



Scottish Information
Commissioner

**Decision 066/2005 – Mr Peter MacMahon of The Scotsman
and the Common Services Agency for the Scottish Health
Service**

Surgical mortality rates

Applicant: Peter MacMahon

**Authority: Common Services Agency for the Scottish
Health Service**

Case No: 200501123

Decision Date: 8 December 2005

**Kevin Dunion
Scottish Information Commissioner**

Kinburn Castle
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Decision 066/2005 – Mr Peter MacMahon of The Scotsman and the Common Services Agency for the Scottish Health Service

Request for mortality rates of surgeons – information withheld by the Common Services Agency for the Scottish Health Service on the basis of section 38(1)(b) and section 30(b)(i), (b)(ii) and (c) of the Freedom of Information (Scotland) Act 2002 (FOISA) – Commissioner found that decision to withhold the information breached Part 1 of FOISA

Facts

On 8 February 2005, Mr MacMahon of The Scotsman requested the Common Services Agency for the Scottish Health Service (CSA) to provide him with a complete list of clinical outcomes (mortality rates) of all surgeons, including the name of each surgeon in each clinical speciality which the CSA could offer.

The CSA refused to release this information on the grounds that:

- it is personal information and thus exempt in terms of section 38 of the Freedom of Information (Scotland) Act 2002 (FOISA) and
- the information is exempt under section 30 of FOISA (effective conduct of public affairs).

The CSA also maintained that it did not routinely analyse the data to provide all the information that Mr MacMahon had requested.

Outcome

The Commissioner found that the CSA had failed to comply with Part 1 of FOISA in refusing to disclose the information to Mr MacMahon. The Commissioner found that although the information was personal data, the release of the information would not breach any of the data protection principles. As a result, the information was not exempt under section 38(1)(b) of FOISA.

The Commissioner also found that the release of the information would not prejudice substantially the effective conduct of public affairs and that, accordingly, the information was not exempt under section 30(b)(i), 30(b)(ii) or 30(c) of FOISA.



The Commissioner ordered the release of the information.

Appeal

Should either the CSA or The Scotsman wish to appeal against this decision, there is an appeal to the Court of Session on a point of law only. Any such appeal must be made within 42 days of receipt of this notice.

Background

1. On 8 February 2005, Mr Peter MacMahon of The Scotsman requested information relating to the mortality rates of all surgeons from the CSA. Mr MacMahon requested the names of the surgeons and their mortality rates in each clinical speciality. Mr MacMahon pointed out that some hospitals and health authorities in England had published “risk-stratified” mortality rates and pointed out that the CSA may wish to adjust its data to take account of the risks involved with individual procedures before its disclosure.
2. On 11 February 2005, the CSA responded, saying that the Information Services Division of the CSA holds NHS data for the whole of Scotland but it does not routinely analyse the available data to provide the information requested by Mr MacMahon. The CSA also stated that it does hold some of the information requested based on the analysis of surgical mortality rates for some specialisms and that in the past it has provided this information to some NHS Boards and to some of the surgeons involved. It also confirmed that the CSA holds copies of some of the information Mr MacMahon had requested but stressed that under FOISA the CSA is obliged to provide copies of information which it holds but that it is not required to carry out new analyses.
3. Nevertheless, the CSA refused to release the information on the grounds that it constituted personal information and was thus exempt under section 38 of the FOISA. The refusal notice emphasised that some of the third parties involved (the clinicians) object to the release of data of this kind requested by Mr MacMahon because the data does not take account of the risk characteristics of individual surgeons’ patients. The CSA were therefore of the opinion that disclosure of such information is likely to be misleading rather than informative and would thus be unfairly detrimental to the clinicians.



4. The CSA also relied on section 30 of the Act and argued that the public interest would not be served by releasing “crude, unadjusted mortality data”.
5. Mr MacMahon was dissatisfied with the decision and, on 16 February 2005, asked the CSA to carry out a review of its decision. Mr MacMahon stated his belief that disclosure of this information is in the public interest. He also accepted that “the issue of risk” is important and offered to look for a way of incorporating the risk element into the published figures [mortality rates].
6. The CSA carried out a review and, in a letter dated 15 March 2005, advised Mr MacMahon that it had upheld its original decision.
7. The review decision recorded Mr MacMahon’s information request as the mortality rates of all surgeons since 2000. This is not entirely accurate as Mr MacMahon had not specified a timeframe for the information he had requested from the CSA.
8. The CSA argued that it does not hold the information to respond adequately to Mr MacMahon’s request and that the data sets that it does hold do not provide a reliable indication of the mortality rates of individual surgeons.
9. According to the CSA, this kind of data is useful to individual surgeons in reviewing their own cases and is available to the Medical Directors who use it during the performance appraisals of consultants. The CSA also argued that the information was not reliable as it had not been adjusted for case-mix. (“Case-mix” is defined in paragraph 29 below.) Quality assurance exercises carried out on the data have shown that the data sometimes contains errors, e.g. the data may be attributed to the wrong surgeon. The CSA stated that publication of such data could have damaging and distressing consequences for the surgeons named in the data.
10. The CSA also stated that it holds better data on certain surgical specialities (such as orthopaedics), than on others. However, the CSA advised me that in these cases data analysis is undertaken at the request of the surgeons involved and is “work in progress”. As a result, according to the CSA, the data held by them cannot be used as a basis for comparing all surgeons in Scotland.



11. The CSA also argued that the information requested contains names of third parties (i.e. surgeons) and is personal data as defined by the Data Protection Act 1998 (DPA). It argued that disclosure of the information would cause inappropriate judgements to be made about the performance of individuals and that the construction of league tables and the subsequent apportionment of blame would cause substantial damage and distress to the surgeons. The CSA believes that the release of the data would not be “fair” on the basis that surgical mortality should not simply be ascribed to individual surgeons. Rather, according to the CSA, surgical mortality is part of a complex process of care which involves the whole hospital system.
12. At review, the CSA also considered the public interest in the release of the information, but without any reference to an exemption in FOISA. (The review made no mention of section 30 which is subject to the public interest test, but mentioned only section 38, Personal Information, the relevant subsection of which is not subject to the public interest test.) The review decision stated that it would be in the public interest to release the information requested by Mr MacMahon if the information would inform members of the public about performance of individual surgeons or surgical units. However, as the information is not complete and comparable information is not available, the CSA believe that the release of the information would not inform the public about the performance of individual surgeons or surgical units. The CSA believe that, for the release of the information to be in the public interest, the information needs to be broken down by surgical procedures and adjusted for case-mix.
13. On 15 March 2005, Mr MacMahon requested further clarification of one specific issue arising from the CSA’s decision. He stated that he was puzzled by the apparent contradiction in the CSA’s decision which, on the one hand, seemed to state that it holds some risk adjusted information used for internal clinical audit and, on the other hand, claimed that it does not hold the information requested.
14. The CSA responded on 17 March 2005 and apologised for giving the impression that it held some risk adjusted data. The CSA confirmed that it has carried out analyses of some data for specific groups of surgeons and therefore holds better surgical data in some areas. This data has been broken down by surgical procedure to allow the surgeons to scrutinise their outcomes, for example, in terms of readmissions. The CSA has fed this information back to the surgical groups and asked them to examine the data to ensure there are no coding errors; and to consider whether the data indicate any need to examine local processes of care.
15. Mr MacMahon remained dissatisfied with this response and, on 22 March 2005, submitted an application to me for a decision. The case was subsequently allocated to an Investigating Officer.



The Investigation

16. Mr MacMahon's application was validated by establishing that he had made a valid information request to a Scottish public authority (the CSA) and that he had appealed to me only after asking the public authority to review its response to his request.
17. On 10 March 2005, I received a similar application for a decision from Mr Fracassini of the Sunday Times, who had also requested the CSA to provide him with the mortality rates of named surgeons. Both Mr MacMahon and Mr Fracassini had requested similar information and had received an almost identical response from the CSA. I therefore considered it appropriate to conjoin the two investigations and advised both the CSA and the applicants of my decision.
18. I invited comments from the CSA as I am required to do under section 49(3)(a) of FOISA and requested copies of the information which had been withheld from Mr MacMahon.
19. The ISD made detailed submissions both in response to my initial request for comments and later during the investigation. In addition, it provided copies of the Confidentiality Rules for ISD Scotland Staff, the ISD Confidentiality Statement and information on Indirect Standardisation. The ISD also provided me with copies of relevant internal correspondence and minutes of meetings. Alongside that I received a submission from the Chief Executive of NHS Quality Improvement Scotland, enclosing Clinical Outcome Indicators reports for 2000, 2002 and 2003 as well as a Health Indicators Report 2004 entitled 'A Focus on Children.'
20. As requested, the CSA supplied me with sample information on surgeons' mortality rates for one NHS Board for one single year period, April 2004 – September 2004. It confirmed that it could provide similar information for all the NHS Boards, if required. This information consists of the names of individual surgeons, their specialism, the hospital they operated in, the episode types and the mortality rates. (A patient coming into a hospital may receive treatment in a number of different wards or specialities. Each of these episodes generates a return to the Scottish Morbidity Record system.)
21. Given that the CSA had made specific reference to the clinical audit conducted by the Scottish Audit of Surgical Mortality (SASM) in its response to Mr MacMahon, I also considered it useful to request specific information and comments from SASM and I received a detailed response, and then further supplementary information, from Professor Graham Teasdale, Chairman of SASM Board.



22. As part of my investigation, I was also interested in learning of the experience elsewhere. I was aware that The Guardian newspaper had, in March 2005, published details of mortality rates for a number of hospitals (including some in Scotland), in respect of surgeons who carry out coronary artery bypass grafts. I therefore wrote to and received information from four hospitals for which mortality data had been provided - North Glasgow University Hospitals, Lothian University Hospitals, University Hospital Birmingham and Bristol Royal Infirmary.
23. I also referred to a number of relevant sources including:
- Ross Coulthart and Princess Alexandra Hospital and Health Service District, Information Commissioner of Queensland – Decision no. 06/2001
 - Birnbauer and Davies v Inner and Eastern Health Care Network, Victorian Civil and Administrative Tribunal 1999
 - The Report of the Bristol Royal Infirmary Inquiry, July 2001
 - NHSScotland Data Quality Assurance Report on Acute Inpatient/Day Case Data 2000-2002 (produced by ISD in January 2004)
 - Statistics Notice 04/4 on Freedom of Information and statistics produced by the Scottish Executive Statistician Group.
 - State of New York Department of State Committee on Open Government Advisory Opinion in the case of Newsday Inc and David Zinman v New York State Department of Health, May 1991
 - Various articles in The Medical Journal of Australia, The Journal of the American Medical Association and The New England Journal of Medicine.
24. In my analysis and findings I do not address explicitly all of the points covered in the material submitted or consulted. However, I am satisfied that I have considered all relevant matters raised with me.

Commissioner's Findings and Analysis

25. In coming to a decision the following are the main considerations:
- Does the CSA hold the information requested?
 - If it is held, is the information personal and would it breach the first data protection principle to release it? If so, the CSA would be entitled to withhold the information under section 38(1)(b) of FOISA, read in conjunction with section 38(2)(a)(i). This is an absolute exemption which does not require the public interest to be taken into consideration.
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- If the information is held and is not exempt under section 38, then would the release prejudice substantially the effective conduct of public affairs? If so, the information would be exempt from release under section 30 of FOISA, but would be subject to the public interest test before it could be withheld.

Does the CSA hold the information requested?

26. In its initial refusal, the CSA stated that it did not hold the information requested by Mr MacMahon, on the basis that FOISA does not oblige public authorities to carry out new analyses of the information it holds in order to produce new information in response to a request.
27. In its review decision, and in subsequent submissions made to my Office, the CSA instead argued that the information it holds is incomplete and does not provide a reliable indication of the mortality rates of individual surgeons. In its submissions during the investigation, the CSA clarified that the information is incomplete because it does not meet the following criteria:
 - the data is not adjusted for case-mix;
 - the data does not include the significant number of cases carried out in the private sector;
 - the rates are not based on reliable denominators; there are errors and miscoding in the data.
28. The argument from the CSA appears to be that if information is requested, which contains inaccuracies or is incomplete, then an authority should be capable of maintaining that the information is not held, on the basis that the information is not fully up to date or fully correct. However, FOISA requires the authority to provide the information it holds, not the information it should hold or would like to hold. Failures in the method of recording information should not be used as a basis for withholding information.



29. It is even less convincing to argue that because information may be capable of misinterpretation that somehow, again, it is not 'true' information and can be withheld. The CSA is concerned that no case mix adjustment has been applied to these figures. It is important to realise that case-mix adjustment of mortality data is essentially standardisation of the data. Case-mix adjustment attempts to remove confounding factors (e.g. age, deprivation category, other morbid conditions such as diabetes or asthma) to allow meaningful comparisons to be made between surgeons and hospitals. The differences in outcome between hospitals are likely to reflect to some extent differences in the case-mix of patients admitted. For example, a hospital, which admits older than average patients or carries out a higher proportion of 'high-risk' surgical procedures, is likely to have a higher overall surgical mortality rate, than one which admits younger patients or carries out a higher proportion of 'low-risk' procedures. Case mix may be a useful comparative tool (although it is not without its own problems as I shall deal with later). Where case mix has not been carried out, this does not, however, invalidate the actual data on surgical mortality rates – it simply means that a method by which such rates can be fully compared is not available.
30. As mentioned above, in response to a request from my Office for copies of the information withheld from Mr MacMahon, the CSA submitted information for one NHS Board for one single year period, April 2004 – September 2004, and confirmed that it could provide similar information for all the NHS Boards, if required. This information consists of the names of individual surgeons, their specialism, the hospital they operated in, the episode type, total number of operations for that consultant and the percentage of patients who died. The table also provides similar statistics, i.e. total number of operations and percentage of mortality at both the NHS Board level and also at Scotland level as a whole.
31. The CSA maintains that even though it is capable of generating such information, it is not information which it holds as it does not routinely analyse the available data to provide the information and cannot be required to generate such information in response to a request under FOISA.
32. I cannot accept this argument. The type of information being sought by Mr MacMahon is similar to the type of information which the CSA uses the data to produce. It seems to me that if an authority gathers data and chooses to use it for its preferred purpose, such as to produce tables of statistics for a particular location or time series, and is then asked to compile the existing data to produce information for a different geographical base or time series, then this is information retrieval, compiled in a stated form, rather than being new information. Under FOISA, an applicant cannot require an authority to go out and acquire new information, but in this case what is being asked is for the existing data to be presented in a particular digest (as provided for by section 11(2)(b) of FOISA), which it is demonstrably practicable for the CSA to do.



33. It is clear that the electronic Scottish Consultant Review of In-Patient Statistics (eSCRIPS) does contain the information which would allow Mr MacMahon's request to be met. The ISD acknowledges in its letter to my Office of 6 April 2005 that eSCRIPS allows consultants to look "at their ... mortality rates". The tables mentioned in paragraph 24 above could be generated from this information.
34. Having examined the information submitted to me by the CSA, I am satisfied that it constitutes surgical mortality rates pertaining to individual surgeons. It may or may not have the quality of completeness, accuracy, or interpretability which the CSA would prefer. However, it would be wrong to conclude that without these qualities the information cannot be considered as constituting mortality rates and therefore can be regarded as not held. It is clear that the nature of the information which the CSA holds would meet Mr MacMahon's request and that it can readily be retrieved.
35. The Investigating Officer asked the CSA to confirm whether this information was available for the period 2000 to 8 February 2005, the date on which Mr MacMahon requested the information. On 20 July 2005, the CSA confirmed that, under eSCRIPS, it only holds 3 years' worth of data. It is the practice of the CSA to discard the earlier year when the most recent data is added to the system and not to retain the data which has been discarded. The CSA currently holds data for financial years 2002/03, 2003/04 and part of year 2004/05 (which will not be complete until the system release which is scheduled for January 2006). The CSA again confirmed that it holds data for all surgeons employed by all NHS Boards for the above years and could provide a compilation similar to the sample information it provided to my Office for the purpose of this investigation.
36. On the basis of this submission from the CSA, I am satisfied that the CSA holds the information Mr MacMahon has requested, but only for the period 2002-04 and for part of 2005.

Section 38 Personal Information

37. Although, in correspondence with Mr MacMahon, the CSA had only cited "section 38" as the basis for withholding the information, during the investigation the CSA confirmed that it was relying on section 38(1)(b) of FOISA to refuse to release the information. Under section 38(1)(b) (read in conjunction with section 38(2)(a)(i)), third party personal information is exempt if its release would breach any of the data protection principles.



38. The CSA has argued that the information requested by Mr MacMahon is personal information relating to living, named third parties and that its disclosure would cause damage and distress to the individual surgeons. In addition, the CSA has argued that disclosure would breach the first data protection principle, which requires that personal data be processed fairly and lawfully.
39. Here, I need to consider whether the CSA has applied the exemption in section 38(1)(b) correctly. The questions that I must address are whether the information requested constitutes “personal data” and, if so, would its disclosure breach the first data protection principle.

Does the information requested constitute “personal data”?

40. The DPA defines personal data in section 1(1) as:

“data which relate to a living individual who can be identified-

(a) from those data, or

(b) from those data and other information which is in the possession of, or is likely to come into the possession of, the data controller, and includes any expression of opinion about the individual and any indication of the intentions of the data controller or any other person in respect of the individual.”

41. I take the view that the information requested in this case constitutes personal data; living individuals are readily identifiable from it as it names individual surgeons, their specialism, the hospital(s) they operate in and indicates their mortality rates. However, of itself, this is not at all conclusive of whether the s38(1)(b) exemption applies, and I need to go on to consider whether in this case there is a breach of the data protection principles. Although there are eight data protection principles, the CSA only referred to the first principle in its submissions. In guidance which the Information Commissioner has published on dealing with requests for third party data (“Freedom of Information Act Awareness Guidance No 1), it is recognised that in practice this principle will be key when considering an application for third party personal data.

Would release of the information breach the first data protection principle?

42. The first data protection principle states that:

“personal data shall be processed fairly and lawfully and, in particular, shall not be processed unless –

(a) at least one of the conditions in Schedule 2 is met, and

(b) in the case of sensitive personal data, at least one of the conditions in Schedule 3 is also met.”



43. I am satisfied that the information requested by Mr MacMahon does not constitute the sensitive personal data (as defined by section 2 of the DPA) of the surgeons named in the information.
44. The first data protection principle consists of two elements which public authorities must adhere to. Personal data must be processed fairly and lawfully and must not be processed unless at least one of the conditions for processing in Schedule 2 of the DPA is satisfied.
45. The CSA has not claimed that it would be unlawful to process the information. (In any event, I do not take the view that the release of the information would be unlawful.) It has, rather, advanced an argument that it would be unfair to the surgeon to process the information. There appear to be two strands to the argument. Firstly, that the information has been always treated as confidential and therefore surgeons have an expectation that it will not be released. Secondly, that the impact of release in terms of conclusions drawn from the information may be unfair to individual surgeons.
46. The CSA has argued that the expectation of surgeons has always been that data on surgical mortality rates is collected in a confidential context. The CSA argues that the collection of the data is designed to improve the quality of care and that surgeons, and others involved in its collection, do not anticipate that the information would be released into the public domain. This, according to the CSA, has been the principle guiding the development of the Scottish Consultant Review of In-Patient Statistics since 1970 and its subsequent electronic development (eSCRIPS). As a result, the CSA restricts access to the data contained in eSCRIPS to surgeons and Medical Directors and the CSA password protects the data.
47. However, it should be noted that once the password has been entered the consultant can 'drill down' to individual patient details. So, although the CSA has sought to highlight references to the words 'confidential' or 'in confidence' in the documents submitted to me, I think it is important to recognise that this has much to do with the confidentiality afforded to patient records and not the confidentiality of the mortality rates themselves.
48. I note also that documents submitted such as the 'Rules for confidentiality, security and release of information for users of NHS Workforce data' and Confidentiality Rules for ISD Scotland staff predate the introduction of FOISA and that one article from the Scottish Medical Journal on the Scottish Consultant Review of In-Patient Statistics submitted during the investigation dates back to 1970. These may indicate a working culture which assumed confidentiality in dealing with information. However, that is now affected by the introduction of FOISA in 2005 which has the general effect, as intended, of causing previous ways of working to be reconsidered and changed.



49. With regard to FOISA, what I must consider is whether the release of information about professionals within public authorities could be construed as unfair, within the terms of the exemption afforded by section 38.
50. In considering the concept of fairness, I have again taken into account the guidance from the Information Commissioner referred to in paragraph 35 above.
51. This guidance states that in thinking about fairness, it is likely to be helpful to ask whether the information relates to the private or public lives of the third party (in this case, the surgeons named in the information). According to this guidance, information which is about the home or family life of an individual, his or her personal finances, or consists of personal references, is likely to deserve protection. By contrast, information which is about someone acting in an official or work capacity should normally be provided on request unless there is some risk to the individual concerned.
52. I take the view that the information requested by Mr MacMahon constitutes personal data relating to surgeons' professional lives. It is collected by administrative procedures in the work place in which surgeons are employed and it describes their professional functions and outcomes from or related to their working activities. Since the introduction of FOISA, professionals working within public authorities cannot maintain that such information can simply be withheld because it was not routinely disclosed before FOISA came into force.
53. I have also considered the CSA's submission that the mortality rates of individual surgeons are potentially misleading and that their disclosure would be distressing to the surgeons and could damage their reputation, standing or professional practice. As will be considered in more detail later, I think it is far from demonstrated that there will be professional damage or distress from the release of the information. However, in this respect, I have again turned to the Information Commissioner's guidance, which emphasises that whilst it is right to take into account any damage or distress that may be caused to a third party by the disclosure of personal information, the focus should be on damage or distress to an individual acting in a personal or private capacity. The exemption should not be used, for instance, as a means of sparing officials embarrassment over poor administrative decisions, or, as in this case, potential embarrassment over mortality rates of the surgeons.



54. This is consistent with cases I have considered from elsewhere. Opinion offered in a freedom of information case in New York, where information as to specific physicians was requested, was that ‘the information sought although identifiable to particular physicians pertains solely to the performance of their duties in a profession...’ The Queensland Commissioner also held that information regarding the unadjusted mortality rates of named surgeons was to be properly characterised as information concerning the performance by surgeons of their duties as government employees...’ and should be released. He did so in the knowledge that this carried the potential to reflect adversely on the professional competence of a practitioner, referring however to a previous decision in which he had taken the view that ‘the FOI Act affords no specific exemption for information that might adversely affect an employee of a government agency.’
55. Whilst the issue of distress or damage cannot be disregarded I take the view that as the information requested relates to the professional lives of the surgeons, the scope for adverse comment or conclusion is limited to professional matters and whilst this may cause annoyance or resentment it does not constitute damage or distress to the extent required to be exempt from disclosure. The CSA has not presented my Office with any evidence which would indicate that disclosure of the information would put any of the surgeons (or any other individuals) at risk.
56. I am therefore satisfied that, although the information constitutes personal information, and surgeons may have expected that the information would not be disclosed, the disclosure of this information would not be unfair or unlawful.
57. Further, I am satisfied that the CSA can satisfy the sixth condition in Schedule 2, which refers to processing which is “necessary for the purposes of legitimate interests pursued by the data controller or by the third party or parties to whom the data are disclosed, except where the processing is unwarranted in any particular case by reason of prejudice to the rights and freedoms or legitimate interests of the data subject.” There is a legitimate interest in details of the information collated by the CSA being made publicly available to the public, particularly where the information could impinge on clinical care in Scotland. The release of the information would allow individual patients to look at the mortality rate of clinicians scheduled to operate on them and allow them to question why their rates differed from others. I am therefore satisfied that disclosing the information would not be unwarranted by reason of prejudice to the rights and freedoms or legitimate interests of the surgeons named in the information.
58. I am also satisfied that the disclosure of the information to Mr MacMahon would not breach any of the other data protection principles and therefore find that the information is not exempt under section 38(1)(b) of FOISA.



Section 30 Prejudice to Effective Conduct of Public Affairs

59. It was unclear from the CSA's original correspondence with Mr MacMahon which part or parts of the section 30 exemption it was relying on to withhold the information from him. As indicated above, the CSA made no mention of section 30 in its review letter to Mr MacMahon, only in the original refusal. It also made no mention of section 30 in its submission to me in response to the invitation to make comment under section 49(3)(a) of FOISA. However, during the investigation, the CSA confirmed that, in deciding to withhold the information, it had relied on sections 30(b)(i), 30(b)(ii) and 30(c) of FOISA.

Section 30 of FOISA provides:

"Information is exempt information if its disclosure under this Act -"

(a) ...

(b) would, or would be likely to, inhibit substantially -

(i) the free and frank provision of advice; or

(ii) the free and frank exchange of views for the purposes of deliberation;

or

(c) would otherwise prejudice substantially, or be likely to prejudice substantially, the effective conduct of public affairs."

Section 30(b)(i) and (b)(ii)

60. The standard to be met in applying the tests in sections 30(b)(i) and 30(b)(ii) is high. It requires evidence that the process of collecting and subsequent use of data on the mortality rates of named surgeons meets the definition of "provision of advice" or "deliberation" and that disclosure of such information would or would be likely to inhibit substantially the process. Both sections 30(b)(i) and 30(b)(ii) are also subject to the public interest test. This means that even if the disclosure of such information would inhibit substantially the process, the information should still be released unless the public interest in disclosure of this information is outweighed by the public interest in withholding it. I expect public authorities relying on section 30(b)(i) and/or 30(b)(ii) to identify the type of advice in question or the deliberative process they are engaged in. For example, I take the view that a deliberative process involves the consideration of various matters with a view to making a decision on a particular matter. The process involves the consideration of factual information, statistical information, opinion, recommendations and results of consultations considered by the public authority. I consider the deliberative process to be well-defined, finite and to conclude when decisions are finalised. I also expect much of the statistical data or factual information used to inform the process of deliberation to be published after its conclusion. It may be argued that there is greater public interest in withholding information while the deliberative process is in progress and decisions have not been made.



61. The argument made in respect of sections 30(b)(i) and 30(b)(ii) by the CSA is brief and is represented by the view that “Clinicians will be unwilling to be frank in reporting errors and being critical of their own and their colleagues’ performance if they feel there is a possibility that the information will be passed to anyone who requests access to it including the media.”
62. This expresses a concern about an outcome which is not at issue here. The request from Mr MacMahon is not to see any comment, opinion, reason or conclusion regarding the performance of clinicians in respect of mortality rates. The information revealed would not include any frank advice or exchange of views.
63. Furthermore whilst the information may be subsequently used by clinicians, e.g. in consideration of their performance, it is important to realise that the information is not derived from any process which requires any input by clinicians by way of frankness in the reporting of errors or supplying their views on the performance of others. Not for the last time, I wish to stress the importance of distinguishing between clinical audit which involves such cooperation and data collection which does not.
64. To my mind the CSA has not made a case for section 30(b)(i) or 30(b)(ii) applying in this instance, and the arguments it makes are little different from those to be considered under section 30(c). I am satisfied that the exemptions in sections 30(b)(i) and 30(b)(ii) do not apply to the information requested by Mr MacMahon. As a result, I am not required to consider the public interest in relation to the use of these exemptions.

Section 30(c)

65. Section 30(c) of FOISA exempts from release information, the disclosure of which would, or would be likely to, prejudice substantially the effective conduct of public affairs.
66. My view is that in order to claim this exemption the damage caused by disclosing the information would have to be real or very likely, not hypothetical. The harm caused must be significant, not marginal, and the CSA must be able to evidence this harm. It is essential to remember that any prejudice which is suffered would have to be substantial and not simply cause an inconvenience or difficulty.



67. The CSA is concerned that release of the information would impact adversely upon the collection of data on clinical performance and would undermine the willingness of clinicians to take part in clinical audit to the extent of substantial prejudice to such activities. The CSA advised me that it has been informed by a number of bodies representing surgeons in Scotland that their members strongly object to disclosure of this information. For example, the CSA has advised me that a number of individual surgeons and one major surgical grouping, Scottish Orthopaedic Surgeons, have expressed their strong objection to the release of this information. Similarly, the CSA has advised me that SASM has decided not to continue with the analysis of the data it holds on individual surgical performance until this matter is resolved.
68. The CSA has set out a scenario for substantial prejudice which depends on the following presumed causal chain of events: information is released which is inaccurate and is not adjusted for case mix; this is published by a media which fails to acknowledge the inadequacies of the information and draws up league tables of performance or draws unwarranted conclusions from the information; this in turn leads to criticism or concern over the performance of individual clinicians, who, in response, withdraw their cooperation from processes which have been established to gather data on, and audit, clinical performance. As a consequence, there would be an impact on the quality of healthcare.
69. This chain of events, however, depends upon a link which is an amalgam of two distinct elements which I believe it is essential to separate out. The process of gathering data (which may be used as a resource in performance review) is quite different from the process of clinical audit as currently carried out in Scotland. I want to address this issue directly as I believe it is essential to understand the distinction and the implications thereof in coming to a decision.
70. The CSA has submitted that it is very important that any information placed in the public domain does not undermine the willingness of clinicians to take part in clinical audit, due to the potential disclosure of information about individual clinicians. The CSA presented SASM as an example of a voluntary surgical audit project. (It may now be that some aspects of the audit process are no longer voluntary, as I understand that all surgeons in Lothian NHS at least are now required to submit risk adjusted audit information to SASM.)



71. Professor Graham Teasdale, Chairman of the SASM Board provided me with a description of the process of clinical audit referred to by the CSA, and, in addition, I consulted the website of SASM to obtain an understanding of SASM for the purposes of this investigation. According to this information, mortuaries, records offices, wards and consultants' secretaries are the source of information for recording deaths occurring within thirty days of an operation or during the patient's last admission. Standard forms are sent to the consultant surgeon in charge of the case. The surgeon is asked to identify the anaesthetist involved, where relevant, and to pass on the anaesthetic standard form and the case notes. Both surgeon and anaesthetist return the completed standard forms to the relevant SASM office. The identification is administrative and the person does not need to have undergone an operation. Completion and return of the standard form by the surgeon is entirely voluntary. After being returned to SASM, the standard form is sent to an assessor. The views of the assessor are then communicated to the original surgeon or the anaesthetist, if relevant. This forms the basis of a person-by-person analysis aimed at identifying events in the management of the patient, on a voluntary and confidential basis, that might have contributed to the death of the patient.
72. As Professor Teasdale points out, SASM cannot be used to provide mortality rates. Given that SASM takes account of patients who have died, but who have not necessarily had an operation, the calculation of mortality rates requires information about the number of patients who have died and about the total number of patients undergoing care. SASM does not include in its work information about the total number of patients being treated by a surgeon.
73. It is clear from this brief outline that SASM relies on several sources of information for mortality data. The process is one of peer review, which results in the production of confidential individual reports of the surgeons' management of patients. I wish to make a clear distinction between SASM's clinical audit and the CSA's retention of mortality data for the general purpose of quality assurance. Furthermore, it is important to note that what has been requested are the mortality rates of named surgeons and not the outcomes of the clinical audits carried out, for example, by SASM or any other such organisation.



74. If the application before me was for information gathered as result of the clinical audit, then in coming to a decision I would take into account issues such as the voluntary nature of the system; the disparate sources of information; the element of individual performance appraisal by self reporting and peer review as well as any other relevant issues not raised here such as contracts of employment; required performance standards or the confidentiality of patient information. These are issues which are quite distinct from the narrower range of matters arising from a discussion of the collection and release of data on mortality which occurs quite separately from the process of clinical audit.
75. This has been addressed *inter alia* by the Victorian Civil and Administrative Tribunal in the case of *Birnbauer and Davies v Inner & Eastern Health Care Network* where the Tribunal concluded that a document which referred to peer reviews conducted and to be conducted of certain instances of patient death should be withheld.
76. Having become familiar with the processes of surgical audit, I can say that generally it is highly unlikely that information gathered for the purposes of contributing to SASM would be released. This is why it would be quite wrong to conclude that a decision on the mortality data has a direct consequence for a request regarding clinical audit or should be used to suggest that by association clinical audit would be substantially prejudiced.
77. Having drawn that important distinction, I now want to turn to the matter of what has actually been requested.
78. The first matter which I have sought to establish is the extent to which release of the requested information would substantially prejudice the capacity to gather such information in future. The CSA has made the point on several occasions that participation in surgical audit is voluntary. However, this is not the case in the collection of the actual data at issue here. In its submissions to my Office, the CSA has confirmed that the surgical mortality data for named surgeons is automatically recorded on hospital patient administration systems (PAS). Consultant surgeons do not generally play a part in the derivation of information other than recording information in discharge letters and patient records. The source of the information, i.e. hospital inpatient/day case discharged records, are compiled and sent to ISD on a routine basis. Information which I have received from a Health Board also indicates that this data is collected automatically from raw data held on the PAS which are subsequently used to produce the Scottish Morbidity Record (SMR01). SMR01 collected from hospitals is routinely used to populate the eSCRIPS.



79. The aims of eSCRIPS are to provide information for clinical governance, audit, annual consultant appraisal and consultant revalidation. It allows the consultants to carry out a range of analyses on their own workload as well as providing comparisons with Health Board and Scottish averages. It allows surgeons to look at their caseload, mortality rates and re-admission rates. It also enables them to examine individual cases and interpret the data in context and combine it with their own knowledge of the cases.
80. Having considered all the relevant evidence before me, I am satisfied that the collection of mortality data of named surgeons is routine and is an integral part of the PAS at hospitals and that the CSA does not have to rely on the goodwill and voluntary participation of surgeons to obtain this information.
81. The CSA has expressed concern that the data sets it holds on individual surgeons' mortality rates are not reliable and do not take into account the risk factors contributing to morbidity. Quality assurance exercises show that data on surgical activities sometimes contain errors such as attributing the activity to the wrong surgeon.
82. However my understanding from the *Report on Acute Inpatient/Day Case Data 2000-2002* is that the relevant information is acceptably accurate. Furthermore it is important to note that FOISA does not allow public authorities to refuse to disclose information on the basis that the information is of poor quality or is unreliable. (I address the issues of accuracy and interpretation in more detail when discussing the public interest below.)
83. It is understandable that the CSA has concerns about the release of the information. However, the CSA bases its view on a worst case scenario in which the information is used out of context and with the intention or unavoidable effect of being misleading and harmful.
84. Whether this is the inevitable outcome or whether even unadjusted surgical mortality rates can be presented in context is not just a matter of conjecture. Since 1 January 2005 information on surgical mortality rates has come into the public domain as a result of applications made under the Freedom of Information Act 2000 and the Freedom of Information (Scotland) Act 2002 and it seems to me that how this has been handled by the press may be indicative of what might happen if further information is released.



85. On 16 March 2005, The Guardian newspaper published risk and non risk-adjusted mortality rates of 244 individual surgeons who carry out Coronary Artery Bypass Grafts (CABG) at a number of hospitals across the UK compiled as a result of responses received to a number of freedom of information requests. In reporting the results, the articles sought to place the information in context so far as drawing conclusions and comparisons was concerned. This included an acknowledgement that “Figures on mortality rates are collected and analysed in various ways by different heart units in hospital trusts around the country, making it impossible to compare individual heart surgeons.” In its leader column, the newspaper made clear that it had deliberately not produced a league table.
86. Separately, The Scotsman newspaper of 4 March 2005 reported on mortality figures for CABG and Aortic Valve Replacement obtained as a result of a freedom of information request from Lothian and Glasgow health boards and similarly placed the information into context, and did not produce a league table.
87. I am not aware of other newspapers using the information published in The Guardian or the Scotsman to subsequently produce national or regional league tables.
88. Clearly hospitals had drawn attention to the issues of interpretation. The comments of the cardio thoracic surgeons at Lothian University Hospitals made to The Guardian were provided to me and I have reproduced them in full below:

“Note on Interpretation of Data – Cardiac Surgery

Interpretation, analysis and presentation of clinical outcomes from cardiac surgery is complex. To ensure that patients and the public are not given misleading analyses and to ensure that the performance of organisations and individuals are not misrepresented, the following factors need to be taken into account:

- Some surgeons and some hospitals operate on patients who are at greater risk of dying. For example, an experienced surgeon who operates on more difficult cases (such as very elderly patients or patients with diabetes) would reasonably be expected to have a higher mortality rate than the national average.
- Without taking such factors into account, it is quite possible that a surgeon classed as having a higher mortality rate may well be ‘better’ than a surgeon classed as having a lower mortality rate. A league table based on data that does not adjust for risk is likely to mislead patients and the public and misrepresent the performance of individual and institutions.



- Mortality rates depend on factors other than just the skill of the individual surgeon. The rates depend on the skill of other medical staff (cardiologists, anaesthetists, intensivists and junior medical staff), the post operative care (nurses, physiotherapists, pharmacists etc.) and the hospital environment (such as infection rates, or the facilities available). This is not taken into account when associating named surgeons with mortality rates.
 - There is a natural variation in mortality rates from year to year. It is to be expected that mortality rates of individual surgeons vary from year to year. Therefore, a high (or low) mortality rate in one particular year does not necessarily relate to the performance of that surgeon.
 - The statistical uncertainty in the mortality rate of a surgeon depends on how many operations they have performed. The more operations a surgeon performs, the more confident we can be that the mortality rate they are operating at is their 'true' mortality rate. Judging a surgeon on a small number of operations may lead to incorrect conclusions."
89. It seems to me therefore that whilst it may be the case that unwarranted conclusions may be drawn from the publication of the information, this is by no means inevitable or likely to be universal. Indeed that has not happened so far. However, even if it were to occur, I do not accept that it would lead to inescapable damage. There are many media outlets, some with specialist health reporters. It is not likely that all would be unaware of or ignore contextual information and there is nothing to prevent the CSA when making such information available to Mr MacMahon from putting it into the public domain at the time of release. Such contextual information is not technical and is intelligible to the general public.
90. The CSA has asserted that clinicians are likely to withdraw from performance review and clinical audit following the publication of data not adjusted for risk. It should be noted that The Guardian article contained risk adjusted and non-risk adjusted data and that in particular none of the Lothian or Glasgow results were risk-adjusted.
91. It may be thought that there would be some evidence of non-cooperation and negative impact on information gathering processes following the publication of the articles in the national press of March 2005, including non-risk adjusted data for individually named surgeons. As part of this investigation, therefore, my Office contacted selected health boards and trusts to find out whether there had been any changes in the level of cooperation of surgeons in reporting their mortality data and to find out whether the publication of mortality rates in The Guardian had affected their ability to collect this data since March 2005.



92. Responses from NHS Lothian and University Hospital Birmingham supported the conclusion that the patient mortality data is routinely captured by the PAS at hospitals and that, accordingly, the publication would not affect their ability to collect this data.
93. The University Hospital Birmingham NHS Foundation Trust (the UHBFT) confirmed that its PAS captures all inpatient activity. The information captured includes the method of discharge and destination. Deaths are included in the information captured. Mortality can therefore be derived from this data source by consultant, speciality, diagnosis and procedure. The UHBFT routinely provides reports on this data. It stated that all the surgeons at the UHBFT participated in the release of this information and that there has been no change in the capture, reporting and using the data for mortality rates since the publication of data in The Guardian newspaper.
94. The NHS Lothian University Hospitals Division has advised me that the information published by The Guardian was not risk-adjusted, although it had been audited, i.e. the data had been checked for accuracy. It also confirmed that, although the mortality data is collected as part of the process of Surgical Morbidity Record, the individual surgeon seldom sees this and it is collected automatically from raw data held on the PAS.
95. United Bristol Healthcare Trust indicated that there was no difference to their approach since publication.
96. North Glasgow University Hospitals also report that the publication of mortality rates in The Guardian has had no effect on the willingness or otherwise of the cardiac surgeons to gather data and continue with their contribution to clinical audit.
97. SASM report that in the year currently undergoing processing, the rate of return is 86.2% of pro-formas sent out compared to 91.2% at a comparable stage last year. SASM say that this drop is a cause for some concern and they do now know why the drop has occurred. However, I am not satisfied that the reduction in the rate of return of pro-formas can be linked to the publication of information in The Guardian or The Scotsman.
98. I therefore take the view that overall the release of this information would not, or would not be likely to, prejudice substantially the process of collection of surgical mortality data.
99. Nor can I conclude that participation in the separate process of surgical audit would be substantially prejudiced.



100. I acknowledge the view from the CSA that many in the medical profession can see little purpose in publishing the data in its present form in terms of public safety or health and that many in the medical profession would be aggrieved by unwarranted conclusions being drawn from the publication of the data.
101. However it is not necessary for the applicant to show that the information would be useful; it is up to the authority to show that substantial prejudice to public affairs would occur. As I have shown it has not been the case that information so far released has caused harm. However, where it was felt that unwarranted conclusions were being drawn, health authorities, hospitals, professional bodies and individual clinicians are well able to robustly defend their position. I have also shown that the collection of routine data would not be affected even if clinicians were unhappy at release. Finally, I have been at pains to point out that release of routinely collected data has no bearing upon the quite separate process of surgical audit, to the extent that I believe it would be unlikely for information gathered for the purposes of SASM to be released. As a consequence I cannot accept that consultants would, en masse, withdraw from performance review and from the separate process of surgical audit.
102. In conclusion, I do not find that the exemption at section 30(c) applies.

The public interest test

103. The CSA has argued that disclosure of this information is not in the public interest. Indeed, it has been keen to argue the public interest issues even where these do not apply to the specific exemption cited and they have also done so without reference to a specific exemption.
104. The issue of public interest cannot be considered in respect of the absolute exemption provided for by section 38(1)(b) as read in conjunction with section 38(2)(a)(i). If the exemption was held to apply then the public interest would not then be considered. If the exemption does not apply I cannot consider whether nevertheless the public interest still justifies withholding.
105. In the case of the exemptions in section 30(b)(i), 30(b)(ii) and 30(c), I am only required to consider the public interest if the exemptions apply, that is if there was substantial prejudice to the effective conduct of public affairs. I have found that they do not apply to this information.
106. However I have addressed many of the issues raised by the CSA regarding public interest issues in discussing whether the exemptions apply, and I am willing to expand upon some of the key issues here, as if, for the purposes of discussion, I had come to a contrary view on the application of the section 30 exemptions.



107. The CSA has argued that it would not be in the public interest to release information which was inaccurate or capable of misinterpretation. These are two separate issues but one may contribute of course to the other.
108. Additionally, in a submission to me, NHS Quality Improvement Scotland emphasised that data on clinical performance is already published, and it supplied the publications detailed at paragraph 13 above as examples. It submitted that, "Publication is the final stage of an extensive process and occurs only when the data are valid and reliable. The mortality rates for named surgeons as the data currently stand do not meet that test. We are therefore concerned that the public release of this information at this time and without being placed in context could be considered misleading."
109. A distinction has to be drawn between information which an authority chooses to publish and that which has to be made available in response to a request under FOISA. Just because an authority would not choose to publish the information is not a reason for withholding it under FOISA.
110. The CSA should be aware also that the Scottish Ministers' Code of Practice on the discharge of functions by public authorities under the Freedom of Information (Scotland) Act 2002, more often known as the Section 60 Code, makes specific reference to how the public interest test should be interpreted.
111. It says that in deciding whether a disclosure is in the public interest, authorities should not take into account the risk of the applicant misinterpreting the information, nor should it take into account possible embarrassment of government or other public authority officials. Of itself then a public authority cannot argue that information should be withheld simply because it is capable of being misinterpreted either because it is incomplete or inaccurate or because it is complex or capable of leading, in the authority's view, to false conclusions.
112. Guidance issued by the Chief Statistician of the Scottish Executive Statistician Group, the terms of which have been agreed by me as being consistent with the principles of FOISA, states that "sometimes statistical collections, particularly first time round, do not yield statistics of usable quality. There is no exemption on the basis of poor quality" (*Freedom of Information and Statistics*, Statistics Notice 04/4, December 2004). The fact that information is unreliable and thus misleading is not sufficient reason for withholding it
113. Nevertheless, the CSA has argued that the information may contain inaccuracies which are a result of mistakes made by health authority staff in completing the data on which the information is compiled. Incorrect information inserted into the SMR 01 forms completed by hospital staff may mean, for example, that a doctor may be held to have had responsibility for a patient who has died in hospital, while the patient was under another clinician's care.



114. Where it is within the capacity of the public authority or public authorities to ensure that accurate information is gathered or is checked for accuracy, then it cannot be proper to maintain that it is not in the public interest to provide the information because of such inaccuracies. Indeed, if this were to be a reason for withholding information, it would assist public authorities who had either not checked data or had not secured improvements in information collection to ensure that the data submitted was accurate. By contrast those authorities who had ensured accuracy would be required to release information. This cannot be right
115. Furthermore, it could even be argued that it is in the public interest to draw attention to the fact that inaccurate figures are being gathered. I think that it is important particularly following the Bristol Royal Infirmary Inquiry, that basic administrative data that may alert hospitals and health authorities in the first instance to any issues regarding performance should be up-to-date and accurate.
116. Although the situation in Bristol cannot necessarily be transposed to Scotland, the Inquiry recognised that systems for clinical audit and for monitoring performance rely on accurate and complete data. The Inquiry recommended that an approach to the collecting of data should be adopted which meant that clinicians can trust and use such data and from which information about both clinical and administrative performance can be derived. In particular, the Inquiry recommended that steps should be taken to build the confidence of clinicians in the data recorded in the patient administration systems and that such steps should include the establishment by trusts of closer working arrangements between clinicians and clinical coding staff.
117. I have sought to establish the extent to which the data held by the CSA can be regarded as accurate. I have looked at the *NHSScotland Data Quality Assurance Report on Acute Inpatient/Day Case Data 2000-2002* (produced by ISD in January 2004). It shows that across Scottish hospitals the accuracy of recording which healthcare professional was responsible for care was 95%, and the accuracy of recording the main operation is also 95% (against a target minimum accuracy of 90%). As I understand it, this data is then used to populate the eSCRIPS reports, which are deemed to be useful to clinicians.
118. So, contrary to the misgivings expressed by the CSA, it appears to me that the basic information relevant to this application is reasonably accurate.



119. There are, however, other deficiencies in recording, which do not affect the accuracy of the raw mortality data, but compromise the capacity to adjust it for case mix, which the CSA argues is necessary to properly interpret the information. The SMR record requires that details of other conditions that co-exist or develop during an episode of healthcare which might affect the management of a patient is entered. The *Report on Acute Inpatient/Day Case Data 2000-2002* found that this information was frequently either omitted or wrongly coded. So, for example, the under-recording for asthma was 59.3%; for diabetes mellitus 39%. As the Report itself says, 'The low reporting in SMR data sets of patients conditions (in addition to the main condition) does not reflect the case mix nor the complexity of cases being treated in Scottish hospitals.'
120. The failure to accurately record other conditions appears to contribute to the CSA not having the case-mix adjusters that it would like to have. Commonly used case-mix adjusters that it does use are age, sex, deprivation category, the severity of illness at diagnosis, pre-operative state, length of stay in hospital and the co-existence of other morbid conditions such as diabetes, when these are available. However, the CSA is uncertain whether these adjusters provide accurate data. According to its submissions, to provide reliable risk-adjusted data for surgical mortality would require a dedicated programme of data collection undertaken in conjunction with Scottish surgeons. There would need to be an agreement on the choice of the most significant case-mix factors and the design and implementation of the data systems to collect these data reliably over a reasonable period of time. Furthermore, the resources necessary to produce reliable risk-adjusted data on surgical mortality are considerable. A comprehensive programme to audit surgical outcomes across all surgical specialities and all conditions would, according to the CSA, realistically have to run over at least 5 years and would be likely to cost several million pounds.
121. The choice in terms of the public interest is not between unadjusted data or risk adjusted data on individual surgical mortality rates, but between unadjusted data or no individual data at all, given the inability of the ISD at this stage to produce risk adjusted data.
122. In these circumstances, I am drawn to the view of the Queensland Commissioner who has said that 'If disclosure of basic statistical information about the performance of publicly- funded medical services could be resisted on the basis urged by the Hospital, there may be no incentive for risk adjusted data to be prepared, and then no information – risk adjusted or otherwise – would be disclosed to inform the public about the performance of publicly-funded medical services. In my view, such a state of affairs could not be to the overall benefit of the public.'



123. The benefits of unadjusted data might be limited but they cannot be said to be non-existent. Individual patients would be able to look at the mortality rate of clinicians scheduled to operate on them and could ask why it differed from others, so to be directly informed about matters such as contributory risk factors which may be relevant to their own particular circumstances.
124. In general, it would be preferable that risk-adjusted data was available. Certainly, the trend seems to be for such information to be risk-adjusted when proactively put into the public domain. However, this is sometimes represented as the true or fair data, and the suggestion may appear to be that it should be used in place of the raw or unadjusted data. But this is not necessarily an appropriate conclusion.
125. According to research funded by the Bristol Royal Infirmary Inquiry on monitoring clinical performance, 'it would be misleading to claim that statistical procedures can ever fully adjust for pre-existing risk factors, and so **unadjusted outcomes should also be provided** (my emphasis).
126. I have found such information available for heart surgeons in Manchester Royal Infirmary, providing cumulative observed (unadjusted) mortality; cumulative predicted (risk-adjusted) mortality as well as upper and lower 95% confidence limits of observed mortality for individual named surgeons.
127. On the basis that there is resistance to the idea that data capable of misinterpretation should not be released, it should not be assumed that this would be removed simply by carrying out risk adjustment and that consequently clinicians would be content with such information being released.
128. Arguments emerge about the basis on which adjustment has taken place and whether this has been susceptible to subjective weighting given to certain risk factors. The methods of weighting may differ between authorities. The risk-adjusted data produced by the Guardian, for instance, used two different risk adjustment methods, the EuroSCORE and Parsonnet systems, which meant that those results could not be directly compared.
129. Others argue that even risk-adjusted data does not provide an adequate basis for comparison based on any one year. The researchers for the Bristol Royal Infirmary Inquiry warned that the practice of ranking institutions to create league tables is inappropriate even where the data is risk-adjusted since "ranks are notoriously sensitive to chance variability" noting that institutions that had been identified as "extreme" tend to become less so when re-examined "since part of the reason for their extremeness was a run of good or bad luck."



130. Even where data has been published for many years there remain those within the medical profession who do not trust the data, do not like how it is interpreted or do not consider it useful to the public.
131. Finally, to the extent that I have been able to identify where similar issues have been addressed by Commissioners, Ombudsmen or Courts elsewhere, the tendency has been to draw a distinction, as I have done, between personal and professional information, as well as to distinguish between information gathered by routine systems and those systems which may be susceptible to the withdrawal of voluntary participation. The Victorian Civil and Administrative Tribunal held that information gathered in confidence should not be released, on the basis that this would be likely to impair the ability of the agency to obtain similar information in the future. Deputy President Macnamara held that the public interest lay in withholding as it was more important to ensure that quality assurance bodies secured the cooperation of clinicians in providing information about adverse events. As the Queensland Commissioner has pointed out, this is materially different from circumstances where the information gathered is from routinely recorded sources, which do not depend upon the contribution or cooperation of clinicians, and he held that unadjusted mortality data should be released for a particular group of surgeons and considered that the public interest lay in release rather than withholding.
132. As I have made clear earlier, I do not accept that an exemption applies to this information under FOISA, but were I to have considered whether the balance of the public interest lay in releasing or withholding, I would have been mindful of the distinction drawn by those Commissioners and, along with the guidance on interpretation of the public interest test if harm came about only as a result of inaccuracies and misinterpretation, then it is likely that I would have concluded that the public interest lay in release. If the harm extended beyond that such that patient health was clearly compromised then I would be likely to come to the contrary view.

Decision

I find that the CSA has not dealt with Mr MacMahon's request for information in accordance with Part 1 of the Freedom of Information (Scotland) Act 2002 (FOISA). In failing to release information to Mr MacMahon, the CSA has breached section 1(1) of FOISA. The reasons for my findings are fully detailed above.



In terms of section 49(6)(b) of FOISA, I require the CSA to release the information sought by Mr MacMahon for the years 2002/03; 2003/04 and year 2004/05 (as held at the date of the receipt of the request by Mr MacMahon).

I cannot require the CSA to release the information to Mr MacMahon until the time allowed for an appeal to be made to the Court of Session has elapsed. I therefore require the CSA to provide the information to Mr MacMahon within two months of the date of receipt of this decision notice.

Kevin Dunion
Scottish Information Commissioner
8 December 2005