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The Illinois Medical Studies Act and Hospital Records: Privilege Without Substance

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I. INTRODUCTION

In the wake of soaring health care costs, physician peer review and hospital quality control procedures have become an integral part of the health care industry.[1] The growth of the peer review process, primarily intended to improve the quality of care, is in part a result of the increase of negligence suits against hospitals.[2] The Illinois Legislature, in the Medical Studies Act (the "Act"),[3] confers a broad privilege upon peer review and medical research bodies by prohibiting discovery of records generated by such bodies. The Act is premised on the idea that ensuring confidentiality of review proceedings will encourage more candid and effective evaluation by protecting records of review activities from discovery in civil litigation.[4]

Illinois courts gradually have eroded the grant of confidentiality, however, by recognizing exceptions to the privilege.[5] Although the shield protecting the review of individual physicians has remained relatively intact, the privilege accorded internal hospital quality control procedures has been interpreted inconsistently. This inconsistency has led to uncertainty as to whether a particular record is discoverable in malpractice litigation.[6] The net result is a chilling effect on hospital review procedures, undermining the Act's goal of promoting internal quality control activities.

This Comment will examine the background of peer review and the recognition by Illinois courts and the Illinois Legislature of the need for confidentiality in review proceedings, and the construction given the Act by Illinois courts.[7] The Comment will then discuss the judicially created exceptions to the statutory privilege, and their effect on disclosure of hospital studies and records.[8] Finally,

1. Comment, *Medical Peer Review Protection in the Health Care Industry*, 52 TEMP. L.Q. 552 (1979).
2. *See infra* notes 10-34 and accompanying text.
3. ILL. REV. STAT. ch. 110, paras. 8-2101 to 8-2105 (1987). *See infra* notes 35-45 and accompanying text.
4. ILL. REV. STAT. ch. 110, paras. 8-2101 to 8-2105 (1987).
5. *See infra* notes 69-105 and accompanying text.
6. *See infra* notes 106-24 and accompanying text.
7. *See infra* notes 10-68 and accompanying text.
8. *See infra* notes 69-105 and accompanying text.

an interpretation of the Act will be suggested which will facilitate the uniform application of the privilege to hospital records.[9]

II. Hospital Peer Review

Courts have long recognized a hospital's independent duty to its patients.[10] Courts have expanded a hospital's duty to maintain the quality of care delivered within the institution by requiring not only retrospective review of patient care, but also by requiring a hospital to exercise care in selecting and supervising physicians on the hospital medical staff.[11] Hospitals have attempted to limit their potential liability by instituting review committees to monitor the level of care delivered.[12] This intra-hospital review, commonly known as peer review, uses self-evaluation by medical professionals to improve the quality and efficiency of medical procedures and techniques.[13]

The Joint Commission on the Accreditation of Hospitals (the "JCAH")[14] requires that a hospital establish procedures for evalu-

9. *See infra* notes 125-39 and accompanying text.

10. Darling v. Charleston Community Memorial Hosp., 33 Ill. 2d 326, 211 N.E.2d 253, *cert. denied* 383 U.S. 946 (1965). In *Darling*, the Illinois Supreme Court stated that a hospital does not merely furnish facilities; a hospital has an affirmative duty to supervise its staff and to review the care given to patients. *Id.* at 332, 211 N.E.2d at 258. A failure to do so may result in a hospital being held liable for the independent acts of its physicians. This theory of a hospital's liability is commonly referred to as corporate negligence.

11. In Pickle v. Curns, 106 Ill. App. 3d 734, 435 N.E.2d 877 (2d Dist. 1982), an Illinois appellate court held that appointing an unqualified physician to the hospital's medical staff constituted a breach of the hospital's duty to its patients. *Id.* at 739, 435 N.E.2d at 881. A hospital is not liable for an independent physician's malpractice, however, unless the hospital had reason to know that the malpractice would occur. *Id. See also* Holton v. Resurrection Hosp., 88 Ill. App. 3d 655, 410 N.E.2d 969 (5th Dist. 1980) (a hospital has the responsibility to determine the qualifications of physicians on its medical staff); Mauer v. Highland Park Hosp., 90 Ill. App. 2d 409, 232 N.E.2d 776 (2d Dist. 1967) (a hospital's right to deny staff privileges is consistent with the imposition of liability for careless selection of staff members).

12. *See, e.g.*, Elam v. College Park Hosp., 132 Cal. App. 3d 332, 342, 183 Cal. Rptr. 156, 161 (1982) ("[t]he hospital's duty to guard against physician's incompetency is further implied by requiring renewal of staff privileges . . . and the periodic review of the medical records of hospital patients"); Johnson v. Misericordia Community Hosp., 99 Wis. 2d 708, 721, 301 N.W.2d 156, 169-70 (1981) ("[o]bviously, the promotion of quality care and treatment of patients requires hospitals to perform a thorough evaluation of medical staff applicants from the standpoint of professional competence, ethics, established reputation, and further, to periodically review the qualifications of its staff through a peer review or medical audit mechanism").

13. *See* Jenkins v. Wu, 102 Ill. 2d 468, 480, 468 N.E.2d 1162, 1168 (1984). For a further discussion of *Jenkins*, see *infra* notes 46-50 and accompanying text.

14. The JCAH (now known as the Joint Commission on the Accreditation of Healthcare Organizations) is a private regulatory committee which establishes standards for health facilities and conducts evaluations of hospitals to determine compliance with its

ating the care rendered in the facility[15] by identifying problems that affect patient care, as well as opportunities for improving the facility.[16] This mandatory review extends to both the qualifications of independent physicians before appointment to a hospital's medical staff, and the treatment given by those physicians while on the medical staff.[17] The JCAH provides guidelines for hospital peer review committees which have two primary functions: retrospective review and credentialing.[18]

Retrospective review boards evaluate the care rendered by a hospital's staff physicians and recommend corrective or disciplinary actions.[19] Retrospective review boards may be composed of several subcommittees, each addressing a particular department or function of the hospital.[20] JCAH standards require that retrospective review boards meet regularly to discuss the supervision and evaluation of care and that they keep records of their conclusions, actions taken, and recommendations.[21]

Credentialing committees examine the qualifications of physicians requesting admission to a hospital's staff.[22] Credentialing committees control the granting and limitation of initial staff privileges,[23] as well as periodic re-evaluation of physicians to determine

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accreditation standards. *See generally* Niven v. Siqueira, 109 Ill. 2d 357, 487 N.E.2d 937 (1985). Pursuant to 42 U.S.C. § 1395x(e) (1982), JCAH accreditation of a hospital is necessary to receive Medicare reimbursement. Medicare and Medicaid payments comprised 29% of all health care expenditures in 1983. *See* Hyman & Williamson, *Fraud and Abuse: Regulatory Alternatives in a "Competitive" Health Care Era*, 19 LOY. U. CHI. L.J. 1133, 1133 n.2 (1988) (citing Gibson, Levit, Lazenby & Waldo, *National Health Expenditures 1983*, 6 HEALTH CARE FINANCING REVIEW 1 (Winter, 1984)). As a result, a hospital's failure to obtain JCAH accreditation can result in substantial financial hardship.

15. Joint Commission on the Accreditation of Hospitals, Accreditation Manual for Hospitals, at 217 (1987) [hereinafter JCAH Manual].

16. *Id.*

17. *Id.*

18. Merritt, *The Tort Liability of Hospital Ethics Committees*, 60 S. CAL. L. REV. 1239, 1256 (1987). *See generally* JCAH Manual, *supra* note 15.

19. JCAH Manual, *supra* note 15, at 112.

20. *Id.* at 283. For example, utilization review committees analyze the allocation of resources within the hospital, such as the propriety of admissions and the necessity of continuing stays. *Id.* Medical audit committees evaluate the care actually provided in the hospital, comparing it to the state of the art and ensuring that each staff member provides, and each patient receives, a uniform level of care. *Id.* at 117. Tissue or surgical committees review the quality and necessity of surgery. *Id.*

21. *Id.* at 116.

22. *Id.* at 109. Staff appointment allows a private physician, although not an employee or agent of the hospital, to use hospital facilities. *See* Elam v. College Park Hosp., 132 Cal App. 3d 332, 335, 183 Cal. Rptr. 156, 157 (1982).

23. JCAH Manual, *supra* note 15, at 110. The JCAH identifies key factors in the credentialing process. These key factors include licensure, training and clinical experi-

whether corrective action, such as a restriction or revocation of privileges, is necessary.[24] Not only is review required by the JCAH, but a hospital's failure either to investigate a physician's qualifications prior to appointment or to evaluate the care provided exposes the hospital to liability.[25] This theory of liability is premised on the hospital's duty to exercise care in the selection of its medical staff.[26]

The result of both retrospective review boards and credentialing committees is the generation of records often pertaining to a physician's incompetence or negligence.[27] Access to these peer review records facilitates a malpractice plaintiff's suit in two ways. First, the records provide the plaintiff with recorded evidence of a physician's negligence which the plaintiff can use in a malpractice suit against the physician. Second, the records may provide the plaintiff with evidence of a hospital's knowledge of the physician's incompetence — the basis of which may permit the plaintiff to sue the hospital under the theory of corporate negligence.[28]

The Illinois Supreme Court, however, has noted that the purpose of peer review "is not to facilitate the prosecution of malpractice cases."[29] The court also has recognized the importance of confidential communication in peer review proceedings.[30] The

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ence, competence, and a physician's health status. *Id.* A credentialing committee may also consider such factors as malpractice suits filed against a physician or a physician's loss of staff privileges at another hospital. *Id.*

24. *Id.* at 119. In renewing staff privileges, the credentialing committee may review the physician's experience at the hospital, the results of treatment rendered by the physician, and other evidence of continuing qualification. *Id.*

25. *See* Johnson v. Misericordia Community Hosp., 99 Wis. 2d 708, 301 N.W.2d 156 (1981). In *Johnson*, the court held that the hospital's failure to fully investigate the qualifications of the plaintiff's treating physician created an unreasonable risk to the patient. *Id.* at 716, 301 N.W.2d at 164.

26. *Id.*

27. As one author stated:

> In fulfilling their duty to review the qualifications and performance of individual members of the medical staff, members of the hospital governing body, administration, and medical staff must frequently make determinations that are adverse to individual practitioners. In making such decisions, the information collected or generated by the hospital's committees or administrative staff is often such that its dissemination might damage the . . . affected professional.

HOSPITAL LAW MANUAL vol. IB, § 7 (1983).

28. *See* Matchett v. Superior Court, 40 Cal. App. 3d 623, 630, 115 Cal. Rptr. 317, 320-21 (1977) ("[i]n a damage suit for in-hospital malpractice against doctor or hospital or both, unavailability of recorded evidence of incompetence might seriously jeopardize or even prevent the plaintiff's recovery"). For a discussion of corporate negligence, see *supra* note 10.

29. Jenkins v. Wu, 102 Ill. 2d 468, 479-80, 468 N.E.2d 1162, 1168 (1984). For a further discussion of *Jenkins*, see *infra* notes 46-50 and accompanying text.

30. *Id.*

need for confidentiality can be traced to physicians' apprehension of reprisals stemming from peer review activities.[31] The physician under review risks exposure to malpractice suits arising from the proceedings; the threat of loss of referrals and professional respect also may deter physicians from candid evaluations of their colleagues.[32] In addition, disclosure of medical research or quality control records may create a chilling effect on research sources[33] or deter hospitals from undertaking programs to appraise and improve hospital procedures for fear that the results would be discoverable in a corporate negligence suit against the hospital.[34]

III. THE ILLINOIS MEDICAL STUDIES ACT

A. Legislative History

In response to the need for protecting peer review records, all fifty states have enacted statutes providing at least some degree of privilege.[35] In 1961, Illinois passed a law providing for the confi-

31. Comment, *supra* note 1, at 558 ("doctors seem reluctant to engage in strict peer review due to a number of apprehensions").

32. *Id. See also Jenkins*, 102 Ill. 2d at 480, 468 N.E.2d at 1168-69.

33. *See* Andrews v. Eli Lilly & Co., 97 F.R.D. 494 (N.D. Ill. 1983). Relying on the goal of improvement of the quality of care, the court in *Andrews* ruled that the data of a study on the effects of diethylstilbestrol ("DES") were not subject to discovery. *Id.* at 503-04. The court reasoned that because researchers must often guarantee confidentiality to their subjects to obtain data and because disclosure might create a chilling effect on future research, the general research data should not be discoverable. *Id.* at 500, 503. The court, however, ordered production of research data concerning the plaintiffs, concluding that selective disclosure would not jeopardize the research. *Id.* at 504. Furthermore, the plaintiffs' previous disclosure of their own medical records indicated that they did not consider the material to be confidential and that they did not assert any available privilege with regard to it. *Id.*

34. *See, e.g.*, Marsh v. Lake Forest Hosp., 166 Ill. App. 3d 70, 76, 519 N.E.2d 504, 508 (2d Dist.), *appeal denied*, 121 Ill. 2d 571, 526 N.E.2d 832 (1988).

35. McCann, *Peer Review, Disclosure, and Reporting*, Utilization Management, PROs and Quality Assurance: The Legal Pitfalls, NHLA, at app. 5-9 (1987). At least one court has created a common law privilege for peer review records. Bredice v. Doctors Hosp., Inc., 50 F.R.D. 249 (D.D.C. 1970), *aff'd*, 479 F.2d 920 (D.C. Cir. 1973). In *Bredice*, the plaintiff brought suit against a hospital, alleging malpractice that resulted in the death of her husband. In the course of discovery, the plaintiff requested hospital committee reports relating to her husband's death, and reports from the hospital to its malpractice insurer. *Id.* at 249-50. The court denied discovery of the committee records, noting the importance of openness in peer review proceedings to the improvement of medical procedures and patient care. *Id.* at 250. The court stated:

> Candid and conscientious evaluation of clinical practices is a *sine qua non* of adequate hospital care. To subject these discussions and deliberations to the discovery process, without a showing of exceptional necessity, would result in terminating such deliberations. Constructive professional criticism cannot occur in an atmosphere of apprehension that one doctor's suggestion will be used as a denunciation of a colleague's conduct in a malpractice suit.

dentiality of certain medical records.[36] The Illinois Medical Studies Act (the "Act")[37] was intended to improve the quality of health care by encouraging participation in and institution of quality control procedures, and fostering "full, frank, and complete communication" within the reviewing body.[38] The legislature realized that without an assurance of confidentiality, the open communication necessary for effective review would be hampered.[39]

The extent of the privilege, like the protected activities and records, has been expanded since the original enactment.[40] The current Act's predecessor[41] prohibited only the introduction of peer review and quality control records into evidence; the discovery of the records nevertheless was permitted. The Act was amended in 1982 to prohibit the discovery of review records, abrogating an appellate court decision in *Walker v. Alton Memorial Hospital*.[42]

The Act currently reads in pertinent part:

Id. The court concluded that unless the plaintiff could show exceptional need for the records, the overwhelming public interest in improving patient care overrode the need for disclosure. *Id. See also* Gillman v. United States, 53 F.R.D. 316 (S.D.N.Y. 1971).

36. 1961 Ill. Laws 3721-22. The law provided that:

> All information, interviews, reports, statements, memoranda or other data of . . . in-hospital staff committees of accredited hospitals, but not the original medical records pertaining to the patient, used in the course of medical study for the purpose of reducing morbidity or mortality shall be strictly confidential and shall be used only for medical research.
>
> Such information, records, reports, statements, notes, memoranda, or other data, shall not be admissible as evidence in any action of any kind . . . .

1961 Ill. Laws 3721.

37. ILL. REV. STAT. ch. 110, paras. 8-2101 to 8-2105 (1987).

38. HOUSE FLOOR DEBATE, 82d Ill. Gen. Assem. (May 17, 1981).

39. *Id.*

40. For instance, the internal quality control activities of hospitals were brought within the scope of the act in 1976. P.A. No. 79-1434, § 4.

41. ILL. REV. STAT. ch. 51, para. 101 (1979).

42. 91 Ill. App. 3d 310, 414 N.E.2d 850 (5th Dist. 1981); HOUSE FLOOR DEBATE, 82d Ill. Gen. Assem. (May 17, 1981). In *Walker*, the plaintiff filed a malpractice suit and requested the defendant hospital to answer interrogatories regarding the review of the plaintiff's treatment. The requested records included the identities of participants, the substance of their discussions, and the results of the proceeding. *Walker*, 91 Ill. App. 3d at 311, 414 N.E.2d at 851. The court ordered disclosure, reasoning that the potential inadmissibility of the records did not prohibit discovery. *Id.* at 314, 414 N.E.2d at 852. *But see* Mennes v. South Chicago Community Hosp., 100 Ill. App. 3d 1029, 427 N.E.2d 952 (1st Dist. 1981). In *Mennes*, the court, interpreting the same statute, reached a different result. The court noted that the Act protected material used for internal quality control or determination of staff privileges. *Id.* at 1032-33, 427 N.E.2d at 953. The court therefore denied the plaintiff's requests for all of the defendant hospital's information regarding the allegedly negligent staff appointment of two physicians. *Id.* In denying discovery, the court reasoned that "if all staff appointment material could be obtained and used against the hospital whenever a plaintiff urged a negligent staff appointment

> All information, interviews, reports, statements, memoranda or other data of . . . allied medical societies, . . . or committees of licensed or accredited hospitals or their medical staffs, including Patient Care Audit Committees, Medical Care Evaluation Committees, Utilization Review Committees, Credential Committees and Executive Committees, (but not the medical records pertaining to the patient), used in the course of internal quality control or of medical study for the purpose of reducing morbidity or mortality, or for improving patient care, shall be privileged, strictly confidential and shall be used only for medical research, the evaluation and improvement of quality care, or granting, limiting or revoking staff privileges . . . .[43]

The Act, by its terms, protects the records of state and municipal health departments, health maintenance organizations, and review committees of licensed or accredited hospitals.[44] The privileged records include those used in internal quality control or to reduce incidence of death or disease;[45] however, it has been left to the courts to determine whether a specific reviewing committee or a particular record is covered by the Act.

B. Illinois Courts' Interpretation of the Act

The Illinois Supreme Court, ruling on the constitutionality of the amended Act in *Jenkins v. Wu*,[46] found that the Act is rationally related to the state's interest in improving the quality of health care through the peer review process and, therefore, does not vio-

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theory, the statutory goal of candid commentary would be compromised." *Id.* at 1031, 427 N.E.2d at 953.

43. ILL. REV. STAT. ch. 110, para. 8-2101 (1987).

44. *Id.*

45. *Id.* The statutes of most other states similarly are interpreted as intending to improve medical care, to reduce disease and death, and to promote medical research. *See* McCann, *supra* note 35, at 5-9. The underlying rationale of a privilege is that it will encourage candid evaluation of medical care by allowing physicians to serve on review boards without fear of reprisal.

The scope of the peer review privilege varies from state to state and may be limited to reviewing bodies which have a certain number of licensed practitioners, or which perform specific activities. *See, e.g.*, COLO. REV. STAT. § 12-43.5-102 (1973 & Supp. 1984); IND. CODE ANN. § 34-4-12.6-2 (West 1983 & Supp. 1988); KAN. STAT. ANN. § 65-4915 (1985); MO. ANN. STAT. § 537.035 (Vernon Supp. 1985); N.Y. EDUC. LAW § 6527 (McKinney 1989). The extent of the privilege varies as well; some statutes prohibit discovery altogether, while others permit disclosure upon a showing of extraordinary necessity. *See, e.g.*, D.C. CODE ANN. § 32-505 (1981); FLA. STAT. ANN. § 768.40 (West Supp. 1984); NEB. REV. STAT. § 49.265 (1981); N.C. GEN. STAT. § 131E-95 (Supp. 1985); PA. STAT. ANN. tit. 63, § 425.4 (Purdon Supp. 1984-85); VA. CODE ANN. § 8.01-581.17 (1984).

46. 102 Ill. 2d 468, 468 N.E.2d 1162 (1984).

late equal protection.[47] In *Jenkins*, which involved a malpractice suit against a physician, the plaintiff requested the personnel file of the physician, committee reports regarding the quality of care provided by him, and a general search of hospital files, including review committee reports.[48] The court upheld the trial court's decision to quash discovery of the records,[49] acknowledging not only the importance of internal review to the quality of care, but also the need for a privilege protecting review activities.[50]

One year after *Jenkins*, the Illinois Supreme Court in *Niven v. Siqueira*[51] expanded the scope of the Act to cover any legitimate medical society's studies and programs, so long as they are intended to improve hospital conditions and patient care, and to reduce death and disease rates.[52] In *Niven*, the plaintiff brought a malpractice action against his physician, claiming that several operations were performed negligently. The plaintiff further alleged that the co-defendant hospital was negligent in granting the physician staff privileges.[53] During discovery, the plaintiff requested documents from the JCAH relating to the hospital's accreditation.[54] The court quashed discovery of the JCAH evaluation, ruling that the JCAH fell within the meaning of "allied medical society" and, therefore, was a privileged entity under the Act.[55] The court concluded that the JCAH materials, used as part of a program to improve the quality of health care, were protected by

47. *Id.* at 482, 468 N.E.2d at 1169. Although peer review records are not discoverable in malpractice actions, the privilege is inapplicable to requests made by a physician contesting a committee's decision. *See* Matviuw v. Johnson, 70 Ill. App. 3d 481, 388 N.E.2d 795 (1st Dist. 1979). In *Matviuw*, the plaintiff physician's cause of action for defamation was based on statements allegedly made during a peer review proceeding. The court allowed disclosure of the statements, reasoning that the Act does not provide an absolute privilege which would have foreclosed the plaintiff's civil action entirely. *Id.* at 487, 388 N.E.2d at 798-99.

48. *Jenkins*, 102 Ill. 2d at 473, 468 N.E.2d at 1165.

49. *Id.* at 482, 468 N.E.2d at 1169.

50. *Id.* at 479-80, 468 N.E.2d at 1168. The court stated that the purpose of the Act is:

> To ensure the effectiveness of professional self-evaluation, by members of the medical profession, in the interest of improving the quality of health care. The Act is premised on the belief that, absent the statutory peer-review privilege, physicians would be reluctant to sit on peer-review committees and engage in frank evaluations of their colleagues.

Id. at 480, 468 N.E.2d at 1168.

51. 109 Ill. 2d 357, 487 N.E.2d 937 (1985).

52. *Id.* at 366, 487 N.E.2d at 942.

53. *Id.* at 361, 487 N.E.2d at 939.

54. *Id.* at 361-62, 487 N.E.2d at 940.

55. *Id.* at 366-67, 487 N.E.2d at 942.

the Act.[56]

The court thus extended the privilege to groups not specifically named or described in the statute, but whose activities and purposes were of the evaluative nature contemplated by the legislature in granting the privilege.[57] The court, however, observed that the question of whether particular materials are within the scope of the Act is a question of fact, which can be determined through an evidentiary hearing concerning the contested records.[58]

An appellate court in *Sakosko v. Memorial Hospital*[59] further expanded the privilege applicable to hospital records. The court concluded that although the information collected by a hospital infection committee was not used exclusively for internal quality control, medical study, or improving patient care, it was still privileged.[60] In *Sakosko*, the plaintiffs alleged that because of the hospital's negligence, they contracted infections following surgery.[61] During discovery, the plaintiffs requested pathology reports of tests performed to determine the source of their infections and a report by a consulting infection expert.[62] The tests and reports had been ordered by the hospital's environmental services committee, whose function was to evaluate and control infection.[63] The court ruled that because the infection committee was established to maintain the level of quality and to improve patient care,[64] its records and reports regarding the plaintiffs' infections were protected by the Act.[65]

Thus, Illinois courts have acknowledged the need for confidentiality in quality control and peer review activities. Courts have quashed attempts to discover hospital evaluations,[66] credentialing

56. *Id.* at 367, 487 N.E.2d at 942. JCAH policy requires that all information regarding the accreditation process, including results and recommendations, be released only to the hospital unless hospital conditions pose a threat to public safety. JCAH Manual, *supra* note 15, at xxiii.

57. *Niven*, 109 Ill. 2d at 367, 487 N.E.2d at 942.

58. *Id.* at 368, 487 N.E.2d at 943.

59. 167 Ill. App. 3d 842, 522 N.E.2d 273 (5th Dist. 1988).

60. *Id.* at 845, 522 N.E.2d at 275.

61. *Id.* at 843-44, 522 N.E.2d at 274.

62. *Id.* at 844, 522 N.E.2d at 275.

63. *Id.* at 844-45, 522 N.E.2d at 275.

64. *Id.*

65. *Id.* at 845, 522 N.E.2d at 276. The court also noted that the hospital's later disclosure of the records to its risk manager did not constitute a waiver of the privilege. *Id.*

66. Niven v. Siqueira, 109 Ill. 2d 357, 366, 487 N.E.2d 937, 942 (1985); *Sakosko*, 167 Ill. App. 3d at 846, 522 N.E.2d at 276.

records,[67] and retrospective review of the care rendered by a physician.[68] The privilege, however, is not absolute. Recently, the courts have begun to carve away at the broad interpretations and applications of the Act.

IV. EXCEPTIONS TO THE PRIVILEGE

The Act itself provides certain exceptions to the general privilege covering peer review activities.[69] The Act, however, is silent as to the extent of the privilege in a negligence suit.[70] In an effort to facilitate discovery, Illinois courts have begun to carve out exceptions to the broad grant of privilege conferred by the Act.

In *Gleason v. St. Elizabeth Medical Center*,[71] an Illinois appellate court held that the *results* of a peer review proceeding were outside the scope of the privilege.[72] The plaintiff, alleging negligent supervision of her treating physician, served interrogatories requesting the defendant hospital to disclose the actions it took to supervise or restrict the co-defendant physician's staff privileges.[73] Because the statute, by its express terms, protects only "information, interviews, reports, statements, memoranda, or other data," the court ordered the hospital to answer the interrogatories and to disclose the names of persons who provided information regarding the doctor prior to his appointment.[74] Although the court acknowledged that the statutory goal, as determined in *Jenkins v. Wu*,[75] was to improve the quality of care by encouraging candid self-evaluation, the court limited the privilege, stating:

> While virtually every action of a doctor or hospital could, in some sense, arguably be connected to something that was said,

67. Mennes v. South Chicago Community Hosp., 100 Ill. App. 3d 1029, 1032, 427 N.E.2d 952, 953 (1st Dist. 1981).

68. Jenkins v. Wu, 102 Ill. 2d 468, 482, 468 N.E.2d 1162, 1169 (1984).

69. The statute allows disclosure of peer review records in a suit brought by the physician under review which challenges an adverse decision regarding staff privileges or alleging bad faith or malice on the part of the reviewing committee. *See* ILL. REV. STAT. ch. 110, para. 8-2101 (1987).

70. In *Jenkins*, the Illinois Supreme Court upheld the exception for the physician under review, holding that it does not deny equal protection to the malpractice plaintiff. *Jenkins*, 102 Ill. 2d at 482, 468 N.E.2d at 1169. The court, however, did not reach the issue of the extent of the privilege in malpractice suits beyond acknowledging the patient's access to her own records. *Id.* at 479, 468 N.E.2d at 1168.

71. 135 Ill. App. 3d 92, 481 N.E.2d 780 (5th Dist. 1985).

72. *Id.* at 95, 481 N.E.2d at 781.

73. *Id.*

74. *Id.*

75. 102 Ill. 2d 468, 468 N.E.2d 1162 (1984). For a further discussion of *Jenkins*, see *supra* notes 46-50 and accompanying text.

> done, or recorded at a peer review session, the statute evinces a legislative intent to shield the review process itself, and not actions later taken in consequence of that process.[76]

In *Richter v. Diamond*,[77] the Illinois Supreme Court confirmed the *Gleason* interpretation, holding that results of a peer review proceeding were outside the scope of the Act.[78] In *Richter*, the plaintiff brought a malpractice action against her physicians and a claim against the hospital, alleging negligent supervision of the medical staff.[79] The plaintiff served interrogatories on the hospital, requesting information concerning restrictions on the defendant physician's staff appointment.[80] The court ordered the hospital to answer the interrogatories, reasoning that the policy underlying the statutory privilege — the promotion of candid review — applied only to the credentialing proceedings themselves.[81] The court further noted that disclosure of the results of peer review would not inhibit the candor intended by the legislature.[82]

Likewise, because disclosure would not impair open discussion during review, Illinois courts allow discovery of information from an independent source, originating outside the peer review proceeding. In *Jenkins*, the court conceded that although a review board's records concerning the defendant physician are privileged, the Act provides the plaintiff with full access to her own records and also that she can depose persons involved in her treatment.[83] Similarly, the *Gleason* court held that the defendant hospital must disclose the identities of persons who provided information relating

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76. *Gleason*, 135 Ill. App. 3d at 95, 481 N.E.2d at 781. Although the Act is silent, several states expressly provide for disclosure of the results of a review proceeding. *See, e.g.*, ARIZ. REV. STAT. ANN. § 36-445.01 (1986) (in a case brought against a hospital for failure to do adequate review, a hospital representative may testify as to whether there was review of the subject matter of the suit); IND. CODE ANN. § 34-4-12.6-2 (West 1983 & Supp. 1988) (hospital administration may disclose action taken concerning a staff physician); IDAHO CODE § 39-1392e (1985) (plaintiff may discover whether an inquiry was conducted and whether any action will be taken).

77. 108 Ill. 2d 265, 483 N.E.2d 1256 (1985).

78. *Id.* at 270, 483 N.E.2d at 1258.

79. *Id.* at 266, 483 N.E.2d at 1256.

80. *Id.* at 267, 483 N.E.2d at 1257.

81. *Id.* at 270, 483 N.E.2d at 1258.

82. *Id.* at 269, 483 N.E.2d at 1258. The court also distinguished the situation from that in Mennes v. South Chicago Community Hosp., 100 Ill. App. 3d 1029, 427 N.E.2d 952 (1st Dist. 1981). In *Mennes*, the information requested (*all* material regarding staff privileges) clearly included privileged information; accordingly, discovery was denied. *Id.* at 1031, 427 N.E.2d at 953.

83. *Jenkins*, 102 Ill. 2d at 479, 468 N.E.2d at 1168. *See also* Sanderson v. Frank S. Bryan M.D, Ltd., 361 Pa. Super. 491, 522 A.2d 1138 (1987) (court denied discovery of peer review records, reasoning that the plaintiff would have access to his own records and to persons with first-hand knowledge of his treatment).

to the physician *before* staff privileges were granted.[84] Thus, merely introducing independent information in a review proceeding does not render the information privileged.[85]

More recently, in *Willing v. St. Joseph Hospital*,[86] an Illinois appellate court held that a physician's application material and the modification of his staff privileges fall outside the protection of the Act.[87] In *Willing*, the plaintiff brought a malpractice suit, alleging that the defendant hospital negligently granted surgical privileges to the co-defendant physician.[88] During discovery, the plaintiff requested information concerning the extent of the physician's staff privileges.[89] The plaintiff also served subpoenas on five non-party hospitals, requesting production of all credentials files and appointment materials maintained on the physician.[90]

The court ordered the non-party hospitals to produce the physician's application materials[91] and to disclose any modification of his staff privileges.[92] The court determined that the physician had voluntarily submitted the application materials to the credentials committees and that the application did not originate in a peer review proceeding. Therefore, the court concluded that disclosure would not breach the confidentiality of the proceedings themselves or hinder the effective self-evaluation contemplated by the legislature.[93] The court, following the *Niven* standard, concluded that

84. *Gleason*, 135 Ill. App. 3d at 95, 481 N.E.2d at 781.

85. Generally, statutes which provide for disclosure of information from an independent source explain that information otherwise obtainable is not privileged merely because it was introduced in peer review proceedings. Independent sources may testify as to matters within their knowledge, but not regarding their testimony before a review committee. *See, e.g.*, FLA. STAT. ANN. § 768.40 (West 1986); GA. CODE ANN. §§ 84-7604, 88-3204 (Supp. 1984); IND. CODE ANN. § 34-4-12.6-2 (West 1983 & Supp. 1988); IOWA CODE ANN. § 147.135 (West 1972); KY. REV. STAT. ANN. § 311.377 (Michie/Bobbs-Merrill 1983); N.C. GEN. STAT. § 131E-95 (Supp. 1985); OHIO REV. CODE ANN. § 2305.24 (Anderson 1983); PA. STAT. ANN. tit. 63, § 425.4 (Purdon Supp. 1984); WIS. STAT. ANN. § 146.38 (West Supp. 1988). *See also* Hallowell v. Jove, 247 Ga. 678, 279 S.E.2d 430 (1981) (information from an independent source is not subject to the privilege by virtue of its introduction in a peer review meeting); Byork v. Carmer, 109 A.D.2d 1087, 487 N.Y.S.2d 226 (1985) (defendant hospital must disclose information regarding previous negligent actions of the physician because there are other ways the hospital could have learned of the negligence outside of a peer review proceeding).

86. 176 Ill. App. 3d 737, 531 N.E.2d 824 (1st Dist. 1988).

87. *Id.* at 744, 531 N.E.2d at 828.

88. *Id.* at 739, 531 N.E.2d at 825.

89. *Id.* at 739, 531 N.E.2d at 826.

90. *Id.* at 740, 531 N.E.2d at 826.

91. *Id.* The requested materials included previous evaluations, recommendations, and transcripts. *Id.*

92. *Id.*

93. *Id.* at 743-44, 531 N.E.2d at 828. The defendant hospital also contended that

the applicability of the privilege to a contested record was to be decided through *in camera* examination, thus allowing the court to determine whether continued confidentiality of the record was necessary.[94]

Finally, in *Marsh v. Lake Forest Hospital*,[95] an Illinois appellate court concluded that certain tests initiated by the defendant hospital's administration for internal quality control were outside the scope of the Act.[96] After the death of his wife in the hospital, the plaintiff brought a malpractice suit. During discovery, the plaintiff's attorney learned that the decedent's medical records had been altered at some time after her death.[97] Furthermore, the hospital had ordered polygraph tests to determine whether any of the nurses who attended the patient were responsible for the alteration.[98]

The hospital argued that the polygraph tests had been initiated for the purpose of internal quality control and to improve patient care, and thus were privileged. The court rejected this contention, stating that "[t]he purpose of the Act is not to shield hospitals from potential liability. The problem of finding doctors to serve on peer-review committees, noted in *Jenkins*, is not present where the investigation is undertaken by the hospital administration."[99] Although conceding that the hospital did have an interest in discovering whether nurses had changed patient records, the court pointed out that nurses, unlike doctors, are not appointed to or removed from staff positions through a peer review process.[100] The court held that the records were not privileged under the Act, reasoning that the polygraph tests were unrelated to the peer review process and that withholding the results did not further the legisla-

records of restrictions placed on the physician's staff privileges following the alleged malpractice constituted evidence of subsequent remedial measures and, therefore, were inadmissible at trial to show negligence. *Id.* at 744, 531 N.E.2d at 829. The court agreed, but observed that inadmissibility of evidence at trial did not necessarily preclude discovery of the materials. *Id.*

94. *Id.*

95. 166 Ill. App. 3d 70, 519 N.E.2d 504 (2d Dist.), *appeal denied*, 121 Ill. 2d 571, 526 N.E.2d 832 (1988).

96. *Id.* at 76, 519 N.E.2d at 508-09. Most states do not extend the privilege to hospital administration records. *See* Humana Hosp. Desert Valley v. Superior Court, 154 Ariz. 396, 742 P.2d 1352 (1987); Matchett v. Superior Court, 40 Cal. App. 3d 623, 115 Cal. Rptr. 317 (1974); Anderson v. Breda, 103 Wash. 2d 901, 700 P.2d 737 (1985). Other jurisdictions have ordered disclosure of board of trustees records. *See* Shelton v. Morehead Memorial Hosp., 318 N.C. 76, 347 S.E.2d 824 (1986).

97. *Marsh*, 166 Ill. App. 3d at 72, 519 N.E.2d at 506.

98. *Id.*

99. *Id.* at 76, 519 N.E.2d at 508-09.

100. *Id.*

tive purpose of encouraging physician participation on review boards.[101]

Illinois courts, therefore, have carved out exceptions to the privilege granted by the legislature. Concluding that disclosure would not hinder the self-evaluation process, courts have ordered discovery of the results of peer review proceedings,[102] information from independent sources,[103] staff appointment application materials,[104] and the results of internal hospital investigations.[105] Only one exception to the privilege, allowing disclosure of records pertaining to the patient's treatment, is expressly authorized by the Act. The remainder have been created by judicial interpretation of the intent of the legislature in codifying the privilege.

V. APPLICATIONS OF THE MEDICAL STUDIES ACT TO HOSPITAL RECORDS

The more restrictive readings of the Medical Studies Act, such as that in *Marsh v. Lake Forest Hospital*, represent a departure from the legislative purpose underlying the Act. In addition, the judicial exceptions to the statutory privilege have emphasized the protection of the physician, rather than the hospital.[106] For example, the privilege granted to the credentialing process has remained fairly intact; for the most part, only the consequences of a credentialing committee's decision are subject to discovery.[107] The credentialing committee, as well as other physician review boards, is clearly identified as a protected entity in the Act,[108] and its activ-

101. *Id.* at 76, 519 N.E.2d at 508. *But see* Andrews v. Eli Lilly & Co., 97 F.R.D. 494, 500 (N.D. Ill. 1983). The *Andrews* court rejected the contention that the Medical Studies Act was applicable only to physician peer review; while assuring confidentiality of the review process was one purpose of the statute, there was no statutory or judicial requirement that the privilege protect only material relating to peer review. *Id.*

102. *Richter*, 108 Ill. 2d at 270, 483 N.E.2d at 1258; Gleason v. St. Elizabeth Medical Center, 135 Ill. App. 3d 92, 95, 481 N.E.2d 780, 781 (5th Dist. 1985).

103. *Gleason*, 135 Ill. App. 3d at 95, 481 N.E.2d at 781.

104. *Willing*, 176 Ill. App. 3d at 744, 531 N.E.2d at 828.

105. *Marsh*, 166 Ill. App. 3d at 72, 519 N.E.2d at 506.

106. *See supra* notes 69-105 and accompanying text.

107. *See* Richter v. Diamond, 108 Ill. 2d 265, 483 N.E.2d 1256 (1985). *Accord* Brown v. Superior Court, 168 Cal. App. 3d 489, 214 Cal. Rptr. 266 (1985). In *Brown*, the court observed that disclosure of the fact of evaluation could be to the advantage of the defendant hospital in a negligent supervision suit. While not inhibiting candor in the peer review proceedings themselves, revealing that the physician was evaluated before appointment could show that the hospital took reasonable care in the selection of staff physicians. *Id.* at 501, 214 Cal. Rptr. at 274.

108. ILL. REV. STAT. ch. 110, para. 8-2101 (1987). The statute specifically mentions patient audit, medical care, utilization, credentialing, and executive committees.

ities are relatively regular.[109]

On the other hand, the Act only vaguely defines the privilege applicable to hospital records, aside from those generated by physician peer review boards.[110] Although the credentialing process is fairly uniform and recognizable, a hospital study may take one of several forms — from the JCAH evaluation in *Niven v. Siqueira*[111] to the polygraph tests in *Marsh* or the pathology review in *Sakosko v. Memorial Hospital*.[112] The *Marsh* court observed that "the purpose of the Act is not to shield the hospital from liability."[113] In creating the privilege, however, the Illinois Legislature envisioned protection for both physician peer review and hospital quality control committees as a means to achieving improved medical care.[114] As the supreme court recognized in *Jenkins v. Wu*, the intention is to encourage health care providers to undertake self-evaluation and studies without the fear of incurring liability as a result.[115] Although the shortage of physicians willing to participate on peer review committees may have precipitated enactment of the statutory privilege,[116] the Act was drafted and amended to include hospitals and other medical bodies. The legislature recognized that more than a physician peer review privilege was necessary to improve the quality and reduce the cost of health care.[117] This intent underlying the Act generally has guided the Illinois courts in determining whether particular records or information fall within its

109. The JCAH considers regular meetings of medical review committees a key factor in its determination of accreditation. JCAH Manual, *supra* note 15, at 116.

110. ILL. REV. STAT. ch. 110, para. 8-2101 (1987). The statute protects records of "committees of licensed or accredited hospitals or their medical staffs . . . used in the course of internal quality control or of medical study for the purpose of reducing morbidity or mortality, or for improving patient care." *Id. Contra* MASS. GEN. LAWS ANN. ch. 111, § 205 (West 1985) (records of hospital risk management and quality assurance programs are expressly granted the privilege accorded to medical peer review committees).

111. 109 Ill. 2d 357, 487 N.E.2d 937 (1985).

112. 167 Ill. App. 3d 842, 522 N.E.2d 273 (5th Dist. 1988).

113. *Marsh*, 166 Ill. App. 3d at 76, 519 N.E.2d at 508.

114. Jenkins v. Wu, 102 Ill. 2d 468, 482, 468 N.E.2d 1162, 1169 (1984). The court stated:

> [The legislature] wanted to give protection to the various health providers in the state with the focus upon the medical profession and doctors. And also, to better supervise the health providers in a hope that we could increase or improve not only the quality of care, but lower the cost of medical health care in the state.

Id. (quoting HOUSE FLOOR DEBATE, 79th Ill. Gen. Assem. (June 11, 1976)). The Act was amended at that time to include hospital quality control procedures, in addition to reports of peer review committees and health departments.

115. *Jenkins*, 102 Ill. 2d at 480, 468 N.E.2d at 1168.

116. *Id.*

117. *Id.* at 482, 468 N.E.2d at 1168.

protection.[118] In *Jenkins*, the supreme court concluded that the Act's purpose is "to ensure the effectiveness of self-evaluation, by members of the medical profession, in the interest of improving the quality of health care."[119]

While the facts of *Jenkins* concern the peer review evaluation of a particular physician,[120] the Act extends the privilege to committees that monitor the quality of care provided by the hospital, as well as those established to grant, limit, or revoke staff appointments.[121] Because of the infection committee's purpose of quality control, the court in *Sakosko* conferred a broad privilege upon its findings and records.[122] This construction of the privilege follows the *Niven* court's protection of candid and voluntary studies to improve hospital conditions. It seems, however, to conflict with a limitation imposed by the Act itself: that the privilege not extend to the patient's own records.[123] The *Sakosko* court reasoned that the plaintiffs' causes of action did not depend on the privileged information. Even though the information regarding the plaintiffs' infections was not the basis of the litigation, the explicit statutory exception for a patient's own records was applicable.[124]

VI. IMPACT

The conflicting decisions of *Sakosko* and *Marsh* illustrate the extremes in construing the Act. Both interpretations, however, lose sight of not only the legislative intent underlying the privilege, but also the express provisions of the statute itself. The broad privilege granted by the court in *Sakosko* potentially disregards the exception allowing the patient access to her own records. The *Marsh* court's reading of the Act, restricting the purpose of the privilege

118. *See supra* notes 46-68 and accompanying text.

119. *Jenkins*, 102 Ill. 2d at 480, 468 N.E.2d at 1168.

120. *Id.*

121. ILL. REV. STAT. ch. 110, para. 8-2101 (1987). The statute protects information "used in the course of internal quality control or of medical study for the purpose of reducing morbidity or mortality, or for improving patient care." *See* Niven v. Siqueira, 109 Ill. 2d 357, 487 N.E.2d 937 (1985).

122. *Sakosko*, 167 Ill. App. 3d at 845, 522 N.E.2d at 275. The court, in fact, noted that the legislature has repeatedly amended the Medical Studies Act and expanded the privilege with each amendment. *Id.*

123. In *Jenkins*, the court conceded that the Act allows discovery of the plaintiff's own medical records; this exception preserved the plaintiff's ability to effectively maintain a cause of action. *Jenkins*, 102 Ill. 2d at 480, 468 N.E.2d at 1168.

124. *See id.* Moreover, the statute, as originally drafted, provided for disclosure of only the "original medical records pertaining to the patient." The word "original" was deleted by amendment in 1981.

to "finding doctors to serve on peer review committees,"[125] renders much of the statute meaningless. It ignores the provisions in the statute protecting information relating to medical research or study, and records of privileged entities such as departments of health or medical societies, that do not use the peer review process.[126] The *Marsh* court noted that the legislative purpose of the Act was absent in investigations undertaken by the hospital administration.[127] Following that analysis, any hospital quality control proceeding, therefore, could fall outside the scope of the privilege.[128] The net effect of decisions such as *Marsh* is to expose a hospital to liability in situations where a physician would be protected. The narrow construction applied in *Marsh* could not only deter hospitals from voluntarily instituting quality control programs,[129] but also create a chilling effect on valuable research intended to improve public health.[130]

Perhaps the best solution, short of amending the Act to define more precisely the boundaries of the privilege, is to follow the standard articulated in *Niven*: extend the privilege to voluntary studies and programs undertaken by the hospital to improve the conditions and the quality of care it provides.[131] Such a guideline encompasses both physician peer review and the hospital's internal quality control, and minimizes the inconsistency of application in the retrospective review situation.

Furthermore, the privilege would not necessarily insulate the hospital from liability or destroy a malpractice plaintiff's case.[132] The *Niven* court acknowledged that although the existence of a privilege is a matter of law, the applicability of the privilege to particular records was an issue of fact to be resolved through an evi-

125. Marsh v. Lake Forest Hosp., 166 Ill. App. 3d 70, 76, 519 N.E.2d 504, 508-09 (2d Dist. 1988).

126. ILL. REV. STAT. ch. 110, para. 8-2101 (1987). *See also* Andrews v. Eli Lilly & Co., 97 F.R.D. 494, 500 (N.D. Ill. 1983). The *Andrews* court noted that the Medical Studies Act was not limited to physician peer review, but extended the privilege to medical research records as well. *Id.*

127. *Marsh*, 166 Ill. App. 3d at 76, 519 N.E.2d at 508-09.

128. *See generally* JCAH Manual, *supra* note 15. JCAH standards indicate that maintaining the quality of care is within the duties of the governing body of the hospital. *Id.* at 49. Moreover, findings of quality assurance investigations are a factor in peer review activities such as the reappointment of staff physicians. *Id.* at 217.

129. *See* Niven v. Siqueira, 109 Ill. 2d 357, 366, 487 N.E.2d 937, 942 (1985).

130. *See Andrews*, 97 F.R.D. at 500 (disclosure of research data would cause sources of information to dry up).

131. *Niven*, 109 Ill. 2d at 366, 487 N.E.2d at 942.

132. *See Jenkins*, 102 Ill. 2d at 479, 468 N.E.2d at 1168.

dentiary hearing.[133] An *in camera* inspection, viewing contested records in light of the legislative goal, also would allow the court to determine whether confidentiality is essential to preserve the integrity of the hospital quality control study.[134] Protecting only that information requiring confidentiality would avoid the sweeping privilege granted in *Sakosko*. Acknowledging the hospital's motive to improve the care it provides would prevent the restricted privilege recognized in *Marsh*. If necessary, the court may redact undiscoverable information or material that would jeopardize the purposes of the research.[135]

Even if discovery of hospital records is quashed, the plaintiff's case need not suffer. Patients may, by the terms of the Act, obtain those records pertaining to their own treatment,[136] or may discover information from those who participated in the treatment. They may retain experts to evaluate the care rendered by the hospital.[137] In negligent supervision actions, plaintiffs may discover what actions were taken by the peer review committee. Moreover, plaintiffs may discover the identities of persons who provided information to the review board prior to the physician's appointment[138] to determine whether the hospital exercised care in granting staff privileges to the physician.

VII. CONCLUSION

The legislature, in passing the Medical Studies Act, intended to promote self-evaluation by health care providers by protecting the review process from discovery in negligence actions. Illinois courts

133. *Niven*, 109 Ill. 2d at 368, 487 N.E.2d at 943. *See also* Walker v. Alton Memorial Hosp., 91 Ill. App. 3d 310, 414 N.E.2d 850 (5th Dist. 1981), discussed *supra* at note 42 and accompanying text. In *Walker*, the court determined that *in camera* inspection of disputed records would preserve the confidentiality of materials subject to the privilege. *Id.* at 314, 414 N.E.2d at 852.

134. *See* Mennes v. South Chicago Community Hosp., 100 Ill. App. 3d 1029, 427 N.E.2d 952 (1st Dist. 1981). The court held that because the material requested was clearly within the scope of the Medical Studies Act, an *in camera* inspection was not necessary to determine the discoverability of the records. *Id.* at 1032, 427 N.E.2d at 953.

135. The court in *Sakosko* did examine the requested documents *in camera*; however, the court held all information contained in the reports to be privileged, rather than redacting records of patients other than the plaintiffs. *Sakosko*, 167 Ill. App. 3d at 844, 846, 522 N.E.2d at 274, 276. While the *Marsh* court noted the availability of *in camera* inspection, there is no indication that the polygraph results were examined in any way. Marsh v. Lake Forest Hosp., 166 Ill. App. 3d 70, 75, 519 N.E.2d 504, 508 (2d Dist.), *appeal denied*, 121 Ill. 2d 571, 526 N.E.2d 832 (1988).

136. ILL. REV. STAT. ch. 110, para. 8-2101 (1987).

137. *Jenkins*, 102 Ill. 2d at 479, 468 N.E.2d at 1168.

138. Gleason v. St. Elizabeth Medical Center, 135 Ill. App. 3d 92, 95, 481 N.E.2d 780, 781 (5th Dist. 1985).

have since carved out exceptions to the privilege in an effort to balance the legislative goal of improved health care with the judicial goal of liberal discovery. These exceptions have preserved the privilege of physician peer review proceedings and records. The privilege, however, has been applied inconsistently to hospital records and quality control studies. Although the disclosure of such records may not necessarily expose the hospital to malpractice or negligent supervision suits, the enhanced potential for liability may create a chilling effect on research or evaluation programs which depend on candor for effectiveness. Uncertainty as to the scope of the privilege conferred by the Act might well deter a hospital from initiating the kind of evaluation that the statute was intended to promote.

The Illinois Legislature intended to encourage voluntary studies as well as peer review — although not at the expense of a patient's cause of action. More vigorous *in camera* inspection of the requested records would serve two interests: (1) that of advancing the quality of health care; and (2) that of recognizing the plaintiff's need for pertinent information. By reviewing and, if appropriate, redacting disputed material, the court could preserve the integrity of the hospital studies and allow disclosure of information to which confidentiality is not essential. Until a uniform privilege is established, hospitals may approach internal quality control with the same caution as if there were no privilege at all.

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