintiff need to show for you to testify that there's a violation of the standard of care?

A Was he doing a procedure that he's not trained to do? No, I think Dr. Altstiel is trained to do it. Is he known to have an unacceptably high complication rate doing that procedure? *I don't know that that's the case.*

(Appellee's Appx. 3: Wingert Dep. 131:9-16 (emphasis added).)

Q So, in order for you to issue an opinion in this case, it would be relevant for you to know what the results of other procedures would have been for this doctor, how did his prior 200 or 300 laparoscopic procedures go?

A **Yes, yes**.

(Appellee's Appx. 3: Wingert Dep. 132:10-15) (emphasis added.)

3. THE PLAINTIFF'S DISCOVERY REQUEST.

As a result of Dr. Wingert's testimony, Wipf served Altstiel with his third request for production of documents, which stated:

> **REQUEST NO. 1:** Please provide copies of all the medical records (beginning with the operative note and including all medical reports or notes generated for the next 30 days that in any way related to care for, or recovery from, the laparoscopic hernia repair surgery) for each patient on which Dr. Terry L. Altstiel performed laparoscopic hernia repair surgery during the years 2009 through 2013.

(*See* Alstiel Appx. pp. 3-5.) On April 9, Altstiel served the following response to Wipf's request and failed to produce any documents:

> Response: Defendants object to the Request as beyond the scope of SDCL § 15-6-26(b). The information sought is not relevant to the subject matter involved in the pending action, nor does the information sought appear reasonably calculated to lead to the discovery of admissible evidence. We understand that Plaintiff seeks the information because he asked a defense expert "how many bad outcomes in a laparoscopic surgery do there need to be before a doctor should be held accountable? What percentage?" Defendants have not asked the expert to render such an opinion. Nor would such an opinion be admissible or relevant to whether Defendant Altstiel met the standard of care in this case. Plaintiff may not make such an opinion relevant simply by asking the question at a deposition.
>
> Defendants object to the Request because it is unduly burdensome and expensive, taking into account the needs of the case. SDCL § 15-6-26(b)(1)(A)(iii). Plaintiff is requesting that Defendants find, copy, and redact perhaps

> hundreds of patient records, and thousands of pages of medical records, for the limited purpose of evaluating an inadmissible non-opinion of an adverse expert. And the requested medical records cannot reasonably be de-identified so as to comply with 45 C.F.R. § 164.514(a), et seq., without excessive burden and expense.
>
> Defendants object to the Request as seeking information that is privileged under SDCL § 19-13-7, and removal of personal identifying information does not overcome the privilege.

(*See* Alstiel Appx. pp. 9-11.) In summary, Altstiel refused to produce the requested records regarding his prior performance of the same hernia repair surgeries on the basis that they are irrelevant, the request would amount to "thousands of pages of medical records," and that the information is privileged.

ARGUMENT AND AUTHORITIES

Appellants Terry Altstiel, M.D., and Regional Health Physicians, Inc., argue this Court should reverse the circuit court's order requiring them to disclose completely redacted medical records of non-party patients because: (1) the physician-patient privilege is liberally construed to expand protection; and (2) redacting medical records is not an exception to the privilege and there is still a risk of identification. Appellee Steven J. Wipf argues that this Court should affirm the circuit court's order because: (1) interpreting South Dakota's physician-patient privilege statute to apply to completely redacted medical records would lead to unreasonable results and violate public policy; (2) a majority of the courts hold that the purpose of the physician-patient privilege statutes, which is to preclude humiliation of the patient and encourage confidential communications with the provider, is not violated when the identity of the patient is redacted or unknown; and (3) The Health Insurance Portability and Accountability Act of

1996 (HIPAA) indicates that when medical records do not identify the patient it does not constitute "individually identifiable health information" that falls within the protection of HIPAA.

1. INTERPRETING SOUTH DAKOTA'S PHYSICIAN-PATIENT PRIVILEGE STATUTE TO APPLY TO COMPLETELY REDACTED MEDICAL RECORDS WOULD LEAD TO UNREASONABLE RESULTS AND VIOLATE PUBLIC POLICY.

"The purpose of statutory construction is to interpret the true intention of the law, which is to be construed primarily from the plain meaning of the statute." *In re Estate of Howe*, 2004 S.D. 118, ¶ 41, 689 N.W.2d 22, 32. "When the language in a statute is clear, certain and unambiguous, there is no reason for construction, and the Court's only function is to declare the meaning of the statute as clearly expressed." *Martinmaas v. Engelmann*, 2000 S.D. 85, ¶ 49, 612 N.W.2d 600, 611 (citations and quotations omitted). "Since statutes must be construed according to their intent, the intent must be determined from the statute as a whole, as well as enactments relating to the same subject." *Id.* "[I]n construing statutes together, [however], it is presumed that the legislature did not intend an absurd or unreasonable result." *Id.* This Court further discussed statutory construction in *Sparagon v. Native Am. Publishers, Inc.:*

> [I]t is a cardinal rule of construction that the whole statute must be taken and construed together. The intention of the legislature is the important thing to be ascertained, and, in order to arrive at this, we are to look at the object sought to be attained, as well as the means to be employed. And while it is no doubt true that if the language of a statute is plain and unambiguous, at least if its literal expression leads to no unjust or absurd consequences, there is no room for construction or interpretation, yet *it is also true that where a close or literal construction of a loosely-worded enactment would lead to unreasonable or absurd consequences, and the act is also fairly susceptible of another construction, the latter is to be adopted, although not a literal but a liberal one*.

1996 S.D. 3, ¶ 39, 542 N.W.2d 125, 134 (citation omitted) (emphasis added).

Altstiel relies on SDCL 19-19-503(b) to support his claim that the medical records of non-parties are completely privileged from discovery. That section states in relevant part:

> A patient has a privilege to refuse to disclose and to prevent any other person from disclosing confidential communications made for the purpose of diagnosis or treatment of his physical, mental, or emotional condition, including alcohol or drug addiction, among himself, physician, or psychotherapist, and persons who are participating in the diagnosis or treatment under the direction of the physician or psychotherapist, including members of the patient's family.

SDCL 19-19-503(b). This Court stated long ago the purpose behind the physician-patient privilege:

> The physician-patient privilege expresses a long-standing policy to encourage uninhibited communication between a physician and his patient. It is a privilege that seeks to insure the free flow of health care, absent any fears on the patient's part that anything he says might later be used against him.

People in Interest of D. K., 245 N.W.2d 644, 648 (S.D. 1976) (internal citations and quotations omitted).

Altstiel is asking this Court to rule that nonparty medical records are never discoverable. Altstiel's interpretation ignores the purpose of the statute and would lead to unreasonable results. In this case, the lower court's order compelling disclosure of non-party medical records does not violate the purpose behind SDCL 19-19-503(b), which is "to encourage uninhibited communication between a physician and his patient," because the records will be completely redacted of any information that would allow someone to identify the patient. Moreover, the records could further be protected by a protective order that would also ensure that even the completely redacted records would never be

disclosed outside the litigation. Nothing related to this discovery order would in any possible way cause patients throughout South Dakota to inhibit their communications with their doctors or cause "fears on the patient's part that anything he says might later be used against him."

Altstiel's literal interpretation of SDCL 19-19-503(b) would also violate public policy. If Altstiel's interpretation is adopted, how could patients injured by the negligence of their doctor ever show that doctor is incompetent to perform a procedure if the patient cannot discover the results of other procedures? For example, if a doctor consistently performed a medical procedure incorrectly, the evidence from those other procedures showing the doctor violated the standard of care would be vital. How could an injured patient ever rebut a doctor's claim in a lawsuit, like in the case at bar, that this is the first time such a complication has occurred during his practice? Altstiel wants to foreclose that evidence from ever being used against him or any other doctor.

Moreover, Altstiel's literal interpretation would mean that the physician-patient privilege is arguably being violated in other types of litigation. For example, in insurance bad faith cases discovery is routinely allowed concerning the insurance company's pattern and practice in handling other claims. *See Burke v. Ability Ins. Co.*, 291 F.R.D. 343, 357 (D.S.D. 2013) (ordering insurer to disclose other claims files regarding decisions on medical necessity of long-term insurance claims); *see also Andrews v. Ridco, Inc.*, 2015 S.D. 24, 863 N.W.2d 540 (addressing the scope of an order compelling the production of claims files in an insurance bad faith lawsuit stemming from a workers' compensation proceeding). These types of cases, and the evidence elicited, often times involve detailed analysis of medical conditions of nonparty insureds or claimants in order

to understand whether an insurer's actions were reasonable or done in bad faith. If Altstiel's interpretation is adopted, wide swaths of evidence, and potentially even the very causes of action, would cease to exist. This would be an unreasonable result and a violation of public policy that would result from Altstiel's literal reading of the statute.

Lastly, if Atlstiel's literal interpretation is adopted, it would mean all the doctors throughout South Dakota are violating SDCL 19-19-503(b) every time they apply to become board certified in their discipline. For example, in order to become a board certified orthopedic surgeon a doctor needs to take a written and oral examination. In order to complete the oral examination, the doctor must "list all of their operative cases" for a six-month period and upload the "images, arthroscopic prints and records" for the cases selected. https://www.abos.org/certification/part-ii-exam.aspx.[2] This would be an absurd result that would result for Altstiel's literal reading of the statute.

Altstiel advocates an interpretation where every sheet of paper in a patient's medical file would be privileged from disclosure no matter what redactions were performed. As one federal district court judge discussed, such an interpretation would lead to preposterous results:

> To be sure, one might argue, as a matter of theory, that the use of the disjunctive in the quoted phrase means that any document containing a patient's identity or diagnosis or evaluation or treatment is privileged-which in essence is what the doctors argue. Such a construction, however, would lead to preposterous results. A scrap of paper upon which a physician had jotted down a patient's name, or wrote only the word "indigestion" (a diagnosis) or "aspirin" (a treatment) or "malingering" (an evaluation) would, or at least could, be privileged. The legislature and the rulemakers could not possibly have so intended. So we must look elsewhere for a clue to what they meant.

[2] The ABOS website further discusses the process used by the Medical Records Director to cross-reference the medical records uploaded with the patients' records at the hospital for verification. https://www.abos.org/certification/part-ii-exam.aspx.

In re Rezulin Products Liab. Litig., 178 F. Supp. 2d 412, 414 (S.D.N.Y. 2001). The same reasoning applies in the case at bar.

This is not about protecting the rights of patients to communicate freely with their physician. This is about a doctor and his insurance company who want to avoid disclosing evidence that may show Dr. Altstiel's competency to perform laparoscopic hernia surgeries is lacking. The importance of discovering the requested evidence in this case, and countless other cases that will inevitably arise in the future, cannot be overstated.

2. THE MAJORITY OF COURTS ALLOW DISCOVERY OF MEDICAL RECORDS WITH REDACTED PERSONAL IDENTIFIERS.

It does not appear that the South Dakota Supreme Court has directly addressed whether medical records with redacted personal identifiers constitutes "privileged information." However, the majority of courts that have addressed this issue have held that such information is *not* privileged. The reasoning endorsed by these courts is that the purpose of the physician-patient privilege statutes, which is to preclude humiliation of the patient and encourage confidential communications with the provider, is not violated when the identity of the patient is redacted or unknown.

In *Rudnick v. Superior Court*, the Supreme Court of California addressed the issue of physician-patient privilege as it related to the disclosure of the medical records of third parties. 523 P.2d 643 (Cal. 1974). The court explained:

> The whole purpose of the privilege is to preclude the humiliation of the patient that might follow disclosure of his ailments. Therefore if the disclosure of the patient's name reveals nothing of any communication concerning the patient's ailments, disclosure of the patient's name does not violate the privilege. If, however, disclosure of the patient's name

> inevitably in the context of such disclosure reveals the confidential information, namely the ailments, then such disclosure violates the privilege. **Conversely if the disclosure reveals the ailments but not the patient's identity, then such disclosure would appear not to violate the privilege**.

Id. at 650 n. 13 (quotations and citations omitted) (emphasis added).

Similarly, the United States District Court for the Southern District of New York addressed this issue (in predicting what the Texas Supreme Court would do) and held "that production of the subpoenaed records after appropriate redaction would be consistent with the Texas physician-patient privilege." *In re Rezulin Products Liab. Litig.*, 178 F. Supp. 2d 412, 416 (S.D.N.Y. 2001). It also noted that almost all the other courts that have addressed this issue have ruled in favor of discovery. *Id.* at 416 n. 16; citing *Bennett v. Fieser*, 152 F.R.D. 641 (D. Kan. 1994); *Ziegler v. Superior Court*, 656 P.2d 1251, 134 Ariz. 390 (Ariz. App. 1982); *Rudnick v. Superior Court*, 523 P.2d 643, 114 Cal.Rptr. 603, 11 Cal.3d 924 (1974); *Cmty. Hosp. Ass'n v. District Court*, 570 P.2d 243, 244-45, 194 Colo. 98, 100-01 (1977) (en banc); *Ventimiglia v. Moffitt*, 502 So.2d 14 (Fla. App. 1986); *Terre Haute Regional Hosp., Inc. v. Trueblood*, 600 N.E.2d 1358, 1360-62 (Ind. 1992); *Baptist Mem. Hosp. v. Johnson*, 754 So.2d 1165 (Miss. 2000); *State ex rel. Benoit v. Randall*, 431 S.W.2d 107 (Mo. 1968); *Osterman v. Ehrenworth*, 256 A.2d 123, 106 N.J.Super. 515 (N.J. Super. 1969); *Hyman v. Jewish Chronic Disease Hosp.*, 15 N.Y.2d 317, 258 N.Y.S.2d 397, 206 N.E.2d 338 (1965). But see, e.g., *Binder v. Superior Court*, 242 Cal.Rptr. 231, 196 Cal.App.3d 893 (Cal. Ct. App. 1987); *Parkson v. Central DuPage Hosp.*, 105 Ill.App.3d 850, 61 Ill.Dec. 651, 435 N.E.2d 140 (Ill. App. 1982).

As Wipf set forth in his discovery request, he has "no objection to Defendants redacting the name and all other personal identifiers related to the patients." (Altstiel Appx. 7.) Wipf further indicated he has "no objection to consulting with counsel regarding an appropriate protective order under which this information may be exchanged." (*Id.*) It is absolutely not Wipf's intent to try to discern the identity of the non-party patients by scrutinizing the medical records disclosed. It is Wipf's intent, however, to discover the information necessary for the medical experts in this case to issue opinions as to whether Altstiel's actions constitute malpractice.

At this stage of the proceeding Altsiel is using the patient privilege statute in SDCL 19-19-503(b) as a shield to protect disclosure of relevant evidence. This evidence would show Altstiel's complication rate while performing these laparoscopic hernia procedures. If Wipf is not allowed to discover the results of Altstiel's other laparoscopic hernia surgeries, then Wipf will be unable to examine Altstiel's expert, Dr. Wingert, regarding Dr. Altstiel's complication rate. If successful in this tactic, Alstiel will then be able to use this lack of evidence as a sword at trial to argue, or at the very least infer, that the perforated bowel Altstiel caused during Wipf's surgery was an isolated incident or as Dr. Wingert testified: "bad things are going to happen a small percentage of the time." (Appellee's Appx. 4: Wingert Dep. 122:18-24.)

Unfortunately, this is not the only case where "bad things" have happened during Altstiel's attempt to laparoscopically repair a patient's hernia. On August 31, 2011, four months after Wipf's surgery, Altstiel performed a laparoscopic hernia repair surgery on Betty Bolstad. Ms. Bolstad died ten days later as a result of overwhelming sepsis secondary to a bowel perforation during the surgery. Notably, Altstiel did not inform

Wingert about Ms. Bolstad's surgery or resulting death. (Appellee's Appx. 5: Wingert Dep. 6:1-8; Appellee's Appx. 6: Wingert Dep. 125:9-126:10.) This case is also pending in the Fourth Circuit before Judge Percy. *Patsy Schmidt, as Personal Representative of the Estate of Betty Bolstad v. Terry L. Altstiel, M.D., and Regional Health Physicians, Inc.*, Civ. 13-193 (S.D. Fourth Jud. Cir.).

3. THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 DOES NOT PROHIBIT DISCLOSURE OF NON-PARTY MEDICAL RECORDS WHEN THE PERSONAL IDENTIFIERS ARE REDACTED.

Another argument that Altstiel made to the circuit court below, but abandoned in this appeal, pertains to the application of The Health Insurance Portability and Accountability Act of 1996 (HIPAA). Altstiel argued that HIPAA obligates him to refuse to disclose the requested records. When the HIPAA regulations were analyzed in detail, however, it became apparent that HIPAA is not applicable for the same reason that South Dakota's patient-privilege statute should not be applicable.

a. Medical records do not constitute "individually identifiable health information" unless the records identify the individual.

In our case, the requested records would not constitute "individually identifiable health information," protected by HIPAA, because the identification of the patients will be removed. The HIPAA rules define what constitutes "individually identifiable health information":

> "Individually identifiable health information" is information that is a subset of health information, including demographic information collected from an individual, and:
>
> (1) Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and
>
> (2) Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual;

> or the past, present, or future payment for the provision of health care to an individual; **and**
>
> (i) **That identifies the individual**; or
>
> (ii) With respect to which there is a reasonable basis to believe the information can be used to identify the individual.

45 C.F.R. § 160.103 (emphasis added). Since the requested records will be redacted and Wipf and his counsel will be unable to identify any individuals, the records will not constitute "individually identifiable health information" that falls within the protection of HIPAA. As such, the fact that HIPAA does not protect from disclosure non-party medical records when the personal identifiers are redacted supports Wipf's argument, and the circuit court's decision, that this information is discoverable so long as protections are in place to protect the identity of the non-party patients.

b. HIPAA preempts State privilege laws that offer protection to de-identified medical records.

The United States District Court for the Eastern District of New York recently addressed the discoverability of de-identified medical records of non-party patients as it relates to state physician-patient privilege laws and HIPAA. *In re Zyprexa Products Liab. Litig.*, 254 F.R.D. 50 (E.D.N.Y. 2008) aff'd, No. 04-MD-1596, 2008 WL 4682311 (E.D.N.Y. Oct. 21, 2008). The court explained that pursuant to HIPAA "there are many circumstances in which a covered entity may use or disclose protected health information without the written authorization of the individual or the opportunity for the individual to agree or object." *Id.* at 53 (quoting 45 C.F.R. § 164.512) (internal quotations omitted). "These include disclosures in response to an order of a court, provided that the covered entity discloses only the protected health information expressly authorized by such order." *Id.* (quoting § 164.512(e)(1)(i)). "Under section 164.512, it is evidently denudate

that a purpose of HIPAA was that health information, that may eventually be used in litigation or court proceedings, should be made available during the discovery phase." *Id.* (quoting *Bayne v. Provost*, 359 F.Supp.2d 234, 237 (N.D.N.Y. 2005) (citing 45 C.F.R. § 164.512(e)(1)(ii)). The court then noted that any claim of privilege would be preempted by HIPAA's suppression clause:

> The court noted that any applicable privilege would be found outside of HIPAA regulations, and pointed to the supersession clause as supporting its conclusion. The court declared: "Provided that medical records are redacted in accordance with the redaction requirements of § 164.514(a), they would not contain 'individually identifiable health information' and the 'more stringent' clause would fall away." A concurring judge put the point succinctly: "In passing HIPAA, Congress recognized a privacy interest only in 'individually identifiable medical records' and not redacted medical records, and HIPAA preempts state law in this regard."

Zyprexa, 254 F.R.D. at 54 (E.D.N.Y. 2008) (citing *Nw. Mem'l Hosp. v. Ashcroft*, 362 F.3d 923 (7th Cir. 2004) (internal citations omitted)); *but see In re Antonia E.*, 16 Misc. 3d 637, 644, 838 N.Y.S.2d 872, 878 (Fam. Ct. 2007) (holding that "statutory physician-patient privilege is more stringent than the HIPAA provisions which broadly allow a court to order discovery in a judicial proceeding, and that HIPAA does not supersede New York law").

CONCLUSION

"Trials are a search for the truth as determined by the jury based upon all the evidence." *Rogen v. Monson*, 2000 S.D. 51, ¶ 21, 609 N.W.2d 456, 461. Altstiel wants to keep buried this evidence to avoid being held accountable for his actions. Based upon the forgoing, Wipf respectfully asks that this Court affirm the lower court's order granting Wipf's motion to compel and allow Wipf to continue searching for the truth.

Respectfully submitted this 9th day of December, 2015.

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REQUEST FOR ORAL ARGUMENT

Appellee respectfully requests the Court grant oral argument on the issues presented in the appeal.

CERTIFICATE OF COMPLIANCE

Pursuant to SDCL § 15-26A-66(b)(4), I certify that Appellee's Brief complies with the type volume limitation provided for in the South Dakota Codified Laws. This brief contains 4,739 words and 30,319 characters, excluding the table of contents, table of cases, jurisdictional statement, statement of legal issues, any certificates of counsel, and any addendum materials. I have relied on the word and character count of our processing system used to prepare this Brief. The original Appellant's brief and all copies are in compliance with this rule.

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CERTIFICATE OF SERVICE

The undersigned hereby certifies that he electronically filed a copy of this legal document with the South Dakota Supreme Court and that the original and two copies of the same were filed by serving them upon:

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APPENDIX
TABLE OF CONTENTS

Tab	**Appendix**
1. Wingert Dep. 54:19-55:9	1
Wingert Dep. 54:11-18	1
2. Wingert Dep. 71:5-8	2
3. Wingert Dep. 131:9-16	3
Wingert Dep. 132:10-15	3
4. Wingert Dep. 122:18-24	4
5. Wingert Dep. 6:1-8	5
6. Wingert Dep. 125:9-126:10	6

Page 53

responsible, a doctor needs to commit gross error. Is that correct?
A Yes.
Q And what does "gross error" mean to you?
A Be incompetent to do the case he's doing or to willingly commit something that will injure a patient purposefully.
Q So you think, in order to be held responsible, a doctor needs to intentionally harm a patient?
A No. Let me put it this way: If the surgeon was doing laparoscopic surgeries and 50 percent of them had a leak, he's got a problem. If the doctor's doing laparoscopic surgeries and one out of 100 leaks, that's going to be expected. So some of it boils down to performance.
Q So isn't it also fair that a doctor should be held responsible if they do something to the patient that's negligent, that shouldn't have happened in the first place?
MR. DUFFY: Object as overly broad and vague.
THE WITNESS: Negligent, yes. Within the scope of "unfortunately bad things happen during surgery," no. I mean I can't put it a different way than that. There's negligence; and there's "things don't go perfect during surgery all the time."

Page 54

BY MR. LEE:
Q So then how many bad outcomes in a laparoscopic surgery do there need to be before a doctor should be held accountable? What percentage?
A I don't know of a listed percentage. I'll go back to Durst's deposition where he said something about -- what did he say -- 0.7 percent leak or something? I don't remember. I'm just -- I'm bringing up what Durst's was.
Q Sure.
A If somebody has a 20-percent leak rate, there's a problem. What do I expect to have happen out of something like this? Somewhere less than five percent, certainly. If somebody has done a thousand of these and, you know, had 50 leaks, there's a problem. If somebody has done a thousand and has had two leaks, I don't think there's a problem.
Q So, if a doctor cuts a patient's bowel during a surgical procedure and cuts another patient's bowel three months later, that's acceptable to you because he had 400 that didn't have evidence of leaks?
MR. DUFFY: Object to the form of the question as to "cut their bowel."
THE WITNESS: Well, I mean I hate to sound like a baseball adage; but it's sort of a batting average. You know, a guy can get hot and raise his average from 250 to 300. I would still look at the guy in the broad spectrum of his practice. Now, sure, if he had done great for 20 years and all of a sudden he's having this, this, this, this, this, and this, I don't know. Has he lost the edge or something? Maybe. But, I've just got to put it in a context.

Page 55

BY MR. LEE:
Q So the first couple bowel perforations a doctor has that go undetected, that's okay?
A Is any bowel perforation okay? No. It's an unfortunate outcome if it happens. No doubt about it. What it boils down to is: Is it a function of somebody who is not performing up to an appropriate standard, or is it "bad things will happen during surgery"?
Q Doctor, I'm going to show you what's been marked as Exhibit 3. This is the expert witness disclosure that Mr. Duffy provided to us. Have you seen this document before?
A Yes.
Q Did you help Mr. Duffy write this, or was this his own writing?
A We talked over the context of this before Mr. Duffy wrote this.
Q I did some highlighting on this, Doctor, to make it easier for you to reference it. You'll note on Page 2 under Number 3, you state: "Dr. Altstiel performed the hernia repair surgery consistent with an appropriate standard of care for the repair of a previously failed hernia repair."
A Yes.
Q And you agree with that?
A Yes.
Q And then a little bit below there you say he was released and his pain was under control?
A Yes.
Q You're aware that, when he left the hospital, his pain was at six out of ten. Correct?
A I would expect that.
Q But that's "under control" to you?
A For immediate post-op after a hernia -- ventral hernia like this, yes.
Q And right before the person is released it's still appropriate at a six out of ten?
A Yes.
Q At the bottom of Number 3 you talk about how Dr. Altstiel's Operative Note and explanation for evaluating the abdomen are consistent with the standard

Page 69

That's in the past. I want to know what's happening with the patient now. That's the information that's pertinent to me.
BY MR. LEE:
Q But don't you, as a doctor, want to have all of the evidence before you make a decision on a patient?
A Well, sure I do; but the problem is: What's all the evidence?
Q Well, wouldn't you like to know what --
MR. DUFFY: He's not finished yet. He's not finished yet.
MR. LEE: Strike the question.
Q Wouldn't you like to know what the patient was presenting with on Saturday with regard to his pain complaints, fever, no BM? Wouldn't you want to know those complaints in addition to what he's complaining about on Tuesday and Wednesday?
A Well, sure I would. But, let's address Saturday. When he was seen on Saturday, even though he says he had a temperature, when he presented to Sturgis, he had no temperature. He had a normal white count. Not having a BM 24 hours after surgery is basically the norm because you're going to get a reactive ileus from that. He was examined by, I assume, a board-certified physician at that point. He had labs. He had X-rays.

Page 70

And that physician, who is accredited -- I'm not here to judge the Sturgis doctors. I'm looking at this from Dr. Altstiel's point of view. But, I assume they're accredited to evaluate postsurgical patients as part of their training. They examined him. They sent him home feeling he didn't present any acute outstanding findings at that point.
Q The last sentence in the next paragraph is: "Dr. Wingert is expected to testify that he sees no evidence to suggest that Dr. Altstiel failed to meet an appropriate standard of care in this case."
Is that correct?
A Correct.
Q So everything went fine as far as Dr. Altstiel's treatment of this patient is concerned?
A I don't find any fall out of standard of care, no.
Q Did he do anything wrong?
MR. DUFFY: I guess object to the form of the question as to "wrong."
THE WITNESS: I don't know that I can answer that for the simple fact: Do I think he caused a gross negligent injury? Absolutely not. Do I think he abandoned his patient intentionally? Absolutely not. Do I think there was an unfortunate outcome of what happened? Sure, but I don't see that there is any

Page 71

negligence. I don't see that there was any abandonment. If that's what you're asking me, absolutely not.
BY MR. LEE:
Q No. What I'm asking is: Did Dr. Altstiel do anything wrong in the handling of his patient, Mr. Wipf, during this procedure?
A I do not believe so, no.
(Exhibit 4 is marked for identification.)
BY MR. LEE:
Q I'm showing you what's been marked as Exhibit 4. This is a copy of the report that Dr. Durst provided in this case. I assume you've had a chance to review that?
A I have.
Q Would you turn to the second page, please.
A (Complied.)
Q I think we already established that first part, that you agree that a surgeon should never cut or clip a body part that the surgeon cannot clearly identify?
A Yes.
Q "Dr. Altstiel failed to take all reasonable steps to avoid cutting or clipping the wrong body part, which could have caused the patient serious injury or death."
You disagree with that?
A Yeah, I do disagree with that for the simple fact no

Page 72

surgeon is obviously going to purposefully cut bowel and leave it. I think he took every reasonable step that was possible to do.
Q Lower down there, Dr. Durst says: "Patients who do not appear to be recovering as expected should arouse the suspicion of a possible surgical injury, as happened in the case of Mr. Wipf, beginning the first day after surgery."
Do you agree with that statement?
A I agree, but I'll also preface it by saying I think he was evaluated the first day after surgery. He went to the -- he called. He was sent to the emergency room in Sturgis. He was evaluated and sent home from there.
Q The next part says: "The patient had several abdominal X-rays without contrast, which reduced the likelihood of discovering a leaking bowel."
Do you agree with that?
A No, I don't really at this point, for the simple fact a CAT scan at this point, day one after surgery, the patient's going to have fluid in his abdomen from old blood and from irrigation. He's going to have free air in the abdomen. The contrast may or may not go through the area that was leaking, which I don't even think was leaking at that time. So I think a CAT scan would have not been helpful for sure on the 23rd.

Page 129

happen? Can it happen every time? No.
You know, if he had actually called Altstiel's office and told the nurse that and Altstiel said, "No, I don't want to see him," then I'd feel different.
But, to my knowledge, Altstiel knew nothing about any problems until that Wednesday at noon, at which time he was not available; and so I can't fault his care at all.
BY MR. LEE:
Q And to clarify again, Doctor -- and I appreciate your explanation -- in medical malpractice cases your standard is there has to be a showing of gross error on the part of the doctor?
MR. DUFFY: Object as a misstatement of the witness's testimony.
THE WITNESS: Gross error? No.
I mean what's "gross error"?
BY MR. LEE:
Q I don't know. That's what you said, and that's what I asked.
A I don't know what you mean by "gross error." I mean, if somebody leaves a sponge in one person, do I think they should lose their license? No. If you leave a sponge in half of the people you do, that's a problem.
Q Here's what I'll say: It was your words that came out

Page 130

with gross error earlier in this deposition, and I'm trying to understand what you mean by "gross error." So can you define "gross error" for me?
A With regard to this particular case.
Q In general, what does "gross error" mean? You talked about the doctor intentionally not doing something, you know, seeing the cut and repairing it if he knows it's there. I understand that. Intentional.
Is that what you mean by "gross error," that the doctor intentionally did something that would lead to a great likelihood of harm to the patient?
MR. DUFFY: I'm going to object because it's asked and answered at least five times. He's testified he doesn't believe Dr. Altstiel fell below the standard of care, and this is at least the fifth time we've gone around on this issue.
MR. BEARDSLEY: Improper objection.
MR. DUFFY: You don't have any standing, Counsel.
MR. BEARDSLEY: I know, but I'm tired of you telling him what to say.
MR. DUFFY: I'm not. I'm tired of him asking the same questions over and over again.
MR. BEARDSLEY: Make a legal objection.
BY MR. LEE:
Q That's all I'm trying to figure out. That's what I'm

Page 131

not clear about. I'm not trying to mess around with you, Doctor. I just -- I want to be clear. This is my only time to talk to you.
When you say "gross error," when we talk about standard of care -- you say that there needs to be a gross error for you to find a violation of the standard of care. Is that fair?
A Well, "gross" is a bad term.
Q Okay. Then what do you mean by -- what does the plaintiff need to show for you to testify that there's a violation of the standard of care?
A Was he doing a procedure that he's not trained to do? No, I think Dr. Altstiel is trained to do it.
Is he known to have an unacceptably high complication rate doing that procedure? I don't know that that's the case.
Did he willingly abandon or fail to see the patient after the case? Did something happen during the case that is completely unreported as never happening? You know, what would be an example here? I don't know. I mean I've seen a case of somebody who was doing a hysterectomy on a female patient and tied off the vessel to her leg. That's malpractice. Okay. She lost her leg over it. That's malpractice. I've seen cases where people operate on the wrong side of

Page 132

the patient. That's malpractice.
Is this patient having a complication that led to a leak? Which, again, I'll stick by that I don't feel happened at the time of the surgery; but it's going to happen 1.8 percent of the time and not be recognized a certain percent of the time. Is that malpractice, happening in this isolated case? I don't believe so, in a surgeon who's otherwise got a long-standing record of good outcomes.
Q So, in order for you to issue an opinion in this case, it would be relevant for you to know what the results of other procedures would have been for this doctor, how did his prior 200 or 300 laparoscopic procedures go?
A Yes, yes.
MR. LEE: Dan, can we take just five minutes to go over some notes and take a break? I think I'm almost done, but I just want to look at a few things.
MR. DUFFY: No problem.
(A brief recess is taken.)
MR. LEE: I have no further questions.
MR. DUFFY: Doctor, we typically make it a point to have you read and sign this before it becomes a part of the record; and we'll have you read and sign.
THE WITNESS: I would like to do that.

Page 121

tears in his op note. There is no way in God's green earth that Dr. Altstiel finished this case, had two one-centimeter tears in his bowel, and didn't recognize it because his belly would have been so full of succus that it would have been blatantly obvious, blatantly.

So, did he make one -- did he make a serosal tear that later became one? Became two? I don't know, but. I don't know if he made -- if one or two spots broke down. I kind of suspect maybe one broke down eventually and one -- once one breaks down, once one thing goes bad, everything goes bad. A second weakened spot will get eaten through by the digestive juices of the bowel.

So, can I say what's acceptable to make? Well, is one acceptable to make? No. In an ideal situation, obviously, none ever. But, you pulled the article that showed me it's going to happen. It's going to happen 1.78 percent of the time. So it's hard for me to quantitate that and put it in a certain way.

Q So, even though the stats say 0.32 percent of the patients who have these laparoscopic hernia repairs that go undetected, that's still acceptable, as a medical surgeon, to you? If a person does that, a doctor does it, it's still acceptable?

A Well, is it ideal? No. Is it going to happen? Yeah.

Page 122

Q So in your mind what does there have to be for a gross error to occur? What does a doctor have to do in order for you to say that was a gross error and they should be held responsible?

MR. DUFFY: I guess it's overly broad and vague. As applied to what?

THE WITNESS: With regard to this surgery?

BY MR. LEE:

Q Sure.

A I can't tell you that, even if there had been an enterotomy at the time of the surgery, that they diagnosed -- let's say he came back -- let's say he called in Saturday morning and said, "I'm having the worst abdominal pain in my life," was sent to the ER. At that time they diagnosed it. Am I going to say Dr. Altstiel was negligent or at malpractice because he caused an enterotomy? No.

Did he cause one and didn't recognize it at that time? No, because the literature says it's going to happen that much. No surgeon would cause one and not treat it knowingly. And I wish everything was perfect in this world. But, as you know, nothing's perfect; and bad things are going to happen a small percentage of time.

Q So going back to what you mean by "gross error,"

Page 123

essentially the doctor needs to intentionally do something wrong in order to be held responsible for malpractice, in your opinion?

MR. DUFFY: Objection. Asked and answered, and that's not what the witness said.

Go ahead.

BY MR. LEE:

Q Well, and if I'm mischaracterizing, explain it.

A No.

Q I just want to figure that out.

A What would have been malpractice -- in this particular case, what would have been malpractice to me?

Number one, he caused a tear and knew about a tear and didn't do anything.

Number two, he knew the patient was doing poorly. The patient called in, said: "I know I'm doing poorly." And the doctor communicated with him: "I'm very concerned about your patient. I think you need to see him," and he says: "No, I'm not going to see him." The patient called the clinic and said: "I'm doing terrible," and he said: "No, I'm not going to see him."

And obviously, if you told me he was a surgeon that did this and 20 percent of his cases have a major complication, I'd say: It's time to look at that guy.

Page 124

There's a problem.

I don't know Dr. Altstiel, but I don't assume that that's the case at all.

Q When Mr. Wipf asked Dr. Altstiel to stop by and see him and Dr. Altstiel just kept driving on, do you think, does that fall under the category you were talking about of being not acceptable medical care?

MR. DUFFY: Object to the question. Mr. Wipf talked --

THE WITNESS: I guess you've got to show me because I have no knowledge of Mr. Wipf asking to stop by and see him.

BY MR. LEE:

Q Mr. Wipf testified that he calls Dr. Altstiel's nurse to have him stop by Sturgis and see him when he was in the emergency room again and that he was told that Dr. Altstiel was on the way to a conference and wasn't going to stop. Is that acceptable given the facts we know about Mr. Wipf's condition?

A I guess you've got to show me where it is because I didn't pick that up.

Q Well, assuming that's true, is that appropriate?

MR. DUFFY: I guess assuming facts not in evidence and overly broad and vague.

THE WITNESS: Yeah, I mean I know nothing about

Page 5

Q Did you review or consult any articles in reaching your opinions in this case?
A I did not.
Q There have been some depositions taken in this case. Have you had the opportunity to review depositions?
A Yes, I have.
Q Whose depositions have you reviewed?
A I've reviewed Dr. Altstiel's deposition, Dr. Durst's deposition, Deposition of Pamela Bain, and the other -- another nurse. I don't remember her name right offhand.
Q Collins?
A Yes, Collins. And I reviewed the patient's deposition, Mr. Wipf's.
Q Were there any other documents reviewed other than what we've discussed so far?
A I reviewed the operative records and the inpatient records from when the patient was at the Spearfish Surgical Center. I reviewed the ER and the inpatient records when the patient was hospitalized in Sturgis, and I've reviewed the records that were available to me from Dr. Wehrkamp at Rapid City Regional and on the patient's post-op follow-up visits.
Q Did you talk with Dr. Altstiel regarding this matter?
A I have not.

Page 6

Q Are you aware of the concurrent lawsuit involving Betty Bolstad?
A I am not.
Q So you are not aware that Dr. Altstiel did a laparoscopic hernia repair just over two months after Mr. Wipf's and Ms. Bolstad died from sepsis because of a perforated bowel?
A I did not know that.
Q Doctor, is an expert like you supposed to be fair and impartial?
A Yes.
Q Do you advertise that you serve as an expert?
A No.
Q How do you get contacted regarding providing expert services?
A In this case I'm unsure how Mr. Duffy got my name. I've never advertised as an expert witness, no.
Q What are you charging for your testimony in this case?
A I believe my review fee is $200 an hour, $250 an hour. I believe my deposition fee is $750.
MR. DUFFY: I think we gave that to you, Brad. I just want to make sure if you didn't get it. I thought that was part of our disclosure.
BY MR. LEE:
Q How many hours have you put in this case so far?

Page 7

A Approximately five hours over this last weekend. I believe in the past, the earliest I reviewed anything on this case, as I recall, was March of 2014. Probably two hours at that time.
I've spoken with Mr. Duffy yesterday for about an hour and a half to two hours and one other time for a short period of time, in I believe December maybe, for half an hour at my office.
Q So approximately 10 to 12 hours?
A That would be about right.
Q Is that something that your office would bill out and send to Mr. Duffy's office?
A Yes.
MR. LEE: Dan, I'd make a request for the billing statements to date if I could.
BY MR. LEE:
Q Have you ever worked with Mr. Duffy on any other cases before?
A I have not.
Q Anybody from Bangs McCullen?
A Not that I'm aware of, no.
Q How often are you retained by injured patients to testify for them in medical malpractice cases?
A Retained by patients?
Q Correct.

Page 8

A I have not been to this point.
Q How many times have you been retained by a doctor or a medical facility to testify on behalf of the defense in a medical malpractice case?
A Specifically by a hospital or by another attorney firm?
Q Well, how many times have you been retained by a law firm to represent either a doctor or a medical facility defending a medical malpractice case?
A Twice previously.
Q What were those cases regarding?
A One was about a case that occurred in Pierre approximately ten years ago with a patient who, as I recall, had a motor vehicle injury and developed adult respiratory distress syndrome and illness.
The other time was about a surgeon from Brookings, South Dakota, who had removed a -- or who had had a patient who had had a bowel -- not a bowel injury, but had a bowel leak after surgery.
Q How long ago was that?
A I'm going to say -- actually, I'll say probably the first case in Pierre may have been as long as 12 or 14 years ago; and the second one was probably in the early 2000s.
Q Do you know the names of the case that took place in Brookings?

Page 125

that. I did not see that in the record anywhere. And I would tell you that, if he's on his way to a conference, the way it works, since nobody can be available 24/7, is if the patient said: "I'm in the hospital. I need to be evaluated," then I don't know if it would have been Altstiel or the guy on call. But I have no knowledge that that was the case.

BY MR. LEE:

Q We talked a little bit about the fact that Dr. Altstiel did a laparoscopic hernia repair a little over two months later on Betty Bolstad and she died from sepsis because of a perforated bowel.

Would that concern you about the competency of Dr. Altstiel that this situation occurred within a two-month period?

MR. DUFFY: Object to the question to the extent that, number one, you're asking the witness to comment on a matter for which he is not involved and has not reviewed any of the records.

THE WITNESS: Yeah, I mean I know nothing about the case. I assume -- as far as I know, Dr. Altstiel is still practicing. Right?

BY MR. LEE:

Q Yes, he is.

A How many cases has he done since two months after this

Page 126

case, since then, that have been fine? I'm sorry and it's unfortunate that he had two people have a bad result in a short period of time.

Trust me, it does bad things to your psyche when that happens. I feel sorry for the patients, and I feel sorry for him because it's very hard on a surgeon to have a bad result. But, assuming he didn't have fifteen of them before this and five of them since then, no, because it's going to happen a certain percentage of the time, I think.

Q Would you have wanted to know about the Betty Bolstad case and what happened in it in forming your opinions here in this case?

MR. DUFFY: Object again to the question. This doctor is reviewing the care and treatment provided in this case.

THE WITNESS: Yeah, I mean I can't speak about it without seeing the chart. I know nothing about Dr. Altstiel other than reputation I've heard from other people, and from everything I've heard he's felt to be a very good surgeon.

So no, it wouldn't have changed my opinion. I would have looked at this record. And, if I thought it was appropriate to say I think his care was appropriate in this case, I would stick by that.

Page 127

BY MR. LEE:

Q And you referenced a number 20 percent. Is that the number a surgeon has to hit as far as having surgeries on a patient and cutting the bowel and having these bad outcomes --

A No.

Q -- is that the number it needs --

A No, there is no number. Obviously, if somebody was doing 20 percent when the literature says it's 1.8 percent, that's a bad problem. If somebody had a five-percent rate, obviously they're two and a half times the normal.

So, no, there's no percentage that I know of. But what I'm looking for more is a person that consistently has problems and bad outcomes.

Q And you have not reviewed any of Dr. Altstiel's prior surgeries that had bad outcomes other than Mr. Wipf?

A No, this is the only case of his I've ever reviewed.

Q And just so I understand, it's your general opinion in this case that the care provided to Mr. Wipf is acceptable medical care in the community of Spearfish, Deadwood, and Sturgis, South Dakota?

A Yeah, my opinion is: Was everything ideal? No.

Was there malpractice, deviation from the standard of care? No.

Page 128

Q And so you don't think Dr. Altstiel or Regional Health Physicians should be held responsible at all for the medical treatment and subsequent injuries that Steve Wipf had as a result of this procedure?

MR. DUFFY: Object to the question to the extent you're asking him for a legal conclusion. He's answered your question about whether Dr. Altstiel met the standard of care or not.

THE WITNESS: Yeah, I mean what happened to him is unfortunate. I'll give you that. It's unfortunate. The problem is, unfortunate things happen to people. And is it always somebody's fault? Do I feel like it's Dr. Altstiel's fault? No.

So in a way, then, if you're going to get a verdict that says: "Dr. Altstiel, you're a bad doctor. You're negligent," do I feel that? No.

So, however the payment is worked out for the patient, that's not up to me.

I'm just -- I'm here saying: Reviewing these records, reviewing stuff, do I see that there was a problem with the standard of care? No.

Were there things that would have made it better? Sure. If Dr. Altstiel had known about it on Monday afternoon and said: "Bring him in. Let me see him," would it have been ideal? Sure, it would have. Did it

IN THE SUPREME COURT
OF THE
STATE OF SOUTH DAKOTA

Appeal No. 27491

STEVEN J. WIPF,

Plaintiff and Appellee,

VS.

TERRY ALTSTIEL, M.D. and **REGIONAL HEALTH PHYSICIANS, INC.**,

Defendants and Appellants

Appeal from the Circuit Court
Fourth Judicial Circuit
Lawrence County
Hon. Michelle Percy, Circuit Court Judge

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Table of Contents

Page

Table of Contents ii

Table of Authorities iv

Summary of Argument 1

Argument 1

1. An expert's mistake does not make evidence relevant, or remove the privilege from privileged documents 1

A. Experts don't set the duty for medical negligence cases 2

B. Even if the expert's opinion would be assisted by access to privileged information, that would not diminish the privilege 6

C. Even if Wingert's standard were correct, Altstiel already produced the complication rate data 6

2. Wipf is wrong about the consequences of applying the statute according to its language. 8

A. The bad faith cases don't apply 8

B. Using medical records for peer review is not the same as using it in private litigation 9

C. Permitting disclosure with redaction does not advance the purposes of the physician-patient privilege because it undermines confidence in open communication. 12

3. HIPAA does not preempt a South Dakota privilege applied in a state court. 17

A. HIPAA does not prevent a state court from applying state privileges. 17

B. Even if Wipf were correct, and HIPAA preempted state law for de-identified records, the circuit court's Order fails to comply with HIPAA's requirements. 19

Conclusion 22

Certificate of Compliance 23

Certificate of Service 24

Reply Appendix 25

Table of Authorities

Page

Cases

Bridge v. Karl's, Inc.,
538 N.W.2d 521 (S.D. 1995) 2

Hanna v. Plumer,
380 U.S. 460 (1965) 19

Hewitt v. Felderman,
2013 S.D. 91, 841 N.W.2d 258 2

In re Rezulin Products Liability Litigation,
178 F.Supp.2d 412 (S.D.N.Y. 2001) 16

In re Zyprexa Products Liability Litigation,
254 F.R.D. 50 (E.D.N.Y. 2008) 18, 19

Janis v. Nash Finch Co.,
2010 S.D. 27, 780 N.W.2d 497 2

Magbuhat v. Kovarik,
382 N.W.2d 43 (S.D. 1986) 2

Martinmaas v. Engelmann,
2000 S.D. 85, 612 N.W.2d 600 2

Matter of Yemmanur,
447 N.W.2d 525 (S.D. 1989) 4

Maynard v. Heeren,
1997 S.D. 60, 563 N.W.2d 830 13

Mousseau v. Schwartz,
2008 S.D. 86, 756 N.W.2d 345 2

Northwestern Memorial Hosp. v. Ashcroft,
362 F.3d 923 (7th Cir. 2004) .....passim

People ex rel. D.K.,
245 N.W.2d 644 (S.D.1976) 13

Rapid City Journal v. Delaney,
2011 S.D. 55, 804 N.W. 2d 388 15

Steele v. Bonner,
2010 S.D. 37, 782 N.W.2d 379 10

Sugarbaker v. SSM Health Care,
190 F.3d 905 (8th Cir. 1999) 12

Wojewski v. Rapid City Reg'l Hosp., Inc.,
2007 S.D. 33, 730 N.W.2d 626 12

Statutes

42 U.S.C. § 11101 12

SDCL § 15-26A-66..... 23

SDCL § 15-6-26 6

SDCL § 19-19-503 ..... 18, 19

SDCL § 19-19-702 2

SDCL § 36-4-26.1 11

SDCL § 36-4-29 4

Regulations

42 C.F.R. § 164.512 17

45 C.F.R. § 160.203 18

45 C.F.R. § 164.514 21

A.R.S.D. § 44:75:04:02 5

Other Authorities

Scott D. Stein, *What Litigators Need to Know about HIPAA*, 36 J. Health L. 433, 436 (2003). 22

Summary of Argument

- The comments of an expert witness cannot overcome South Dakota's physician-patient privilege because experts do not establish the law, and the expert's comments were directed at the licensing and privileging standard, not the medical negligence standard.
- Applying the South Dakota physician-patient privilege according to its terms works no unreasonable results.
- HIPAA has no application to this appeal. The circuit court's order does not comply with the de-identification requirements and the supersession clause doesn't apply to a state court applying state law.

Argument

1. An expert's mistake does not make evidence relevant, or remove the privilege from privileged documents.

Wipf urges that Altstiel's expert made Altstiel's complication rate relevant. Therefore, Wipf reasons, the physician-patient privilege must give way to support the expert's opinion.

First, even if Wipf were right, the expert has already testified that he does not have access to that information. Therefore Wipf's remedy is to move to strike the opinion. An expert opinion that lacks a factual basis is inadmissible. SDCL § 19-19-702(1). But, Wipf is not right.

A. Experts don't set the duty for medical negligence cases.

South Dakota is not a "trial-by-expert" state. *Bridge v. Karl's, Inc.*, 538 N.W.2d 521, 525 (S.D. 1995); *Hewitt v. Felderman*, 2013 S.D. 91, ¶ 17, 841 N.W.2d 258, 263. Rather, the duty in a negligence case is a question of law determined by the court. *Janis v. Nash Finch Co.*, 2010 S.D. 27, ¶ 8, 780 N.W.2d 497, 501.

The duty of physicians is to "use that care and skill ordinarily exercised under similar circumstances by physicians in good standing." *Martinmaas v. Engelmann*, 2000 S.D. 85, ¶ 31, 612 N.W.2d 600, 608; *Mousseau v. Schwartz*, 2008 S.D. 86, ¶ 22, 756 N.W.2d 345, 354. That care and skill is established by expert testimony, *Magbuhat v. Kovarik*, 382 N.W.2d 43, 46 (S.D. 1986); but, the expert may not change the underlying duty.

Altstiel's expert, Dr. Wingert, opines that Altstiel's care, as explained at his deposition, was consistent with the standard of care for a general surgeon. Wingert further opines that, even if Wipf's bowel was injured during the surgery, it was not fully perforated when Altstiel completed the surgery. So, the reason Altstiel did not find a bowel perforation, is that it did not exist until after the surgery was over. (Defendants' Expert Witness Disclosure, Reply Appendix, p. 2-3.)

During his deposition, Wingert testified about the importance of complication rates in deciding whether a physician is competent to perform a given procedure. Wingert testified that a physician's competence can be reflected in their complication rates. But Wipf has not questioned Altstiel's competence to perform hernia repair surgery. The only question in this case is whether Altstiel properly inspected Wipf's bowel after finishing the surgery. When answering the deposition questions, Wingert confused the standard for licensing and hospital privileging with the standard in a medical negligence case.

When the South Dakota Board of Medical and Osteopathic Examiners considers whether to discipline a physician's license, one basis is "satisfactory proof by a preponderance of the evidence . . . of such a licensee's . . . professional incompetence." SDCL § 36-4-29. "Professional incompetence" means that the physician lacks the minimum knowledge and skills to be at least reasonably effective. SDCL § 36-4-29.

At his deposition, Wingert, over objection, talked about making "a gross error in judgment or treatment," (Deposition of Dr. Donald Wingert, 12:10-15; R. 145), by which he meant that the physician was "incompetent to do the case he's doing or to willingly commit something that will injure a patient purposefully." (Wingert Deposition, 53:5-7; R. 156; Appellee Appx. 1.) That language is similar to the previous medical practices act, which was "gross incompetence." This Court has ruled that the "gross incompetence" standard is not the same as the medical malpractice standard, and they are not interchangeable. *Matter of Yemmanur*, 447 N.W.2d 525, 528-29 (S.D. 1989).

Wingert's statements about reviewing Altstiel's complication data is also how hospital medical staffs review practitioners for competence to receive "privileges" (or, permission) to perform certain procedures. A medical staff must review its members' performance on an ongoing basis.

> The medical staff shall establish a credentials committee to review the qualifications of practitioners applying for admitting or patient care privileges and recommend to the governing body practitioners eligible for appointment to the medical staff by the governing body. The review shall include recommendations regarding delineation of admitting and patient care privileges.

A.R.S.D. § 44:75:04:02. The Joint Commission has established standards by which the medical staff evaluates applications for privileges, and they include reviewing the practitioner's complication data. (Joint Commission Medical Staff Standard MS.06.01.05, attached as Reply Appendix pp. 9-10.)

This case has nothing to do with Altstiel's license, privileges, or general competence. There is no dispute that injuring a bowel during surgery is not, itself, malpractice. But failing to inspect the bowel to see if it is perforated is malpractice. Altstiel says he inspected the bowel and found no perforation. Wingert testified that

Altstiel did not identify a perforation because the bowel was not perforated when Altstiel completed the surgery. Wipf says it was perforated, and Altstiel missed it. Those issues do not require giving Wipf the medical records of non-parties.

B. Even if the expert's opinion would be assisted by access to privileged information, that would not diminish the privilege.

Rule 26 permits discovery of information that is not privileged and that is relevant. SDCL § 15-6-26(b). No matter how much relevance one establishes, one still must establish that the information sought is not privileged. A privilege which could be overcome by a showing of relevance is no privilege at all. Because the failure to establish relevance renders the information undiscoverable, there would be no point in a privilege that was limited only to irrelevant information.

C. Even if Wingert's standard were correct, Altstiel already produced the complication rate data.

Wingert never said that the medical records of non-parties were important to him. He said that he would review Altstiel's

complication rate, specifically, bowel perforations. Wipf already has that information.

Altstiel has been practicing medicine for 33 years. (Defendant Terry Altstiel, M.D.'s Answers to Plaintiff's First Set of Interrogatories, Interrogatory No. 7, Reply Appendix p. 8.) Between April of 2001 and July of 2013, Altstiel estimates that he performed about 950 hernia repair surgeries. (Interrogatories No. 29 & 30, Reply Appendix p. 10.) In all of that, the only cases in which a patient was later determined to have a bowel perforation are the two cases that Wipf references in his brief. (Interrogatory No. 27, Reply Appendix p. 9; November 20, 2013, Duffy letter to Lee, attached as Reply Appendix pp. 11-12.)

While Wingert's testimony about complication rates is not relevant to whether Altstiel committed malpractice in Wipf's surgery, Altstiel has already given Wipf all of the information that Wingert said he would consider.

2. Wipf is wrong about the consequences of applying the statute according to its language.

Wipf argues that if the Court actually applies the physician-patient privilege according to the language of the statute, it would result in unintended and adverse effects. None of the examples that he provides apply to the Court's consideration of this case.

A. The bad faith cases don't apply.

Wipf says that courts permit plaintiffs to obtain non-party claims files in cases alleging bad faith denial of insurance claims. The cases cited by Wipf don't say anything about medical records, or the physician-patient privilege. There is no indication that any of these claims files contained medical records. If they did contain medical records, there is no indication that anyone ever asserted the physician-patient privilege. Nor is it even clear from those cases why medical records would have been implicated.

In *Andrews vs. Ridco, Inc.* 2015 S.D. 24, 863 N.W.2d 540, the issue was the application of a "Large Loss Initiative" in evaluating claims. The theory in that case was that insurance company employees were receiving an incentive to deny claims. The

defendant asserted the attorney-client privilege against producing the claims files. There is nothing in the opinion indicating medical records were included in the claims files. There is also no discussion that medical records would have been relevant to the claims handling process at issue, or that the physician-patient privilege was ever invoked.

In *Burke vs. Ability Insurance Company*, 291 F.R.D. 343 (D.S.D. 2013), there was no objection based on the physician-patient privilege. The case was about the defendant using different definitions for the exact same policy terms with different claimants. The claimants' medical records were not germane to the inquiry, and there is no suggestion that they were ever produced.

B. Using medical records for peer review is not the same as using it in private litigation.

Wipf argues that reversing the circuit court in this case would deny peer review committees access to the medical records they need to determine the competence of physicians. That argument proves both too little and too much. It proves too little because peer review is completely different than private litigation. It proves too much

because all of Wipf's authority turns on the redaction of medical records, and peer review committees use unredacted records.

First, Wipf does not cite a single case, anywhere, where any court has ruled that a peer review committee may not access medical records because of any state's physician-patient privilege. There is simply no support for the proposition that a peer review committee's access to necessary medical records is affected by the restriction or breadth of any state's physician-patient privilege. That waives the argument. *Steele v. Bonner*, 2010 S.D. 37, ¶ 35, 782 N.W.2d 379, 386 ("As has been stated many times by this Court, Bonner's failure to cite authority is fatal.").

Second, the reason that no court applies the physician-patient privilege to deny peer review committees access to information is that peer review and malpractice are subject to different standards. As discussed above, peer review bodies seek to determine whether a physician is generally competent to provide care to patients. Medical malpractice cases, however, test whether a physician applied the appropriate care and skill in the treatment of that particular patient. That is, a malpractice case asks whether Dr. Jones made a

mistake in her treatment of Mr. Smith; while peer review decides whether Dr. Jones should, in the future, ever provide care for patients like Mr. Smith.

Peer review is subject to hyper-protection, not available to any other information. Under SDCL § 36-4-26.1, no data whatsoever from the peer review functions of a peer review committee is subject to any discovery or disclosure. The statute is not really a privilege because it strictly prohibits anyone from either discovering the information or disclosing it. So, unlike a privilege, it is not waivable—no one is authorized to disclose the information, "under chapter 15-6 or any other provision of law." SDCL § 36-4-26.1.

Peer review is necessary for a larger social purpose than the benefit of a private litigant. While private litigation seeks to obtain compensation for a past harm, the purpose of peer review is to save patients from acts of future malpractice.

> The Health Care Quality Improvement Act . . . was passed to improve the quality of medical care by encouraging physicians to identify and discipline physicians who are incompetent or who engage in unprofessional behavior. Congress gave immunity to participants engaged in professional peer review actions in order to advance effective peer review.

Wojewski v. Rapid City Reg'l Hosp., Inc., 2007 S.D. 33, ¶ 14, 730 N.W.2d 626, 632 (citations omitted). Congress passed HCQIA to protect patients from incompetent doctors by encouraging hospital medical staffs to police their members. 42 U.S.C. § 11101; *Sugarbaker v. SSM Health Care*, 190 F.3d 905, 911 (8th Cir. 1999). Congress believed that granting immunity from money damages improved effective peer review. *Sugarbaker* 190 F.3d at 911.

There is simply no basis for assuming that the Court's decision in this case is applicable to any peer review functions of any peer review committee.

C. Permitting disclosure with redaction does not advance the purposes of the physician-patient privilege because it undermines confidence in open communication.

Wipf asserts that a majority of courts permit discovery of redacted medical records because it does not offend the purpose of the privilege. That is too sweeping a generalization of the thought and analysis courts applied to these cases.

The holding in almost every case came down to one of two tests. As pointed out in Appellants' Brief, some courts simply apply

the language of their physician-patient privilege statutes, and hold that redaction is an exception to the privilege only if the statute so provides. Other courts permit the disclosure of nonparty medical records if, but only if, there is no way that nonparty patients can ever be identified. There is no doubt that the former test better meets the objectives of the physician-patient privilege. The best that can be said of the latter test is that it limits the threat to the privilege.

It appears the parties agree on the object of the privilege.

> The physician-patient privilege expresses a long-standing policy to encourage uninhibited communication between a physician and his patient. It is a privilege that seeks to insure the free flow of health care, absent any fears on the patient's part that anything he says might later be used against him.

Maynard v. Heeren, 1997 S.D. 60, ¶ 8, 563 N.W.2d 830, 833 (*quoting People ex rel. D.K.*, 245 N.W.2d 644, 648 (S.D.1976)). Any risk of identifying patients undermines that objective. But the objective is also undermined if patients fear they might be identified, even if no one ever identifies the patient.

In *Northwestern Memorial Hosp. v. Ashcroft*, 362 F.3d 923 (7th Cir. 2004), the Seventh Circuit addressed the United States government's subpoena for late-term abortion records. The court discussed the damage done by permitting disclosure of redacted records, even if no one ever identifies any of the patients.

> Some of these women will be afraid that when their redacted records are made a part of the trial record in New York, persons of their acquaintance, or skillful "Googlers," sifting the information contained in the medical records concerning each patient's medical and sex history, will put two and two together, "out" the 45 women, and thereby expose them to threats, humiliation, and obloquy.

Id., at 929. The court also observed that it violates a patient's privacy to know that someone else has their private information, even if they do not connect it back to the patient.

> Even if there were no possibility that a patient's identity might be learned from a redacted medical record, there would be an invasion of privacy. Imagine if nude pictures of a woman, uploaded to the Internet without her consent though without identifying her by name, were downloaded in a foreign country by people who will never meet her. She would still feel that her privacy had been invaded.

Id. Finally, the court notes that such a disclosure damages patient trust in the doctor or hospital that is compelled to produce its patients' information.

> If Northwestern Memorial Hospital cannot shield the medical records of its abortion patients from disclosure in judicial proceedings, moreover, the hospital will lose the confidence of its patients, and persons with sensitive medical conditions may be inclined to turn elsewhere for medical treatment. It is not as if the government were seeking medical records from every hospital and clinic that performs late-term abortions, in which event women wanting assurance against the disclosure of their records would have nowhere to turn. It is Dr. Hammond's presence in the New York suit as plaintiff and expert that has resulted in the governments subpoenaing Northwestern Memorial Hospital.

Id.

While Wipf agrees to entry of a protective order, court proceedings are public, and the fact that Altstiel was compelled to provide these records is a matter of public record. See, generally, *Rapid City Journal v. Delaney*, 2011 S.D. 55, 804 N.W. 2d 388. Who would be comfortable if it were reported that his or her doctor had been ordered to produce all patient records to plaintiff's counsel? As the *Northwestern Memorial* Court notes, redaction poorly protects

the objectives of the physician-patient privilege, and does not advance that objective, at all.

Even the cases cited by Wipf turn on that concern. For example, in *In re Rezulin Products Liability Litigation*, 178 F.Supp.2d 412 (S.D.N.Y. 2001), the court relied on demographic data to distinguish a multistate class action against a drug manufacturer from a case brought by an individual in rural Texas. The *Rezulin* Court relies upon the 2000 census to contrast the risk of identifying patients. Spearfish Regional Surgery Center, and most South Dakota clinics and hospitals, serves a community that creates a much greater risk of identification than the cases relied upon by Wipf.

The best way to advance the purposes of the physician-patient privilege is to apply the statute according to its language. Redaction is not an exception to the statute, and the Court should not adopt such an exception.

3. HIPAA does not preempt a South Dakota privilege applied in a state court.

First, Altstiel did not abandon his HIPAA argument—it was mooted by the circuit court's order. HIPAA provides that a provider may disclose medical information in compliance with a court order. 42 C.F.R. § 164.512(e)(1)(i). Therefore, the circuit court's order relieved Altstiel of any obligations under HIPAA, mooting those objections.

A. HIPAA does not prevent a state court from applying state privileges.

Wipf is incorrect when he claims that HIPAA preempts state physician-patient privilege statutes so long as the records are redacted. Wipf cites no case, and Altstiel is aware of none, that prevents a state court from applying more stringent state privilege laws. Rather, the law relied upon by Wipf is simply the recognition that federal courts apply federal procedural statutes, and HIPAA is a procedural statute.

HIPAA does not create a federal physician-patient privilege. *Northwestern Memorial Hospital vs. Ashcroft*, 362 F.3d 923 (7th Cir. 2004). Its section on use and disclosure in litigation and

administrative proceedings simply establishes the federal procedure for obtaining medical records. *Northwestern Memorial Hosp. v. Ashcroft*, 362 F.3d 923, 925-26 (7th Cir. 2004).

HIPAA preempts state law that is contrary to its provisions, unless the state law "is more stringent" than HIPAA. 45 C.F.R. § 160.203(b). Wipf argues that redacted records are not "individually identifiable," and therefore HIPAA preempts SDCL § 19-19-503. Wipf relies upon the U.S. District Court case of *In re Zyprexa Products Liability Litigation*, 254 F.R.D. 50 (E.D.N.Y. 2008), which relies heavily upon *Northwestern Memorial Hospital*. *Northwestern Memorial* made clear that state courts are free to apply their own, more stringent, privileges.

> Although the issue is not free from doubt, we agree with the government that the HIPAA regulations do not impose state evidentiary privileges on suits to enforce federal law. Illinois is free to enforce its more stringent medical-records privilege (there is no comparable federal privilege) in suits in state court to enforce state law[.]

Northwestern Memorial Hosp. v. Ashcroft, 362 F.3d 923, 925 (7th Cir. 2004). HIPAA's application in federal courts is different because it is a procedural rule.

Federal courts do not apply state privileges to federal question cases. *In re Zyprexa Products Liability Litigation*, 254 F.R.D. at 52. And, because HIPAA is "purely procedural," *Northwestern Memorial Hosp.*, 362 F.3d at 926, federal courts apply HIPAA even in cases where state law supplies the substantive law. *See*, *Hanna v. Plumer*, 380 U.S. 460, 465 (1965) ("federal courts are to apply state substantive law and federal procedural law").

HIPAA does not prevent South Dakota courts from applying SDCL § 19-19-503 in state proceedings.

B. Even if Wipf were correct, and HIPAA preempted state law for de-identified records, the circuit court's Order fails to comply with HIPAA's requirements.

Wipf's HIPAA argument fails on its premise—even if HIPAA preempted SDCL § 19-19-503 as to de-identified records, the Order Granting Plaintiff's Second Motion to Compel does not comply with HIPAA's de-identification requirements. The Order (Appellants' Appx. 1-2) orders Altstiel to redact the following information:

1. Patient's name;
2. Address;

3. Phone number;

4. Date of birth; and

5. Social security number.

HIPAA de-identification requires removing the following information—not just for the patient, but also for all relatives, employers, or household members of the patient:

1. Names;

2. All geographic subdivisions smaller than a State;

3. All elements of dates (except year) for dates directly related to an individual, including

    a. birth date,

    b. admission date,

    c. discharge date,

    d. date of death, and

    e. all ages over 89 and all elements of dates (including year) indicative of such age;

4. Telephone numbers;

5. Fax numbers;

6. Electronic mail addresses;

7. Social security numbers;
8. Medical record numbers;
9. Health plan beneficiary numbers;
10. Account numbers;
11. Certificate/license numbers;
12. Vehicle identifiers and serial numbers, including license plate numbers;
13. Device identifiers and serial numbers;
14. Web Universal Resource Locators (URLs);
15. Internet Protocol (IP) address numbers;
16. Biometric identifiers, including finger and voice prints;
17. Full face photographic images and any comparable images; and
18. Any other unique identifying number, characteristic, or code.

45 C.F.R. § 164.514(b)(2)(i). As one scholar explained, "[t]o sufficiently 'de-identify' health information . . . is a cumbersome task. . . . As a practical matter, when large numbers of records are involved, the process of de-identification may be as prohibitively

burdensome and expensive as obtaining individual consent [from each patient]." Scott D. Stein, *What Litigators Need to Know about HIPAA*, 36 J. Health L. 433, 436 (2003).

Nothing in HIPAA supports the circuit court's order, or disclosure of the non-party medical records.

Conclusion

The Court should reverse the decision of the circuit court compelling production of Altstiel's nonparty medical records, vacate the Order Granting Plaintiff's Second Motion to Compel (R. 200-201), and remand with instructions to deny Plaintiff's Second Motion to Compel (R. 134-35).

Respectfully submitted December 23, 2015.

BANGS, MCCULLEN, BUTLER,
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BY: */s/ Jeffrey G. Hurd*
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Certificate of Compliance

This brief is submitted under SDCL § 15-26A-66(b)(2). I certify that the brief complies with the type volume limitation. In reliance upon the document properties provided by Microsoft Word, in which this brief was prepared, the brief contains 4503 words and 24045 characters, including the table of contents, table of cases, jurisdictional statement, statement of legal issues, and any certificates of counsel, but excluding any addendum materials.

Certificate of Service

The undersigned hereby certifies that he electronically filed a copy of this legal document with the South Dakota Supreme Court and that the original and two copies of the same were filed by serving them upon:

Ms. Shirley A. Jameson-Fergel
South Dakota Supreme Court
500 East Capitol Avenue
Pierre, SD 57501-5070

A true and correct copy of *Appellants' Reply Brief* was provided by electronic means to:

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which addresses are the last addresses of the addressees know to the subscriber.

Dated this 23rd day of December 2015.

Jeffrey G. Hurd
Jeffrey G. Hurd

Reply Appendix

Page

1. Wingert's Expert Report.....1

2. Excerpts from the Joint Commission standards for Medical Staffs.....5

3. Excerpts from Defendant Terry Altstiel, M.D.'s Answers to Plaintiff's First Set of Interrogatories 7

4. November 20, 2013, Duffy letter to Lee..... 11

STATE OF SOUTH DAKOTA	)	IN CIRCUIT COURT
	) SS	
COUNTY OF LAWRENCE	)	FOURTH JUDICIAL CIRCUIT

STEVEN J. WIPF, Plaintiff, vs. TERRY L. ALTSTIEL, M.D., and REGIONAL HEALTH PHYSICIANS, INC., a South Dakota corporation. Defendants.	)	Civil No. 13-131 **DEFENDANTS' EXPERT WITNESS DISCLOSURE**

Pursuant to this Court's September 8, 2014, *Scheduling Order*, Defendants Terry L. Altstiel, M.D., and Regional Health Physicians, Inc., a South Dakota corporation ("Dr. Altstiel"), respectfully submit the following Expert Witness Disclosure:

Dr. Donald Wingert:

1. Dr. Donald Wingert, Surgical Institute of South Dakota, 911 East 20th Street – Suite 700, Sioux Falls, SD 57105. Dr. Wingert's CV is attached to this disclosure as DefRHP0337-339. Dr. Wingert charges $350/hour for review of documents, $750/hour for deposition or telephone conferences, and $1,500/hour plus travel expenses for trial;

2. Dr. Wingert was provided the medical records from Spearfish Regional Surgery Center (SPRSC 1-47); Sturgis Regional Hospital (STRH – 1-110); and Massa Berry Regional Medical Clinic (MBRMC – 1-91), as well as the deposition transcripts for Dr. Terry Altstiel; Steven J. Wipf;

Dr. Edward Durst (and expert witness disclosure); Lori Collins; and Pamela Bain.

3. Dr. Wingert is expected to rely upon the medical records and deposition testimony in this case for purposes of his opinions. Dr. Wingert is expected to testify that Dr. Altstiel properly evaluated and identified Mr. Wipf as a candidate for hernia repair surgery, as Mr. Wipf clearly had a previous hernia repair that had failed. Dr. Wingert is further expected to testify, based on the medical records and deposition testimony, that Dr. Altstiel performed the hernia repair surgery consistent with an appropriate standard of care for the repair of a previously failed hernia repair. Once the hernia repair surgery was completed, the medical records and testimony indicate that Mr. Wipf had no problems with bleeding, his vital signs were stable, he was making urine, his pain was under control, and he was therefore properly discharged following a short stay in the recovery area of the surgery center. Dr. Wingert is also expected to testify that, during his deposition, Dr. Altstiel appropriately explained his operative note and his process for evaluating the abdomen following the completion of the hernia repair, and the placement of the mesh repair. Dr. Wingert is expected to testify that Dr. Altstiel's operative note and explanation for evaluating the abdomen are consistent with the standard of care for evaluating a patient following a hernia repair surgery like this.

   The standard of care does not require a surgeon to manipulate the entire bowel following a laparascopic hernia repair surgery like this. In fact, Dr. Wingert is expected to testify that it would actually violate the standard of care, and risk potential injury to the patient, if the surgeon were to manipulate and disrupt the entire bowel following a laparoscopic surgery like this one. Dr. Wingert is expected to testify that a surgeon will typically evaluate the area of the bowel impacted by the surgery in order to determine if there is evidence of injury, such as blood, succus entericus, or some other evidence of concern that might be evident before completing the surgical process. In this instance,

there was no evidence of injury or any other problems to alert Dr. Altstiel before completing the surgery.

Dr. Wingert is expected to testify that, even when a surgeon performs the surgery within the standard of care, an injury to the bowel or other organs can occur during laparascopic surgery. If an injury occurs, this does not mean that a surgeon did something that fell below the standard of care. Dr. Wingert is expected to testify that there is no evidence to confirm that the perforation of Mr. Wipf's bowel occurred during this surgery. If an injury did occur during this hernia repair surgery, it was likely related to a serosal injury of the bowel tissue, which may not be evident for several days. This can occur and does not mean the surgery was performed below the standard of care.

Dr. Wingert is expected to testify that Mr. Wipf was discharged with appropriate discharge instructions. Several days following Mr. Wipf's discharge, Dr. Altstiel was contacted by another physician regarding Mr. Wipf's post-operative condition. At this time, Dr. Altstiel advised the contacting physician that, if Mr. Wipf did not show improvement, a CT scan should be considered.

Dr. Altstiel provided appropriate care to Mr. Wipf, including a hernia repair surgery that was performed within the standard of care. Based on his review of the medical records in this case, as well as his review of the deposition testimony, Dr. Wingert is expected to testify that he sees no evidence to suggest that Dr. Altstiel failed to meet an appropriate standard of care in this case.

Treating physicians and other healthcare providers:

Dr. Altstiel reserves the right to call any and all treating physicians and other healthcare providers including, but not limited to, those medical doctors and healthcare providers identified in Plaintiff's medical records. Those treating physicians and healthcare providers identified in the medical records from the following healthcare providers are expected to testify in a manner consistent with their medical records:

1. Queen City Regional Medical Clinic.
2. Spearfish Regional Surgery Center.
3. Massa-Berry Regional Medical Clinic.
4. Regional Medical Clinic.
5. Sturgis Regional Hospital.
6. Regional West Center of Behavioral Health.
7. Regional Pain Management Center.
8. Black Hills Rehabilitation Hospital.
9. Rapid City Regional Hospital.
10. Veteran's Administration Hospital and Medical Center, Sturgis, SD.

Dated this 5th day of December, 2014.

BANGS, McCULLEN, BUTLER,
FOYE & SIMMONS, L.L.P.

By: _____

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Attorneys for Defendants
Terry L. Altstiel, M.D., and
Regional Health Physicians, Inc.

Program: Hospital

Chapter: Medical Staff

MS.06.01.05: The decision to grant or deny a privilege(s), and/or to renew an existing privilege(s), is an objective, evidence-based process.

Rationale: Not applicable.

Introduction: Introduction to Standard MS.06.01.05

Privileging
The organized medical staff is responsible for planning and implementing a privileging process. This process typically entails the following:
- Developing and approving a procedures list
- Processing the application
- Evaluating applicant-specific information
- Submitting recommendations to the governing body for applicant-specific delineated privileges
- Notifying the applicant, relevant personnel, and, as required by law, external entities of the privileging decision
- Monitoring the use of privileges and quality of care issues

The criteria for granting a new privilege(s) to a practitioner with a record of competent professional performance at the organization (for example, a practitioner seeking an additional privilege[s]) should include information from the practitioner's professional practice evaluation data, which are collected and assessed on an ongoing basis.

For the applicant who does not have a current professional performance record at the privileging organization, current data should be collected during a time-limited period of privilege-specific professional performance monitoring conducted at the organization.

Elements of Performance

1 All licensed independent practitioners that provide care, treatment, and services possess a current license, certification, or registration, as required by law and regulation.

EP Attributes

New	FSA	CMS	MOS	CR	DOC	SC	ESP
	- Risk	§482.11(c) §482.22(a)(2)		2		A	ESP-1

2 The hospital, based on recommendations by the organized medical staff and approval by the governing body, establishes criteria that determine a practitioner's ability to provide patient care, treatment, and services within the scope of the privilege (s) requested. Evaluation of all of the following are included in the criteria:
- Current licensure and/or certification, as appropriate, verified with the primary source
- The applicant's specific relevant training, verified with the primary source
- Evidence of physical ability to perform the requested privilege
- Data from professional practice review by an organization(s) that currently privileges the applicant (if available)
- Peer and/or faculty recommendation
- When renewing privileges, review of the practitioner's performance within the hospital

EP Attributes

New	FSA	CMS	MOS	CR	DOC	SC	ESP
		§482.11(c) §482.12(a)(6) §482.22(a)(2) §482.26(c)(1) §482.54(c)(4)(i)			D	A	ESP-1

3 All of the criteria used are consistently evaluated for all practitioners holding that privilege.

EP Attributes

New	FSA	CMS	MOS	CR	DOC	SC	ESP
		§482.22(a)(1) §482.54(c)(4)(i)				A	

4 The hospital has a clearly defined procedure for processing applications for the granting, renewal, or revision of clinical privileges.

EP Attributes

New	FSA	CMS	MOS	CR	DOC	SC	ESP
					D	A	ESP-1

5 The procedure for processing applications for the granting, renewal, or revision of clinical privileges is approved by the organized medical staff.

EP Attributes

New	FSA	CMS	MOS	CR	DOC	SC	ESP
						A	ESP-1

6 An applicant submits a statement that no health problems exist that could affect his or her ability to perform the privileges requested.
Note: The applicant's ability to perform privileges requested must be evaluated. This evaluation is documented in the individual's credentials file. Such documentation may include the applicant's statement that no health problems exist that could affect his or her practice. Documentation regarding an applicant's health status and his or her ability to practice should be confirmed. Initial applicants may have their health status confirmed by the director of a training program, the chief of services, or the chief of staff at another hospital at which the applicant holds privileges, or by a currently licensed doctor of medicine or osteopathy approved by the organized medical staff. In instances where there is doubt about an applicant's ability to perform privileges requested, an evaluation by an external and internal source may be required. The request for an evaluation rests with the organized medical staff.

EP Attributes

New	FSA	CMS	MOS	CR	DOC	SC	ESP
		§482.22(a)(2)			D	A	ESP-1

7 The hospital queries the National Practitioner Data Bank (NPDB) when clinical privileges are initially granted, at the time of renewal of privileges, and when a new privilege(s) is requested.

EP Attributes

New	FSA	CMS	MOS	CR	DOC	SC	ESP
		§482.12(a)(6) §482.22(a)(1)				A	ESP-1

8 Peer recommendation includes written information regarding the practitioner's current:
- Medical/clinical knowledge
- Technical and clinical skills
- Clinical judgment
- Interpersonal skills
- Communication skills
- Professionalism

Note: Peer recommendation may be in the form of written documentation reflecting informed opinions on each applicant's scope and level of performance, or a written peer evaluation of practitioner-specific data collected from various sources for the purpose of validating current competence.

EP Attributes

New	FSA	CMS	MOS	CR	DOC	SC	ESP
		§482.11(c) §482.12(a)(6) §482.22(a)(1) §482.22(a)(2)			D	A	ESP-1

9 Before recommending privileges, the organized medical staff also evaluates the following:
- Challenges to any licensure or registration
- Voluntary and involuntary relinquishment of any license or registration
- Voluntary and involuntary termination of medical staff membership
- Voluntary and involuntary limitation, reduction, or loss of clinical privileges
- Any evidence of an unusual pattern or an excessive number of professional liability actions resulting in a final judgment against the applicant
- Documentation as to the applicant's health status
- Relevant practitioner-specific data as compared to aggregate data, when available
- Morbidity and mortality data, when available

EP Attributes

New	FSA	CMS	MOS	CR	DOC	SC	ESP
		§482.12(a)(6) §482.22(a)(1) §482.22(a)(2)				A	ESP-1

10 The hospital has a process to determine whether there is sufficient clinical performance information to make a decision to grant, limit, or deny the requested privilege.

EP Attributes

New	FSA	CMS	MOS	CR	DOC	SC	ESP
	- Risk	§482.22(a)(1)				A	ESP-1

11 Completed applications for privileges are acted on within the time period specified in the medical staff bylaws.

EP Attributes

STATE OF SOUTH DAKOTA	)	IN CIRCUIT COURT
	) SS	
COUNTY OF LAWRENCE	)	FOURTH JUDICIAL CIRCUIT

STEVEN J. WIPF, Plaintiff, vs. TERRY L. ALTSTIEL, M.D., and REGIONAL HEALTH PHYSICIANS, INC., a South Dakota corporation. Defendants.	)	Civil No. 13-131 **DEFENDANT TERRY ALTSTIEL, M.D.'S ANSWERS TO PLAINTIFF'S FIRST SET OF INTERROGATORIES**

Defendant Terry Altstiel, M.D. ("Dr. Altstiel") responds to Plaintiff's First Set of Interrogatories as follows:

INTERROGATORIES

General Response: Dr. Altstiel has responded to each discovery request with the information currently available, subject to each asserted objection, which is asserted as part of this general response for any discovery request that, among other things, is overly broad, vague, ambiguous, confusing, or otherwise seeks privileged information or communications. During the course of discovery, Dr. Altstiel anticipates that additional information may be produced, provided or generated through deposition testimony, document requests, interrogatories, requests for admission, affidavits, subpoenas, or

INTERROGATORY NO. 3: State your education background, including name and address of each school attended, the years during which you attended each school, and any degrees obtained.

ANSWER: High School: Yankton, SD 1967 – 1970 Diploma
University of South Dakota, Vermillion, SD 1970 – 1976 BS, BSM
University of South Dakota, Vermillion, SD 1976 – 1980 MD
Sacred Heart Hospital, Yankton, SD: General Surgery
Internship/Residency: July 1980 – June 1985

INTERROGATORY NO. 4: State the name and address of the hospital at which you interned, the inclusive dates of your internship, and your field of specialty during your internship.

ANSWER: See Answer to Interrogatory No. 3.

INTERROGATORY NO. 5: State the name and address of the hospital at which you received your residency and training, the inclusive dates of your residency, and your field of specialty during your residency.

ANSWER: See Answer to Interrogatory No. 3.

INTERROGATORY NO. 6: For each state in which you are licensed to practice medicine, please state the date you received your license and your license or certificate number.

ANSWER: Licensed in SD since July 1, 1981 (License No. 1107). Licensed in Wyoming since October 9, 2004 (License No. 7082A).

INTERROGATORY NO. 7: For how many years have you been actively engaged in the practice of medicine?

ANSWER: 33 years.

INTERROGATORY NO. 8: Has any professional license held by you ever been suspended or revoked, or has a renewal ever been refused? If so, please give the details of each suspension, revocation, or refusal of renewal; the name of the state; the date of suspension, revocation, or refusal of renewal; and the reasons and the date, if any, on which your license was reinstated. Please identify all documents regarding the foregoing and the custodian of the same.

answered. After Plaintiff discloses his expert witness, and that expert identifies an alleged breach of the standard of care, then Dr. Altstiel will explain why his care did not breach that particular standard. At that time, we will supplement the Interrogatory.

INTERROGATORY NO. 27: Please identify any and all other claims for personal injury and/or death made against Defendant Altstiel, and for each claim, please set out the following:

(a) The identity of the claimant;
(b) The nature of the claim;
(c) The date when the claim was made;
(d) Attorneys for the claimant;
(e) If litigation was started, the name and location of the court, as well as the number given to the litigation;
(f) Your response to the claim;
(g) The identity of your counsel;
(h) The outcome of the claim;
(i) Any documents regarding the foregoing; and
(j) The custodian of any documents identified in response to the previous subpart.

ANSWER: Bolstad is the only other claim.

a. Betty Bolstad
b. Plaintiff's counsel in this case is the same as in the Bolstad case.
c. Complaint is dated 5/31/13.
d. Brad Lee and Gary Jensen
e. State of South Dakota, County of Lawrence, Circuit Court, Fourth Judicial Circuit, Civil No. 13-193.
f. Deny
g. Jeff Hurd, Daniel F. Duffy and Jessica L. Fjerstad
h. Currently in litigation
i. See Answer to Interrogatory No. 27b.
j. See Answer to Interrogatory No. 27b.

INTERROGATORY NO. 28: Identify all training you have received regarding hernia repair surgery. Please include the dates of such training, the entity providing such training, and whether you received a degree or certificate in connection with such training. Please identify all materials in

your possession custody, and/or control or otherwise available to you that you received or that were made available to you in the course of such training.

ANSWER: 1980 – 1985 Studied under Dr. Chester McVay.

May 2003 - Advanced Course in Laparoscopic Ventral Hernia Repair: University of Washington Center for Videoendoscopic Surgery.

Certified on 5/9/03 - Laparoscopic Preperitoneal mesh repair of inquinal hernias (course and proctorship).

INTERROGATORY NO. 29: State the number of times you performed or assisted in performing hernia repair surgery prior to April 22, 2011.

ANSWER: I can only approximate as to the number of hernia repair surgeries prior to April 22, 2011 and in my 31 years of practice and residency. In the ten years prior to April 2011, I believe I performed/assisted with approximately 870 hernia repair surgeries.

INTERROGATORY NO. 30: State the number of times you have performed or assisted in performing hernia repair surgery since April 22, 2011.

ANSWER: 85 hernia repairs after 4/22/11 to 7/31/13.

INTERROGATORY NO. 31: Identify each hernia repair surgery you have performed where the patient sustained the same or similar type of injury as alleged by Plaintiff in his Complaint. Plaintiff and his attorneys shall keep the identity of each patient confidential. With regard to each such surgery, please provide the date of the surgery and identify the following information:

(a) All documents regarding the surgery, including each pre-operative report, the hospital history and physical, the operative report for the surgery, and the hospital discharge summary; and
(b) The custodian of the records referred to in your answer to the previous subpart.

ANSWER: Object. First, the Interrogatory is vague and ambiguous as to the phrase "sustained the same or similar type of injury." Without waiving said objection, please see Answer to Interrogatory No. 27. Second, the Interrogatory seeks privileged information under the physician-patient privilege.

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November 20, 2013

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Beardsley, Jensen &
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Re: Steven J. Wipf v. Terry L. Altstiel, M.D., et al.
Civ. No. 13-422

Dear Brad:

I think we are getting close. The Hospital conducted another search using the most recent parameters we discussed, including the codes you requested. Here is what I can tell you.

As promised, the Hospital performed a search using the following laparoscopic hernia surgery CPT codes: 49650-49659. The Hospital then ran these CPT codes against a cross-reference of Diagnosis Codes for Intestinal Complications or Surgical Complications, not limited by time.

The search was intended to identify any patient who had a laparoscopic hernia repair surgery, and who was later admitted with one of these Diagnosis Codes. The Intestinal Complication and Surgical Complication Diagnosis Codes that were cross-referenced included 569.80—569.89; 567.00—567.90; 038.00—038.90; and 998.00—998.90. This list of Diagnosis Codes includes a far greater universe of patients than we discussed, since many of these codes have nothing to do with an intestinal perforation. But it also captures those patients, like Wipf, who had the Perforation

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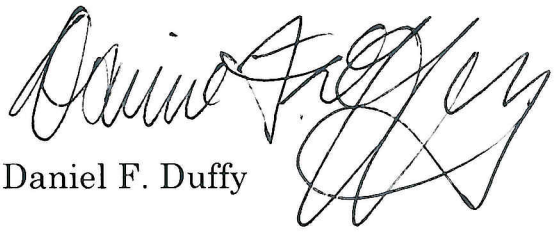
of Intestine code (998.2), and Betty Bolstad, who had the Accidental Op Laceration code (569.83).

This search was conducted for every Hospital or ambulatory surgical center for the last four years, beginning in 2009. The search identified Wipf and Bolstad, as was stated above. The search identified only one other patient who had a laparoscopic hernia repair surgery who was later admitted with one of the Diagnosis Codes for Perforation of Intestine or Accidental Op Laceration, including 998.2 and 569.83. From the information provided to us, we do not even know if this patient's situation would be germane to the issue you identified in your motion.

Once you receive this letter, Brad, give me a call and let's discuss it.

All the best,

BANGS, McCULLEN, BUTLER,
FOYE & SIMMONS, L.L.P.



Daniel F. Duffy

DFD:bjw