VERMONT: Summary of Fraud and Abuse Statutes and Regulations

Prepared by
Linda J. Cohen (lcohen@dinse.com)
Michael Thomas (mthomas@dinse.com)
Dinse Knapp & McAndrew PC
Burlington, VT

CONTENT:
1) Vermont False Claims Act
2) Medical Necessity
3) Anti-Kickback and Professional Conduct
4) Prohibition on Self-Referrals
5) General Whistleblower Protections
6) Marketing of Prescribed Products and Gift Ban
7) Unprofessional Conduct by Physicians
8) Peer Review Privilege
9) Hospital Liability for Failure to Obtain Consent

1) VERMONT FALSE CLAIMS ACT


The Vermont False Claims Act ("VFCA") was passed in May 2015 and is largely based on the Federal False Claims Act. The VFCA allows for civil actions to be brought for any false claims made for state funds and can result in significant civil penalties. Like the Federal False Claims Act, the VFCA is applicable across a wide range of industries, including healthcare, and imposes liability for a broad range of prohibited activities. The following are examples of activity prohibited under 32 V.S.A. § 631(a):

i. "knowingly present, or cause to be presented, a false or fraudulent claim for payment or approval";

ii. "knowingly make, use, or cause to be made or used, a false record or statement material to a false or fraudulent claim";

iii. "knowingly conceal or knowingly and improperly avoid or decrease an obligation to pay or transmit money or property to the State"; and

iv. conspire to submit false claims.

Section 630 of the VFCA defines "knowing" and "knowingly" to include:

i. actual knowledge;

ii. acting in deliberate ignorance of the truth or falsity of information; and

iii. acting in reckless disregard of the truth or falsity of the information.

Additionally, there is no requirement to show proof there was a specific intent to defraud.
Under 32 V.S.A. § 631(b) a finding of liability under the VFCA imposes the following mandatory penalties:

i. civil penalties not less than $5,500 and not more than $11,000 for each violation;

ii. three times the amount of damages sustained by the State; and

iii. costs of investigation and prosecution of such violation.

While mandatory, 32 V.S.A. § 631(c) allows for a reduction of damages in the event the person self-reports within 30 days of obtaining information regarding the violation, cooperates with the investigation, and no action has commenced at the time of reporting. The statute of limitations on any VFCA claim is six years from the date on which the violation was committed or within three years after the date the facts are known or should have been known. However, in no event can a claim be brought more than 10 years after the date on which the violation was committed. 32 V.S.A. § 639.

The five main categories of claims under the VFCA are mischarge, fraud-in-the-inducement, false certification, substandard product or service, and reverse false claims.

1) Mischarge – Covers an invoice or bill for goods or services not delivered or priced higher than the goods or services that were actually delivered. An example from the healthcare industry would be up-coding.

2) Fraud-in-the-Inducement – Fraud stemming from a false statement or illegal act during the formation of the state contract. Included in this category is inflating prices to cover kickbacks.

3) False Certification – When a person falsely certifies they qualify for a government program, are eligible for state benefits, or that their claim is compliant with program requirements.

4) Substandard Product or Service – In the healthcare arena this claim would arise from failure to meet the “quality of care” standard.

5) Reverse False Claims – Receiving an overpayment from the state or benefiting from an inadvertent submission of a false claim and discovering the falsity of it will result in liability under the VFCA if the beneficiary fails to disclose the overpayment within 120 days or the date of the corresponding cost report. This type of claim also imposes liability for making or using a false statement to avoid or reduce the amount owed to the government.

Qui Tam Actions

Section 632(b)(1) of the VFCA allows for qui tam actions. 32 V.S.A. § 632(b)(1). These are actions in which a citizen who is aware of the false claim files suit against the alleged wrongdoer on behalf of the state. In a qui tam action, the citizen bringing the suit must be independently aware of the false claim and cannot rely on the news, media, or other public information as the source of the claim. Any claim brought with sufficient independent information will remain under seal for 60 days from the date of
filing by the citizen, and will be reviewed by the attorney general. If the attorney general determines the case has merits, it may intervene on behalf of the state or decline intervention and permit the citizen to continue with the action. 32 V.S.A. § 632. Any payment received by the citizen will be limited to a percentage of the proceeds collected by the state and may include additional payment for reasonable attorney’s fees and expenses. 32 V.S.A. § 635.

The court may use it’s discretion in limiting any payments if the citizen planned or initiated the violation in any way. However, it is important to note that the citizen’s role in any violation will only effect the citizen’s payment and not that made to the state. Additionally, a citizen may be liable for defendants attorney’s fees if the suit is “clearly frivolous, clearly vexatious, or brought primarily for purposes of harassment.” 32 V.S.A. § 637.

Relevant Case Law:
Universal Health Services (UHS) operated a mental health facility that provided services in the Massachusetts area. During the course of treatment the parents of a patient discovered that very few of the caretakers at the facility were actually qualified to perform and administer the care given. Despite the unqualified caretakers, the facility submitted Medicaid reimbursement claims that implied the specified services were provided by qualified professionals, and did not disclose that unqualified personnel were performing the actual services.

UHS was accused of violating the False Claims Act through a theory of “implied false certification.” This theory treats a “payment request as a claimant’s implied certification of compliance with relevant statutes, regulations, or contract requirements that are material conditions of payment and treats a failure to disclose a violation as a misrepresentation that renders the claim ‘false or fraudulent.’” Universal Health Services, 136 S. Ct. at 1993. The Supreme Court held this theory can form a basis of liability under the False Claims Act when the claimant “makes specific representations about the goods or services provided, but fails to disclose noncompliance with material statutory, regulatory, or contractual requirements that make those representations misleading with respect to those goods or services.” Id. at 1993-94.

The limitation on this theory of liability is that the misrepresentation about compliance must be material to the government’s decision to make payments. This materiality requirement is demanding and merely labeling the requirement as “material” will not make it so. In determining whether a misrepresentation is material the court must take a holistic approach and examine the effect on the likely or actual behavior of the recipient of the alleged misrepresentation. See Id. at 2002-03. The Court in Universal points out that the False Claims Act is not meant to be a method of pursuing minor, “garden variety” breach of contract or regulatory violations. Id. at 2003.
Upon remand, the First Circuit determined that the misrepresentations in this case were material and warranted liability. U.S. ex rel. Escobar v. Universal Health Services, Inc., 842 F.3d 103, 110 (1st Cir. 2016). The court reasoned that ensuring licensed professionals are administering care is a central concern to the Massachusetts Medicaid program and is material to the government’s decision to pay. See Id. at 111.


A surgeon in this case performed SI joint surgery on a patient using a newer, less invasive technology. After completing the surgery and filing a claim for Medicaid reimbursement, the surgeon used the charge code for traditional SI surgery instead of the code intended for newer, emerging practice surgeries. The complaint alleged that the defendant induced the surgeon to submit the incorrect reimbursement code, knowing it was not the correct code for the surgery and in doing so violated the False Claims Act.

The court denied the plaintiff’s motion to dismiss, finding the alleged facts were enough to meet the fraudulent and knowing requirements of the False Claims Act.

**State Enforcement**

The Medicaid Fraud and Residential Abuse Unit of the Office of the Vermont Attorney General investigates and prosecutes fraud against the Medicaid system by health care service providers, as well as incidents of fraud in the administration of the Medicaid program. The annual reports for the Unit summarizing all prosecutions are available here.

Notable cases include:
- Settlement with a durable medical equipment provider for renting oximeters to Medicaid beneficiaries while also billing for equipment such as oximetry probes that were necessary to the operation of the rented machine. The provider paid $451,621.09 and entered a Corporate Integrity Agreement in resolution of the claims.
- Settlement for $83,678 with a podiatrist for billing Medicaid for custom orthotic devices at a rate higher than the podiatrist billed other insurers.
- Settlement with clinical laboratory for improper billing of urinalysis drug testing. The laboratory varied the charges submitted based on the number of drugs tested, which resulted in significant overpayments. The lab paid $6.75 million to resolve the case.

**Professional Conduct**

VT. STAT. ANN. TIT. 26 § 1354(a)(16) and VT. STAT. ANN. TIT. 3 § 129(a)(7)

Physicians may be subject to licensure sanctions for unprofessional conduct involving billing. It is unprofessional conduct for a physician to:
- Grossly overcharge for professional services on repeated occasions, including the filing of false statements for collection of fees for services not rendered; 26 V.S.A. § 1354(a)(16)
• Willfully make or file false reports or records in the practice of the profession; willfully impede or obstruct the proper making or filing of reports or records; or willfully fail to file the proper reports or records. 3 V.S.A. § 129(a)(7)

Unprofessional conduct subject the physician to licensure sanction by the Vermont Board of Medical Practice (BMP); see below.

2) MEDICAL NECESSITY

The most common definition of medical necessity (1.4(HH)), required by insurance regulation by the Medicaid Agency 7103 (the Department of Vermont Health Access, “DVHA”) and used in statute is quite broad. Medically necessary care is: health care services, including diagnostic testing, preventative services and aftercare, that are appropriate in terms of type, amount, frequency, level, setting and duration to the member’s diagnosis or condition. Medically-necessary care must be informed by generally accepted medical or scientific evidence and consistent with generally accepted practice parameters as recognized by health care professions in the same specialties as typically provide the procedure or treatment, or diagnose or manage the medical condition; must be informed by the unique needs of each individual patient and each presenting situation; and

1. Help restore or maintain the member’s health; or
2. Prevent deterioration of or palliate the member’s condition; or
3. Prevent the reasonably likely onset of a health problem or detect and incipient problem.

Case Law:


In Carey, the Office of Vermont Health Access, the state agency that administers the Medicaid program that has been renamed DVHA, appealed an administrative law judge’s (ALJ’s) decision to deny coverage for home health services. The ALJ found that the home health services provided were not reasonable and necessary. The U.S. District Court for the District of Vermont affirmed the magistrate’s reversal of this decision and held that the ALJ had not given sufficient weight to the treating physician’s opinion. The court held that in the Medicare context, the determination of whether a service is reasonable and necessary must place “significant reliance” on the treating physician’s opinion and either apply the “treating physician rule” or supply a reasoned basis for declining to do so.
3) ANTI-KICKBACK and PROFESSIONAL CONDUCT

VT. STAT. ANN. TIT. 26, §§ 1354 (a)(6), 1354(a)(12) and 1354(a)(27); VT. STAT. ANN. TIT. 3 §§ 129a(a) and 129a(d)

It is unprofessional conduct to promote the sale of drugs, devices, appliances, or goods provided for a patient in such a manner as to exploit the patient for the financial gain of the physician or selling, prescribing, giving away, or administering drugs for other than legal and legitimate therapeutic purposes. 26 V.S.A. § 1354(a)(6). Any division of fees or an agreement to split or divide the fees received for professional services based on referrals is also considered unprofessional conduct. 26 V.S.A. § 1354(a)(12).

It is considered unprofessional conduct for a physician to willfully exercise undue influence on or take improper advantage of a person using professional services, or promoting the sale of services or goods in a manner that exploits a person for the financial gain of the practitioner or a third party. 3 V.S.A. § 192a(a)(12). This includes promotion by a treatment provider of the sale of drugs, devices, appliances, or goods provided for a patient or client in such a manner as to exploit the patient or client for the financial gain of the treatment provider, or selling, prescribing, giving away, or administering drugs for other than legal and legitimate therapeutic purposes. 3 V.S.A. § 192a(a)(18).

In addition to the above anti-kickback provisions, failure to comply with provisions of other federal or state statutes or rules governing the practice of medicine or surgery may be considered unprofessional conduct. 26 V.S.A. § 1354(a)(27).

VT. STAT. ANN. TIT. 26, § 1354(a)(16) and VT. STAT. ANN. TIT. 3 § 129a(a)(7)

It is considered unprofessional conduct for a physician to grossly overcharge for professional services on repeated occasions. Including the filing of false statements for collection of fees for services not rendered. 26 V.S.A. § 1354(a)(16).

It is also considered unprofessional conduct for a physician to willfully make or file false reports or records in the practice of the profession; willfully impede or obstruct the proper making or filing of reports or records; or willfully fail to file the proper reports or records. 3 V.S.A. § 129a(a)(7).

Unprofessional conduct subjects the physician to licensure sanctions by the Vermont Board of Medical Practice.

4) PROHIBITION ON SELF-REFERRALS

VT. STAT. ANN. TIT. 26 § 1354(a)(6) and VT. STAT. ANN. TIT. 3 § 129a(a)(12)

Vermont does not have a state law akin to Stark prohibiting self-referrals.

Professional Conduct

Unprofessional conduct for physicians includes some conduct that might fall under Stark. A physician who promotes the sale of drugs, devices, appliances or goods
provided for a patient in such a manner so as to exploit the patient for the financial
gain of the physician, or who sells, prescribes, gives away or administers drugs for
other than legal and legitimate therapeutic purposes may be guilty of unprofessional
conduct.

Most other health care professionals are also professionally bound against
exercising undue influence on or taking improper advantage of a person using
professional services or promoting the sale of services or goods in a manner that
exploits a person for the financial gain of the practitioner or a third party. 3 V.S.A. §
129a(a)(12)

5) GENERAL WHISTLEBLOWER PROTECTIONS

Hospitals and nursing homes are prohibited from taking retaliatory action against
any employee who:

1) discloses or threatens to disclose to any person or entity any activity, policy,
practice, procedure, action, or failure to act of the employer or agent of the
employer that the employee reasonably believes is a violation of any law or that
the employee reasonably believes constitutes improper quality of patient care;
2) provides information to, or testifies before, any public body conducting an
investigation, a hearing, or an inquiry that involves allegations that the employer
has violated any law or has engaged in behavior constituting improper quality of
patient care; or
3) objects to or refuses to participate in any activity, policy, or practice of the
employer or agent that the employee reasonably believes is in violation of a law
or constitutes improper quality of patient care. 21 V.S.A § 507(b).

Subdivisions (1) and (3) of the above section shall not apply unless an employee
first reports the alleged violation of law or improper quality of patient care to the
employer, supervisor, or other person designated by the employer to address
reports by employees of improper quality of patient care, and the employer has had
a reasonable opportunity to address the violation. The employer shall address the
violation under its compliance plan, if one exists. The employee shall not be required
to make a report under this subsection if the employee reasonably believes that
doing so would be futile because making the report would not result in appropriate
action to address the violation. 21 V.S.A. § 507(c).

Retaliatory action is defined as discharge, threat, suspension, demotion, denial of
promotion, discrimination, or other adverse employment action regarding the
employee’s compensation, terms, conditions, location, or privileges of employment.
21 V.S.A. § 507(a)(7).

Any employee who believes they have been the subject of retaliatory action is
permitted to utilize any available internal process to resolve the dispute or may bring
an action in superior court of the county in which the violation is alleged to have occurred. 21 V.S.A. § 508(a). In the event an employee decides to utilize an internal process, completion of the internal process is not necessary prior to bringing an action in superior court. 21 V.S.A. § 508(b). In the event retaliatory action has been taken against an employee, the court may order reinstatement of the employee, including employment benefits, seniority, and same or equivalent position, shift schedule, or hours worked as the employee had before the retaliatory action; payment of back pay, lost wages, benefits, and other remuneration; any appropriate injunctive relief; compensatory damages; punitive damages; attorney's fees; or any other relief deemed appropriate by the court. 21 V.S.A. § 508(d).

Relevant Case Law:


A Vermont resident brought an action against a New Hampshire hospital alleging illegal retaliation under Vermont’s whistleblower protection statute. The claim was dismissed by the court upon finding that the legislative history of § 507 indicated the definition of hospital under that section is meant only to apply to Vermont hospitals. Given the defendant hospital in this case was located in New Hampshire, there was no grounds for the plaintiff’s claim in Vermont.


Acknowledging that the Vermont whistleblower statute has no express statute of limitations provision, the court held that the nature of the harm done is the controlling factor in construing the two statutes of limitations provisions, 12 V.S.A § 511 and 12 V.S.A. § 512. In this case, because the plaintiff’s alleged harm under the whistleblower statute consisted purely of emotional distress, the three year limitations period applying to personal injury claims was used and as such the plaintiff’s claim was barred.


In order to establish a prima facie case of retaliation a plaintiff must follow the _McDonnell Douglas_ framework. See _McDonnell Douglas Corp. v. Green_, 411 U.S. 792, 802-804 (1973). This framework involves establishing the following 4 elements: (1) the plaintiff engaged in a protected activity; (2) the employer was aware of the activity; (3) the plaintiff suffered adverse employment consequences as a result of the activity; and (4) there was a causal connection between the activity and the consequences. If the plaintiff makes out a prima facie case, the burden shifts to the defendant, who must state legitimate, non-retaliatory reasons for the adverse employment action. _Griffis v. Cedar Hill Health Care Corp._, 967 A.2d 1141, 1146 (Vt. 2008). In _Griffis_, the Vermont Supreme Court found that the plaintiff had not met her burden of proof and found no retaliation by the employer.
6) MARKETING OF PRESCRIBED PRODUCTS AND GIFT BAN

VT. STAT. ANN. TIT. 18 §§ 4631a-4632 – Prescription Drug Cost Containment
Vermont law bans most gifts from manufacturers of prescribed products (pharmaceuticals, biological products and medical devices) to health care providers. For those gifts that are permitted (“Allowable Expenditures”) the manufacturer must make required disclosures to the Attorney General.

Manufacturers of prescribed products within the scope of the statute include pharmaceutical companies (not wholesale distributors, retailers or pharmacists), medical device companies and manufacturers of biologics. Those manufacturers can’t give gifts (anything of value that is not exempted) to those authorized to dispense or purchase prescribed products for distribution. That includes individual or institutional health care providers, PBMs, insurers.

Allowable Expenditures, or gifts that can be given, include benefits at fair market value such as research contracts, faculty honoraria for CME, expenses for medical device training, interview expenses for jobs, royalties, and snacks, are permitted. Similarly, some specific things that benefit patients are permitted such as samples, short-term device loans, demonstration units, clinical articles or journals, free clinic donations, patient assistance programs, coffee/snacks at conference booths, are also permitted.

Each permitted gift given must be disclosed. Information required in the disclosure includes the value, nature and purpose of the gift and to whom it was given. Some proprietary or confidential information is excluded such as royalties and licensing fees, rebates and discounts, interview expenses. Also, some more minor items are excluded such as short term loans of medical devices or coffee and snacks at conference booths.

The Attorney General is authorized to bring a civil action against a manufacturer for non-compliance. Penalties of up to $10,000 per violation may be assessed for each unlawful gift or expense and for each failure to disclose a permissible gift or expenditure.

Additionally, manufacturers must disclose the distributions of samples of prescribed products to Vermont health care providers.

7) UNPROFESSIONAL CONDUCT BY PHYSICIANS

VT. STAT. ANN. TIT. 26, §§ 1311-1403—Vermont Medical Practice Act
Unprofessional conduct by physicians is covered in the Vermont Medical Practice Act under 26 V.S.A. § 1354. Section 1354 covers a wide range of acts and omissions that may subject a physician to discipline or revocation of license. Such offenses include the fraudulent procurement or renewal of a medical license,
conduct that evidences unfitness to practice medicine, failure to promptly supply copies of medical records upon patient’s request, consistent improper utilization of services, and disruptive behavior that interferes with patient care. 26 V.S.A. § 1354(a). Among the more specific offenses, unprofessional conduct can also be found for failure to comply with provisions of federal or state statutes or rules that govern the practice of medicine or surgery. 26 V.S.A. § 1354(a)(27).

Patient abandonment is also covered under § 1354. 26 V.S.A. § 1354(a)(4). The Vermont Board of Medical Practice has issued guidance outlining the factors in considering the proper termination of a physician-patient relationship. These factors include: (1) whether there was timely notice of the termination (generally 30 days); (2) whether the physician provided necessary treatment for an existing problem and/or emergency care during this transition period (generally 30 days); and (3) whether the physician diligently transferred records to the new physician. In addition, under 26 V.S.A. § 1354(a)(24) it is unprofessional conduct for failure to comply with the patient’s bill of rights, located under 18 V.S.A. § 1851.

Along with a physician’s personal conduct, the physician may be held responsible for the actions of those working under them. A supervising physician may be found to have committed unprofessional conduct for the improper use of a physician’s assistant. 26 V.S.A. § 1354(a)(39). The supervising physician may be held legally liable for the physician assistant’s actions if the supervising physician improperly delegated duties. 26 V.S.A. § 1739(a).

A physician may also be liable for certain acts of a nurse practitioner. It is unprofessional conduct for a physician to allow a nurse practitioner to: (1) perform medical actions that are outside of the physicians own practice; (2) perform acts outside of ones training or experience; or (3) acts that an ordinary reasonable and prudent physician would agree is outside the practitioners practice. 26 V.S.A. § 1354(a)(26).

In addition to the above mentioned regulations, the Vermont Board of Medical Practice has released new administrative rules that became effective October 15, 2017. Failure to comply with the new regulations may also result in disciplinary action by the Vermont Board of Medical Practice.

8) PEER REVIEW PRIVILEGE

VT. STAT. ANN. TIT. 26, §§ 1441-1443—Vermont Peer Review Privilege
Section 1441 lists four types of entities that qualify as a “peer review committee”: (1) the Vermont professional standards review organization or its subsidiary committees; (2) the Vermont Program for Quality in Health Care, Inc. or its subsidiary committees; (3) a peer-review or other comparable committee established by an HMO in accordance with 18 V.S.A. § 9414; and; (4) a committee of a state or local professional association or of a hospital or other health care provider. The overarching goals of such committees are to evaluate and improve the quality of
healthcare rendered by determining whether the services were professionally indicated, and if so, whether or not the services were performed in compliance with the applicable standard of care consistent with providers in that area. 26 V.S.A. § 1441. In an effort to protect candor among these types of entities, the court has interpreted this section broadly to include entities whose goal is to evaluate the standard of the care given in an effort to improve overall patient care, even if not specifically covered in one of the four categories above. See Russo v. Brattleboro Retreat, 5:15-CV-55, 2016 WL 299020, at *2 (D. Vt. Jan. 25, 2016).

Any member of a peer review committee will remain free from liability, under the condition that such person has acted without malice and the actions taken by the committee are reasonable in light of the facts known after a reasonable effort to obtain all the facts. 26 V.S.A. § 1442.

The proceedings, reports, and records of the peer review committees, in addition to any evidence that is required, are to be considered confidential and privileged. 26 V.S.A. § 1443(a). They are not subject to discovery or introduced into evidence in any civil action against any provider of health services arising out of matters which are the subject of evaluation by the peer review committee. 26 V.S.A. § 1443(a). In addition, no person who was in attendance at a committee meeting is permitted or required to testify as to the findings, recommendations, evaluations, opinions, or other such actions of the committee. Id. However, merely because such information, documents, or records were presented during committee proceeding, does not make them immune if they would otherwise be discoverable from their original sources. Id.

Relevant Case Law:

This case is a wrongful death action arising out of the suicide of a young woman while at a treatment facility. The plaintiff filed a motion to compel records of contact between the defendant and the medical accreditation commission and the HMO that paid for the decedents stay at the retreat. While neither of the third parties would be included in § 1441 under a literal reading, the court felt their functions necessitated their inclusion as both were formed for the purpose of reviewing incidents and investigating whether professional errors occurred. Finding the third parties were entitled to protection under § 1441, the court determined the documents produced by these committees and supplied to defendant were entitled to protection. The court conducted an in camera review of the documents, finding there were no “original source” issues and that the documents consisted of “communications regarding the investigations, a physician chart review, analysis, recommendations, and conclusions.” Russo, 2016 WL 299020, at *3.

A secondary argument made by the plaintiff was that the peer review privilege was waived when the third parties conducting the review disclosed the peer review materials to defendant. While not specifically addressing the issue the court points out that, “a ‘strong argument’ could be made that no waiver is permissible, ‘since 26 V.S.A. § 1443 does more than provide a privilege, but arguably announces a
mandatory policy against disclosure." See also Wheeler v. Central Vermont Medical Center, Inc., 155 Vt. 85, 88, 582 A.2d 165 (Vt. 1989).

This is a medical malpractice lawsuit arising from the death of a patient caused by a heart attack. In examining a motion to compel, the court determined what types of formalities are necessary to invoke the peer review privilege. The plaintiff sought to compel the defendants to answer questions related to meetings regarding the standard of care in this particular incident. The two meetings involved were an office meeting between the practicing physician and department chair and a monthly department meeting.

In ultimately ruling both meetings discoverable, the court stated that documents or conversations arising in the ordinary course of business operations are not protected. Noting that if there are no apparent peer review formalities, mere conversations between department chiefs and staff will not be protected. “The peer review privilege is designed to protect the honest exchange of opinions among medical professionals for the purpose of self-improvement. To that end, states generally privilege conversations and documents that arise during the review and evaluation of medical care by a designated reviewing body.” Robinson, 2010 WL 503096, at *2. In determining whether something is the ordinary business operation or designated reviewing body, the court looks for formalities such as a designated committee and labeled peer-review reports.

This is a defamation case filed by a physician against his former employer. The plaintiff filed a motion to compel production of the plaintiff’s personnel file, evaluations, records of peer relations, and conversations among his co-workers regarding his performance. The defendants sought to exclude documents related to investigation by the medical director under protection of the peer review statute. In a strict reading of the statute, the court ordered the defendants to produce the documents, rejecting the idea that a “committee” could be composed of only person. The court reasoned that had the legislature intended to include a “committee of one,” it would have included the term “individual” in the statute.

In another strict interpretation of statute, the court declined to apply privilege to the credentialing information used by the hospital. Stating that if credentialing was intended to be included, the legislature would have specifically listed it in the statute. This case presents a slight departure from other decisions that broadly apply the peer review privilege. A possible distinguishing aspect of this decision is the policy consideration around the peer review privilege. As mentioned above, the overall goal of the peer review privilege is to improve patient care by allowing a free and open review of the care rendered. That concern was not directly at issue in this case and may have been the driving factor behind such the strict interpretation adopted by the court.
This lawsuit alleged negligence by the hospital in awarding hospital and surgical privileges to a surgeon. During trial, medical records used in a peer review process were introduced by separate means through testimony on behalf of the plaintiff. The plaintiff’s expert utilized this information in making his recommendation on what the outcome of a peer review “should have been.” The court denied the defense’s objection to such testimony, acknowledging that although the expert was aware of the privileged material, there was no evidence he relied on the privileged materials in his testimony. The mere fact the same facts were used by the peer review committee to make their decision, did not preclude the expert witness from reviewing them. This case highlights the statutory language that the peer review privilege does not extend to protect information “independently replicable or of the type whose existence is assured and that is independently verifiable.” Wheeler, 155 Vt. at 90.

9) HOSPITAL LIABILITY FOR FAILURE TO OBTAIN CONSENT

VT.STAT.ANN. TIT. 12 §1909
A lack of informed consent includes:
- failure of a treating provider to disclose the alternatives to and reasonably foreseeable risks involved as a reasonable provider would under the circumstances and in a manner permitting the patient to make a knowledgeable evaluation; 12 V.S.A. § 1909

Failure to answer a specific question about foreseeable risks and benefits, practitioners should not withhold any requested information. 12 V.S.A. § 1909

VT.STAT.ANN.TIT. 18 § 1852(3) and (4) – The Hospital Bill of Rights
Each hospital patient is entitled to receive from his/her physician the information necessary to give informed consent before treatment. This should include the medically significant risks involved and probable duration of incapacitation. Information about medically significant alternatives identified by the practitioner or asked about by the patient should be provided. 18 V.S.A. § 1852