



Credentialing & Peer Review

LEGAL INSIDER

How to navigate National Practitioner Data Bank reports effectively

Legal experts offer tips for medical staffs and practitioners

Nothing grabs a credentials committee's attention like a National Practitioner Data Bank (NPDB) report. It's a serious, career-long mark against a practitioner and a substantial action for a hospital to take.

To ensure that both sides know how to navigate these reports effectively and repeal them when necessary, read the following tips from **Shirley P. Morrigan, Esq.**, a partner at Los Angeles-based Foley & Lardner, LLP, and **Frances Cullen, Esq.**, an Atlanta-based attorney who specializes in healthcare issues.

Advice for the medical staff

► **Talk to your legal counsel sooner rather than later about problem practitioners.** Most problems that medical staffs identify in practitioners have developed

over time, such as impairment due to substance abuse or mental or personality disorders. Therefore, it's important that the medical staff take progressive disciplinary action and avoid trying to fix a series of problems with one action that leads to an NPDB report.

Along the way, the medical staff should communicate with its legal counsel to ensure that the actions it is taking meet legal standards.

"What I see sometimes is that people tolerate bad behavior for 20 years, and then they want to take action today," Morrigan says. In situations such as these, the response from the practitioner is usually, "If you're mad at me for 20 years of actions,

"I think it's a good idea for people to know what's on their data bank report and check it periodically because then they can correct any inaccuracies."

—Frances Cullen, Esq.

why did you reappointment me 10 times?"

It's a valid point from the practitioner and one that the courts will likely listen to, especially if the medical staff didn't follow the corrective action steps outlined in its bylaws. Keeping your legal counsel regularly updated about these problem practitioners will help avoid hastily made reports to fix years of problems.

► **Meet about final disciplinary actions and the NPDB report.** Morrigan recommends spelling out summary suspension language in the bylaws. Such language should state that within a week after the MEC's meeting during which it discusses a potential practitioner suspension, it should meet face-to-face with the practitioner. The MEC should notify the practitioner of this meeting in advance so the practitioner can consult his or her legal counsel.

However, when the MEC and practitioner meet, neither side should have legal counsel present. The pur-

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pose of the meeting is for the MEC to state why it wants to suspend the practitioner, and the practitioner has a chance to state his or her case.

Afterward, the MEC meets again and formally decides whether to uphold or rescind the suspension. If the MEC upholds the suspension, it should also decide what definitive action it wants to recommend, such as termination or permanent restriction. Keep in mind that, with the exception of summary suspension, a practitioner on a hospital's medical staff is entitled to a hearing and appeal before an NPDB report is filed.

► **Take targeted actions and suspend privileges as needed.** Medical staffs shouldn't hastily suspend

all privileges if the practitioner only has problems performing a few of them, says Morrigan. For example, if a practitioner has OB/GYN privileges and only has problems performing obstetrical procedures, Morrigan would advise the medical staff not to terminate the gynecological privileges.

If a medical staff uses this targeted disciplinary action, it may be possible for a practitioner to continue working at an organization while he or she goes through a hearing and appeal. The practitioner may file a dispute against the organization for the NPDB report it filed. This could create a tense working situation between the medical staff and the practitioner, and the involved parties need to consider ways to manage this.

► **Consider alternative disciplinary actions.**

When a practitioner derails the medical staff's goal of providing quality patient care, there are several options to get the practitioner back on track. These options include recommending termination or restriction, which are NPDB-reportable suspensions.

There are also nonreportable options, such as monitoring and counseling. (Some of these nonreportable disciplinary actions may be why studies question medical staffs' NPDB reporting rates. Read more about this issue in the sidebar on p. 3.)

► **Ask counsel about legal standards.** A recent study in California found that medical staff leaders may not know when they are required to report peer review actions to the state licensure board. "I don't think they should be required to know; that's what the medical staff lawyer is around for," says Morrigan.

Advice for practitioners

Note: MSPs can pass along the following section of the article to medical staff members and leaders as an educational tool.

► **Know your rights and options.** Practitioners spend years training for their clinical responsibilities, but not nearly as much time is spent learning about the legal

Editorial Advisory Board

Credentialing & Peer Review Legal Insider

HCPRO

Associate Group Publisher: **Erin Callahan**,
ecallahan@hcpro.com

Associate Editor: **Emily Berry**, eberry@hcpro.com
781/639-1872, Ext. 3228

Associate Editor: **Elizabeth Jones**, ejones@hcpro.com
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or administrative aspects of their careers. “I think it’s a good idea for people to know what’s on their data bank report and check it periodically because then they can correct any inaccuracies,” says Cullen. The NPDB details practitioners’ options for disputing submitted reports on its Web site (www.npdb-hipdb.hrsa.gov/dispute.html).

► **Ask the organization to consider revising its report before it’s submitted to the NPDB.** If you are concerned that a potential NPDB report is inaccurate, discuss those concerns with the medical staff and legal counsel before the medical staff submits the report. “If clients come to me early enough, we first try to resolve the case or work with the reporting entity so the circumstances will not trigger a data bank report or try to obtain more favorable reporting language,” says Cullen. She notes that hospitals and licensing boards are often amenable to changing the language in an NPDB report as long as the facts remain accurate.

When licensure boards and organizations file their reports, there are codes that describe the action that triggered the report. Sometimes, boards or organizations are willing to change these codes. For example, the difference between a patient abandonment and patient neglect code may make a difference in how a future employer evaluates a practitioner with that code on his or her record.

► **Determine the level of interaction you want your legal counsel to have with the medical staff.** The way a practitioner presents himself or herself to a medical staff during disciplinary disputes can affect the outcome. For example, if the practitioner seems willing to work with the medical staff and compromise on actions, the medical staff may reciprocate that mind-set.

Cullen says clients have approached her with questions about a case, explaining that they don’t want to

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Are hospitals reporting enough practitioners to the NPDB?

Hospitals are not reporting practitioners to the National Practitioner Data Bank (NPDB) as often as they should, claims a May 2009 study by Health Research Group, a branch of the consumer advocacy organization Public Citizen (www.citizen.org/documents/1873.pdf).

The study compared the number of reports the NPDB expected to receive to the number of reports it actually received. “Prior to the opening of the NPDB in September 1990, the federal government estimated that 5,000 hospital clinical privilege reports would be submitted to the NPDB on an annual basis, while the healthcare industry estimated 10,000 reports per year. However, the average number of annual reports has been only 650 for the 17 years of the NPDB’s existence,” the report states.

What does the low number of incoming reports compared to initial estimates say about physician reporting? Some lawyers dispute the conclusion that medical staffs aren’t meeting their reporting obligations.

“I don’t believe that there is a huge number of practitioners who aren’t being reported,” says **Shirley P. Morrigan**, a partner at Los Angeles-based Foley & Lardner, LLP. “There

was no way in 1990 to predict how many reports hospitals would file. The reporting requirements are technical and have never contemplated any alternative ways that medical staffs could deal with their members. Medical staff review is done by peers, and short of intense governmental oversight of the process, there is no way to assess whether an individual medical staff is meeting its reporting obligations.”

Frances Cullen, Esq., an Atlanta-based attorney, agrees with Morrigan’s assessment that medical staffs aren’t overly negligent in reporting.

“There are ways to avoid data bank reports, which I don’t think is necessarily bad,” Cullen says. “It certainly depends on the severity of the situation.”

For example, instead of a hospital suspending a practitioner’s privileges for more than 30 days as a disciplinary action, which the medical staff would be obliged to report to the NPDB, Cullen suggests an alternative. The medical staff could require the practitioner to undergo monitoring or attend an educational course, which the NPDB does not require the medical staff to report.

Navigate NPDB

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appear to the medical staff as though they are aggressively pursuing legal action. In those cases, she tells them what actions to take and what to say during medical staff hearings, but she will not directly contact the medical staff on behalf of those clients.

➤ **Stick to the facts when disputing a case.**

NPDB reports focus on the black-and-white facts of a case and don't provide supplemental information, such as character references. Because of this, Cullen focuses on the facts when she works with a client to petition an organization to revise the report.

Character assessments contain qualitative information that may be interpreted differently by different people. However, quantitative information is easier to provide as evidence. For example, if a report claims that a practitioner performed nine surgeries and made the same error each time, but patient records show errors only occurred during three surgeries, the organization is more likely to revise its report.

➤ **File a statement with the report.**

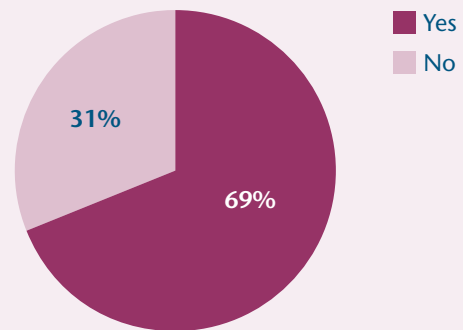
If a practitioner is unsuccessful in getting an organization to revise its report and the NPDB denies the requests to repeal the report, physicians have one other option: They can file a statement to the NPDB that gets attached to the original report. Think of this statement as the dissenting opinion in a Supreme Court ruling. Although the main NPDB re-

port outlines the facts of a case as the reporting organization sees them, this statement allows the practitioner to tell his or her side of the story.

The medical staff and individual practitioners should consider these tips to help ease what is often a grueling process. With the help of legal counsel, accurate reporting, and careful communication, both parties can help smooth NPDB reporting and peer review in general. ■

Poll results: NPDB reporting

A poll question on the Credentialing Resource Center Blog asked HCPro readers whether they've ever worked at an organization that reported a practitioner to the National Practitioner Data Bank (NPDB) while they were working there. More than 200 readers answered.



Source: <http://tinyurl.com/ybrvj43>.

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Streamline fair hearings for APPs, but don't cut corners

The fair hearing process for medical staff members outlined in the Health Care Quality Improvement Act (HCQIA) is pretty cut-and-dried, but what about fair hearings for advanced practice professionals (APP)? Details for medical staffs tend to get a little hazy when it comes to determining what constitutes a fair hearing for APPs. Although these practitioners are credentialed and privileged through the medical staff, the majority of APPs are not technically medical staff members. This means they often aren't granted the same hearing rights as physicians, and that can lead to medical staffs getting dragged into court for charges of discrimination or antitrust.

CPRLI talked to several experts to help you avoid a court appearance based on these charges.

What is the APP's relationship to the medical staff?

Before jumping into the ins and outs of the fair hearing process for APPs, it is important to understand these practitioners' relationship to the medical staff. According to The Greeley Company's *Advanced Practice Professionals Manual*, APPs are credentialed and privileged through the medical staff, but they are generally not eligible for medical staff membership (some states allow nonphysician practitioners to be medical staff members, but many do not). Psychologists, physician assistants, and advanced practice RNs, including nurse-midwives, nurse practitioners, nurse anesthetists, and clinical nurse specialists, are all considered APPs.

Whether fair hearings occur for APPs depends on their relationship to the hospital. APPs may be independent practitioners, employees of the hospital, employees of a physician on the medical staff, or employees contracted through a medical group.

Generally, employed or contracted APPs are not granted the right to a fair hearing at all, or they are not granted the same kind of hearing as that granted to medical staff members, says **Michael R. Callahan, Esq.**, an

attorney at Katten Muchin Rosenman, LLP, in Chicago. This is because most contracts between hospitals or physicians and APPs specify that an APP does not have the right to a fair hearing if his or her employment is terminated because the APP is not a member of the medical staff, explains Callahan.

However, independent APPs, although a minority, are usually granted fair hearing rights under medical staff bylaws because The Joint Commission (formerly JCAHO) requires some type of review process for independent practitioners. Even if your facility is not Joint Commission-accredited, medical staffs should do this out of fairness and to protect themselves from accusations of discrimination or anti-trust.

What triggers a fair hearing for APPs?

The answer to that question will depend on what is outlined in your medical staff bylaws. But as a general rule, the same events that trigger fair hearings for physicians trigger fair hearings for APPs. These may include quality-of-care concerns and violations of medical staff bylaws or hospital procedures.

The sample bylaws language on p. 6 is developed by The Greeley Company and will help you determine when a fair hearing for an APP should be triggered.

What fair hearing rights are afforded to APPs?

Joint Commission standard MS.10.01.01, element of performance 1, states that the medical staff must develop a fair hearing and appeals process that may differ for members and nonmembers of the medical staff. Medical staffs are left to decide how the process will differ, but they should always include four key rights, Callahan says. Medical staffs should:

- Give the APP written notice that corrective action is being taken against him or her. This notice should also detail the reasons the medical staff has decided to recommend corrective action.

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APPs

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- Provide the APP with documents that support the medical staff's recommendation to take corrective action, such as meeting minutes and performance reports.
- Provide an opportunity for the APP to defend himself or herself (in other words, provide a fair hearing).
- Allow the APP to hear feedback from the individuals who have spoken up against him or her during the hearing.

"There is no magic formula, but these are the key features in order to be fair and less susceptible to challenge," says Callahan.

Although some medical staffs choose to offer APPs the same fair hearing rights as physicians, others offer far fewer. They may choose to eliminate the following:

- The right to have counsel present during the hearing
- The right to have a fair hearing officer present

- The right to directly examine and cross-examine witnesses

Although no law precludes medical staffs from giving APPs these rights, many choose not to in an effort to streamline the fair hearing process, Callahan says.

Who is involved in a fair hearing for an APP?

Many medical staffs scale down the number of people involved in an APP hearing to simplify the process. A fair hearing for a physician typically involves the physician in question, a fair hearing committee made up of a handful of individuals, a hearing officer, the hospital's legal counsel, and the physician's counsel.

"For APPs, the fair hearing might just involve the department chair and a couple of members of the medical executive committee," says **Mary Hoppa, MD, MBA, CMSL**, senior consultant at The Greeley Company, a division of HCPro, Inc., in Marblehead, MA.

Sample bylaws language: Fair hearings for APPs

Whenever the activities or professional conduct of an advanced practice professional (APP) adversely affect or are reasonably likely to affect patient safety or the delivery of quality patient care, or are disruptive to the organization's operations, the matter may be referred to the credentials committee (or other appropriate committee), which shall review the matter or designate an ad hoc or existing peer review body to perform the review. The matter may also be handled by the employing organization as described in organization-specific policies and procedures (applicable to hospital-employed APPs only). External third parties may be used by the credentials committee to conduct all or part of the review or to provide information to the review body. The review may involve an interview of the APP involved, his or her supervising physician, and other individuals or groups.

Source: *The Greeley Company.*

Who makes the final decision?

When deciding who will hear the case and make a recommendation or decision regarding the APP's privileges, remember that committees made up of multiple members often make more balanced recommendations or decisions than a single individual, says **George Indest, Esq., MPA, LLM**, managing partner at The Health Law Firm in Orlando, FL.

"To me, having a committee involved is always more preferential to having an individual making a decision. With a committee, you are far more likely to have a comprehensive evaluation of the underlying facts and, therefore, more likely to have a correct decision," says Indest.

However, some medical staffs simply do not have enough medical staff leaders to form a fair hearing committee, or the leaders available may pose a conflict of interest. These organizations may choose to have a single individual oversee the hearing.

Whether you choose an individual or a committee, consider selecting individuals who practice in the same or similar specialty as the APP. This often means that the chair of the department in which the APP practices oversees the hearing. If a committee is involved, the committee likely includes physicians from that department as well.

However, committee participation from within the same department may cause real or perceived conflicts of interest. It is important to build some flexibility in your fair hearing process by allowing other specialties to participate, says Callahan.

For example, if a nurse-midwife has been summoned for a fair hearing due to legitimate quality concerns, having the chair of the obstetrics department oversee the fair hearing may not pose a conflict of interest. However, if the midwife believes that the complaints against her are made with the intent to drive her out of the hospital, having the chair of the obstetrics department oversee the hearing would appear to pose a conflict of interest. In such a case, the medical staff may decide to have the chair of the surgery department oversee the case. The surgery chair should be familiar enough with OB/GYN procedures to determine whether the midwife's performance was appropriate, but he or she should be far enough removed from any conflict of interest to remain objective.

Another way to build flexibility (and legal protection) into the process is to give final decision-making power to the board of directors or the hospital's CEO. If the department chair or committee overseeing the fair hearing makes the final decision, and the APP alleges a conflict of interest, "that could arguably raise discrimination or anti-trust issues," says Callahan.

Leaving the last word up to a higher administrator can help legally protect the physicians. "If you get the hospital's blessing, either in the form of an appeal or review, that has the effect of insulating the physicians from legal action [by the APP]," Callahan says.

Do hospitals have to report APPs to the NPDB?

Hospitals are not obligated to report APPs who have had actions taken against their privileges to the National

Practitioner Data Bank (NPDB), so many of them don't, says Callahan.

However, many state medical boards have reporting requirements, usually regarding impaired practitioners. Check with your state's medical board to ensure that your organization is in compliance.

"The reporting obligations may, in part, drive your process because you are trying to gain certain legal protections or there may be a mandated process," Callahan says.

What laws govern the fair hearing process for APPs?

As mentioned earlier, HCQIA is a federal statute that specifies the fair hearing process for physicians. Although guidelines for APPs are not mentioned specifically in the statute, it's a good idea to use it as a blueprint for developing a fair hearing process for APPs, says Indest.

Individual states also have laws regarding the fair hearing process. Visit your state's medical board's Web site to obtain a copy. And don't forget that following medical staff bylaws is the primary defense against being taken to court by disgruntled practitioners.

"There is possible civil liability on the part of the hospital and the individuals involved in the process if you do not follow what is in your medical staff bylaws or what is required by state law or the federal Health Care Quality Improvement Act," says Indest.

Although many medical staffs provide APPs with a pared-down hearing process to save time and expense, Indest says anyone involved in the fair hearing process at the medical staff or hospital level should strive to provide APPs with a hearing process similar to that provided to physicians.

However, Hoppa says that medical staffs need to closely consider how far they want to delve into the fair hearing process. "We want to be fair and stay within regulatory constraints, but we don't want the process to get any more burdensome and time-consuming than it needs to be," she says. "Using a less burdensome process while remaining fair to the APP seems to offer the best of both worlds." ■



Recent court rulings

Negligent credentialing claim okay without malpractice suit

The Supreme Court of Ohio ruled that a plaintiff can bring a negligent credentialing claim against a hospital without filing a malpractice claim against an individual practitioner.

The plaintiff was a patient who underwent two foot surgeries to alleviate pain. Both surgeries were performed by the same practitioner. After the surgeries, the plaintiff claimed that she experienced more pain than she had previously. She sued the practitioner for malpractice and the hospital where he practiced for negligent credentialing.

The practitioner filed for bankruptcy, and the plaintiff dismissed her claim against him without prejudice. However, the plaintiff upheld her claim against the hospital for negligent credentialing.

The hospital denied her negligent credentialing allegations and said that the negligence of the hospital could not be argued until the negligence of the practitioner's actions could be proven through a malpractice case.

The court acknowledged that this was an unusual case but ruled that the plaintiff could attempt to prove the practitioner committed medical malpractice as an element of the negligent credentialing claim.

The two dissenting justices disagreed with the ruling because of the

unusual circumstances of the case, including the practitioner's bankruptcy claim.

Source: Schelling v. Humphrey, Slip Opinion No. 2009-Ohio-4175. August 26, 2009, decided.

Connecticut Supreme Court puts peer review on ice

The Connecticut Supreme Court's decision in *Director of Health Affairs Policy Planning, University of Connecticut Health Center v. Freedom of Information Commission* puts to rest a question that has rattled back and forth in the state's court system like a ping-pong ball: Should certain peer review documents be discoverable?

The ball got rolling when Louis J. Russo, a former patient of Jacob Zamstein, MD, requested to see documents pertaining to the University of Connecticut Medical Center's decision not to renew Zamstein's privileges.

The medical center produced minutes from four meetings but withheld other documents that it claimed comprised Zamstein's credentialing file and were thus immune from disclosure under the Freedom of Information Act (FOIA). FOIA protects peer review documents and proceedings from being used as evidence in civil proceedings.

Russo then filed a claim with the Freedom of Information Commission,

which concluded that the medical center was a public agency, making Zamstein's records public documents.

The commission also concluded that matters before the commission do not constitute civil proceedings, and that FOIA only applies in civil proceedings.

As a result, the commission requested that the medical center disclose the documents.

A trial court later disagreed with the commission's decision and ruled that the documents should be protected.

An appeal brought the matter to the Supreme Court, which agreed with the commission that the documents should be disclosed, save for four documents that remained exempt under 45 CFR §60.13.

"We recognize the possibility that the purpose of the peer review privilege may be undermined by allowing disclosure under the act of peer review proceedings ... It is therefore possible that disclosure under the act may have the same chilling effect that the legislature sought to avoid by enacting §19a-17b [the state's peer review immunity statute]," said the Supreme Court in its opinion statement.

Source: SC 18286. Director of Health Affairs Policy Planning, University of Connecticut Health Center v. Freedom of Information Commission. August 25, 2009, decided. ■