OFFICE OF THE INFORMATION COMMISSIONER (QLD)

Decision No. 06/2001
Application S 189/99

Participants:

ROSS COULTHART
Applicant

PRINCESS ALEXANDRA HOSPITAL AND HEALTH SERVICE DISTRICT
Respondent

DECISION AND REASONS FOR DECISION

FREEDOM OF INFORMATION - refusal of access - matter in issue comprising a statistical table of adverse outcomes from carotid artery surgery performed by the respondent's Vascular Surgery Unit over a specified time period - whether matter in issue comprises information concerning the professional affairs of the surgeons who were part of the Unit at the relevant time - whether disclosure could reasonably be expected to have an adverse effect on the professional affairs of a surgeon - whether disclosure could reasonably be expected to prejudice the future supply of like information to government - whether disclosure would, on balance, be in the public interest - application of s.45(1)(c) of the *Freedom of Information Act 1992* Qld.

FREEDOM OF INFORMATION - refusal of access - whether disclosure of matter in issue would disclose the purpose or results of research - whether disclosure could reasonably be expected to have an adverse effect on the agency or other person by or on whose behalf the research is being, or is intended to be, carried out - application of s.45(3) of the *Freedom of Information Act 1992* Qld.

Freedom of Information Act 1992 Qld s.5(1)(a), s.14, s.45(1)(c), s.45(3), s.74(1)(b), s.81, s.87
Freedom of Information Act 1982 Cth s.43(1)
Freedom of Information Act 1989 NSW s.59A(b)
Freedom of Information Act 1982 Vic

Accident Compensation Commission v Croom [1991] 2 VR 322
"B" and Brisbane North Regional Health Authority, Re (1994) 1 QAR 279
Birnbauer and Anor and Inner and Eastern Health Care Network, Re (1999) VAR 9

DECISION

I set aside the decision under review (being the decision made on behalf of the respondent by Mr Lindsay Pyne on 26 July 1999). In substitution for it, I find that the matter remaining in issue (which is described in paragraph 8 of my accompanying reasons for decision) does not qualify for exemption under s.45(1)(c) or s.45(3) of the *Freedom of Information Act 1992* Qld, and that the applicant is therefore entitled to be given access to it under the *Freedom of Information Act 1992* Qld.

Date of decision: 10 August 2001

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INFORMATION COMMISSIONER

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REASONS FOR DECISION

Background

1. The applicant, Mr Coulthart, who is a reporter for Channel 9's "SUNDAY" programme, seeks review of a decision made by the Princess Alexandra Hospital and Health Service District ("the Hospital") to refuse him access, under the *Freedom of Information Act 1992* Qld (the FOI Act), to parts of one folio which contains a statistical table of adverse outcomes from carotid artery surgery performed by the Hospital's Vascular Surgery Unit between January 1994 and June 1996.

2. By letter dated 22 April 1999, the applicant made an FOI access application to the Hospital in the following terms:

> *1. We understand that the PA Hospital's Vascular Unit conducted an Internal audit about two years ago into outcomes after carotid surgery. The document we seek reviewed about 120 cases, involving surgery by five surgeons. It summarised the number of strokes and death end-points from that surgery relative to each surgeon.*
>
> *2. The second item of documentation we seek relates to decisions taken by the hospital as a result of that internal audit. We especially seek any documentation discussing the results or conclusions reached from this review involving the following people:*
>
> - *Dr McLeod, the Chairman of the Department of Surgery.*
> - *Dr Tim McGahan, the surgical supervisor.*
> - *Dr Reg Magee, Head of the Department of Vascular Surgery.*
> - *Dr John Quinn, Chairman of the RCS Division of Vascular Surgery.*

3. By letter dated 23 June 1999, Ms B M Boel of the Hospital advised the applicant that she had located 22 folios which fell within the terms of part 1 of the applicant's FOI access application, and that she had decided to refuse access to those folios on the basis that they comprised exempt matter under s.45(1)(c) of the FOI Act. Ms Boel also advised the applicant that she had been unable to locate any documents which fell within the terms of part 2 of the applicant's FOI access application.

4. On 9 July 1999, the applicant requested an internal review of Ms Boel's decision. The internal review was conducted by Mr L Pyne, District Manager of the Hospital, who, by letter to the applicant dated 26 July 1999, affirmed Ms Boel's decision.

5. By letter dated 13 September 1999, the applicant applied to me for review, under Part 5 of the FOI Act, of Mr Pyne's decision.

External review process

6. Copies of the 22 folios to which the applicant had been refused access were obtained and examined. They comprised paper copies of overhead slides. Their origin was explained in a statutory declaration by Dr Timothy James McGahan, made on 2 December 1999, and lodged by the Hospital in support of its case in this review. In 1996, Dr McGahan, while employed as the Hospital's Staff Vascular Surgeon and Surgical Supervisor, undertook a project with the aim of comparing the complication rate for carotid surgery performed at the Hospital, as well as the complication rate recorded in other published reports in the medical literature, against those of an experimental procedure - carotid stenting - which was receiving considerable attention at that time in medical journals. As an aspect of that project, Dr McGahan examined the surgical outcomes experienced by patients at the Hospital who had undergone a particular form of carotid artery surgery (endarterectomy) between January 1994 and June 1996. Dr McGahan presented the results of his survey at a public lecture (presented during "PA Week") in July 1997. For the purposes of his presentation, Dr McGahan prepared a series of 22 overhead slides covering the historical aspects of carotid surgery, the various surgical options available, and the results of his survey of the outcomes of endarterectomies performed at the Hospital. Dr McGahan used slides 1-2 and 4-22 during his presentation, but did not show slide 3 or refer to the information contained on slide 3.

7. By letter dated 27 October 1999, I wrote to the Hospital to communicate my preliminary view that, on the basis of the material before me, the 22 folios in issue did not qualify for exemption under s.45(1)(c) of the FOI Act. In the event that it did not accept my preliminary view, I invited the Hospital to lodge written submissions and/or evidence in support of its case for exemption.

8. By undated letter (received at this office on 3 December 1999), the Hospital advised that it withdrew its claim for exemption in respect of folios 1-2 and 4-22, and in respect of parts of folio 3. (The folio numbers correspond to the slide numbers referred to in paragraph 6 above.) The applicant was given access to that matter, which is no longer in issue in this review. However, the Hospital continued to claim that parts of folio 3 were exempt from disclosure, relying upon s.45(1)(c) and s.45(3) of the FOI Act. The Hospital lodged written submissions, and the statutory declaration by Dr McGahan dated 2 December 1999, in support of its position.

9. Copies of the submissions and statutory declaration lodged by the Hospital (edited so as to remove references to the matter claimed to be exempt, as required by s.87 of the FOI Act) were provided to the applicant for response. By letter dated 12 January 2000, the applicant lodged written submissions in response to the issues raised by the Hospital, and in support of his case for disclosure of the matter in issue. The applicant's submissions were provided to the Hospital, and, on 16 February 2000, the Hospital lodged short points of reply which were, in turn, provided to the applicant.

10. At a late stage in the review, an issue arose as to the identity of the patients who were the subject of the matter in issue, i.e., whether they were public or private patients. Dr McGahan confirmed that his research related only to public patients of the Hospital, and that no private patients of any of the individual medical practitioners were included in his study. In light of that information, the Deputy Information Commissioner wrote to the Hospital on 27 October 2000 to communicate his preliminary view that the matter in issue could not properly be characterised as information concerning the professional affairs of the medical practitioners in question under s.45(1)(c) of the FOI Act, according to principles stated in *Re Pope and Queensland Health* (1994) 1 QAR 616, because it related solely to the treatment of public patients. In the event that it did not accept the Deputy Information Commissioner's preliminary view in that regard, the Hospital was invited to lodge written submissions and/or evidence which addressed that particular issue.

11. By undated letter received at my office on 20 January 2001, the Hospital advised that it did not accept the Deputy Information Commissioner's preliminary view and lodged written submissions addressing the issue of the medical practitioners' professional affairs. A copy of the Hospital's submissions was provided to the applicant for response. By e-mail dated 26 February 2001, the applicant lodged written submissions in response, which were forwarded to the Hospital.

12. In addition to the matter in issue itself, I have taken the following material into account in making my decision in this case:

- the applicant's external review application dated 13 September 1999 and written submissions dated 12 January 2000 and 26 February 2001;
- the initial decision of Ms Boel dated 23 June 1999;
- the internal review decision of Mr Pyne dated 26 July 1999;
- the Hospital's written submissions received on 3 December 1999, 16 February 2000 and 29 January 2001; and
- the statutory declaration of Dr McGahan dated 2 December 1999.

13. In the initial stages of this external review, the applicant raised a 'sufficiency of search' issue in relation to the adequacy of the Hospital's searches to locate documents falling within the terms of part 2 of his FOI access application dated 22 April 1999. Following inquiries of the Hospital and discussions with my staff, the applicant decided not to pursue the 'sufficiency of search' issue.

Application of s.45(1)(c) of the FOI Act to the matter in issue

14. Section 45(1)(c) of the FOI Act provides:

> ***45.(1)*** *Matter is exempt matter if—*
>
> …
>
> *(c) its disclosure—*
>
> *(i) would disclose information (other than trade secrets or information mentioned in paragraph (b)) concerning the business, professional, commercial or financial affairs of an agency or another person; and*
>
> *(ii) could reasonably be expected to have an adverse effect on those affairs or to prejudice the future supply of such information to government;*
>
> *unless its disclosure would, on balance, be in the public interest.*

15. The correct approach to the interpretation and application of s.45(1)(c) is explained in *Re Cannon and Australian Quality Egg Farms Limited* (1994) 1 QAR 491 at pp.516-523 (paragraphs 66-88). In summary, matter will be exempt under s.45(1)(c) of the FOI Act if:

(a) the matter in issue is properly to be characterised as information concerning the business, professional, commercial or financial affairs of an agency or another person (s.45(1)(c)(i)); and

(b) disclosure of the matter in issue could reasonably be expected to have either of the prejudicial effects contemplated by s.45(1)(c)(ii), namely:

(i) an adverse effect on the business, professional, commercial or financial affairs of the agency or other person, which the information in issue concerns; or

(ii) prejudice to the future supply of such information to government;

unless disclosure of the matter in issue would, on balance, be in the public interest.

Section 45(1)(c)(i) - whether disclosure of matter in issue would disclose information concerning business, professional, commercial or financial affairs

16. The first requirement for exemption under s.45(1)(c) is that disclosure of the matter in issue would disclose information concerning the business, professional, commercial or financial affairs of an agency or another person. In the context of s.45(1)(c)(i), the word "concerning" means "about, regarding": see *Re Cannon* at p.516, paragraph 67. Judicial decisions in Victoria and New South Wales have adopted a confined approach to the construction of comparable terms in the corresponding exemption provisions of the Victorian and New South Wales FOI legislation: see *Wittingslow Amusements Group Pty Ltd v Director-General of the Environment Protection Authority of NSW* (Supreme Court of NSW, Equity Division, No. 1963 of 1993, Powell J, 23 April 1993, unreported); *Re Croom*

and Accident Compensation Commission (1989) 3 VAR 441; *Accident Compensation Commission v Croom* [1991] 2 VR 322; relevant passages from those decisions are reproduced in *Re Cannon* at pp.517-518; paragraphs 69-72. It is not sufficient that the matter in issue has some connection with a business or professional practice, or has been provided to an agency by a business or professional practitioner, or will be used by a business or professional practice in the course of undertaking its operations. In order to satisfy this requirement, disclosure of the matter in issue itself must disclose information about business, professional, commercial or financial affairs.

17. In his internal review decision dated 26 July 1999, Mr Pyne decided that the matter in issue concerned the professional affairs of the Hospital. I disputed that finding in my letter to the Hospital dated 27 October 1999, and the Hospital conceded that it does not have professional affairs in the requisite sense in which that phrase is employed in the context of s.45(1)(c) of the FOI Act (as to which, see *Re Pope* at p.625, paragraph 29). The Hospital submitted, however, that the matter in issue concerned the professional affairs of the individual surgeons who were part of the Hospital's Vascular Surgery Unit at the relevant time.

Professional affairs

18. In *Re Pope*, I held that information concerning the work of a research scientist who was a salaried employee of a Queensland government agency was not information concerning that individual's "professional affairs", as that term is employed in the context of s.45(1)(c) of the FOI Act. Because it was a critical issue in that case, I considered in some detail the correct meaning to be accorded to the term "professional affairs" in the context of s.45(1)(c), and I incorporate by reference, for the purposes of these reasons for decision, my analysis and conclusions from *Re Pope* at pp.622-628, paragraphs 21-46. I will reproduce the conclusion I reached in *Re Pope* at p.625, paragraphs 28-29:

> *28. The basic object of s.45(1) of the FOI Act is to provide a means by which the general right of access to documents in the possession or control of government agencies can be prevented from causing unwarranted commercial disadvantage to persons and business entities engaged in private sector commercial activities (who supply information to government or about whom government collects information) and to government agencies which carry on commercial activities. In my opinion, the object of s.45(1)(c) and the objects of the FOI Act as a whole, are best served by giving the word "professional" a meaning which takes its colour from the words "business", "commercial" and "financial" which surround it in the context of s.45(1)(c). At paragraph 81 of my reasons for decision in* Re Cannon*, I observed that the common link among those three words is to activities carried on for the purpose of generating income or profits.*
>
> *29. The four adjectives in the phrase "business, professional, commercial or financial affairs" were clearly not intended, because of the substantial overlap between them, to establish distinct and exclusive categories, but rather the phrase was intended to cover, in a compendious way, all forms of private sector commercial activity, and thereby to also cover commercial activities carried on by government agencies. The use of the words "professional affairs" was, in my opinion, intended to cover the work activities of persons who are admitted to a recognised profession, and who ordinarily offer their professional services to the community at large for a fee, i.e. to the running of a professional practice for the purpose of generating income.*

19. The Hospital informed me that, currently, three of the five surgeons identified in folio 22 (that has already been disclosed to the applicant) are affiliated with the Hospital as "Visiting Medical Officers" who attend the Hospital for a certain number of hours per week, but who otherwise work in private practice, and that the other two surgeons have no current contractual relationship with the Hospital and work exclusively in private practice. The Hospital therefore submitted that the surgeons currently have "professional affairs" within the meaning of s.45(1)(c) of the FOI Act.

20. However, in his letter to the Hospital dated 27 October 2000, the Deputy Information Commissioner put to the Hospital (for response) the flaw he perceived in the Hospital's case so far as the satisfaction of s.45(1)(c)(i) was concerned:

> *A member of my staff recently made inquiries of Dr McGahan, who confirmed that the matter in issue relates only to public patients of the Hospital, and that no private patients of any of the individual medical practitioners were included in Dr McGahan's study. Applying the principles in* Re Pope *as set out above, this information would support a finding that the matter remaining in issue cannot properly be characterised as information concerning the professional affairs of the medical practitioners in question because it relates to the treatment of public patients, i.e., the medical practitioners were performing their duties of employment as government employees, rather than providing their professional services for a fee.*
>
> *Accordingly, while it may be correct to state that each of the practitioners currently has professional affairs because each has a right of private practice, it would appear that the matter in issue does not relate to the conduct of that private practice and therefore cannot properly be characterised as information concerning the professional affairs of the practitioners in question, according to the meaning which the term "professional affairs" has in the specific context of s.45(1)(c) of the FOI Act.*

21. In its response received on 29 January 2001, the Hospital raised several points of contention. First, it was said that, applying the Deputy Information Commissioner's analysis, "it would seem that if the patients in the case review had been a mixture of public and private patients, then the records relating to the private patients would be potentially exempt under s.45(1)(c), while those relating to public patients would not. It is difficult to see the logic behind such a result, in terms of the stated objects of the FOI Act".

22. While the result which the Hospital has hypothesised might seem anomalous, I do not accept that it is illogical in terms of the objects of the FOI Act. One of the primary objects of the FOI Act is to enhance the accountability of government, which includes accountability of individual government employees for the performance of their employment duties in the service of the public. This extends to the performance by salaried employee medical professionals of the services they are paid (from public funding) to perform for public patients. There is no similar accountability regime, through access to information, that applies to information held by private medical practitioners and private hospitals concerning services performed for their patients (though the desirability of a scheme for access by individual patients to their own medical records has been canvassed by the Commonwealth Privacy Commissioner). I do not consider it at all illogical, in terms of the objects of the FOI Act, that information about the performance by medical practitioners and private hospitals of services for which citizens are directly charged, might be eligible for exemption under s.45(1)(c) of the FOI Act (provided other elements of the test for exemption are satisfied), while information

concerning the performance of services for public patients by salaried employee medical professionals paid from public funds is excluded from eligibility for exemption by the terms of s.45(1)(c)(i) of the FOI Act.

23. Secondly, the Hospital contended that: "… the analysis in *Re Pope* places an unwarranted gloss on the plain words of s.45(1)(c) in emphasising income or profit as the requisite underpinning of activities which potentially qualify for exemption under s.45(1)(c)." The submissions by the Hospital have not persuaded me that my analysis and conclusions in *Re Pope* were incorrect. I note that they accorded with the views expressed by the Senate Standing Committee on Legal and Constitutional Affairs in its 1987 *Report on the Operation and Administration of the Freedom of Information Legislation*, Parliamentary Paper No. 441/1987, as to the meaning of the words "professional affairs" in s.43(1) of the *Freedom of Information Act 1982* Cth (the Commonwealth FOI Act):

> *14.21 The Committee takes the view that the expression "professional affairs" should be confined to activities analogous to business. The emphasis should be on the running of a medical, legal etc practice, not an individual's membership of a professional body or entitlement to practise as a member of the profession.*
>
> …
>
> *14.23 To avoid possible doubts, the Committee recommends that the Act be amended to make clear that "professional affairs" relates to the running of a professional practice, not the status of an individual as a member of a profession.*

24. Amendments to the Commonwealth FOI Act to give effect to that Senate Committee recommendation were made in 1991 (as explained in paragraph 31 of *Re Pope*), a year before the Queensland FOI Act was passed by the Legislative Assembly. I note in this regard the remarks of Derrington J in *Queensland Law Society Incorporated v Albietz* (1996) 2 Qd R 580 at p.585:

> *Where reform legislation of this kind* [i.e., the FOI Act] *follows the principles and forms adopted elsewhere, it is not asking too much to expect that the history of such anterior legislation and the explanation of its scope and purpose would be known to the domestic legislators who followed such precedents. The explanation for any departures from such precedents, or significant variation in the terminology used may qualify this view but, absent matters of this kind, with modern tools of communication and research, the broad sweep of principle behind such legislation should be expected to be identical as it appears progressively through similar legislatures.*

25. My analysis and conclusions in *Re Pope* on the meaning of "professional affairs" in s.45(1)(c) also accord with the decision of Beaumont J of the Federal Court of Australia in *Harris v Australian Broadcasting Corporation* (1983) 78 FLR 236, who held that a solicitor, employed by the ABC to manage its in-house legal department, was not entitled to rely on s.43(1)(c) of the Commonwealth FOI Act in respect of information which related to her discharge of the duties of that position, and which she claimed would, if disclosed, adversely affect her professional affairs: see *Re Pope* at pp.627-629, paragraphs 34-42. Beaumont J said that "the benefit of the operation of s.43 is not available to a person within an agency… .".

26. Thirdly, the Hospital contended that:

> … *the Information Commissioner's analysis in* Re Pope *pays insufficient regard to the unique position of professionals employed by government agencies, who also carry on some degree of private practice.* ... [The matter in issue relates to] *conclusions drawn about the surgical competence of the practitioners named on folio 22, which is the very crux of their work as members of one of the traditionally accepted "learned professions", both within the public sector and through their rights of private practice. Such information, it is submitted, would not be excluded from the operation of the analogous Commonwealth provision (on the basis discussed in paragraph 30 of* Re Pope*), and similarly should not be excluded from the scope of the s.45(1)(c) exemption in Queensland's FOI Act.*

27. I am not convinced that information concerning the performance of employment duties by a salaried employee professional in a Commonwealth government agency, who also had a limited right of private practice, would be eligible for exemption under s.43(1) of the Commonwealth FOI Act, in so far as the information related to the performance of duties as a salaried employee. *Harris v ABC* indicates that it would not. However, there is no point in my exploring that issue. I am satisfied that information concerning the performance by a salaried employee professional, in a Queensland government agency, of the employment duties for which he or she is paid from the public purse, is not eligible for exemption under s.45(1)(c) of the FOI Act, because it is not information concerning his or her "professional affairs" in the sense that term is used in the context of s.45(1)(c), as explained in *Re Pope* at paragraphs 28-29.

28. I accept that this carries the potential for information that reflects adversely on the professional competence of a salaried medical practitioner (or lawyer, architect, or other professional), in respect of professional services performed as an employee of a government agency, to affect their professional reputation, and ability to attract private patients or clients (whether pursuant to a limited right of private practice, or in the running of a professional practice after resigning from public employment). However, in my view, this is no more anomalous than it would be if (as would be the consequence of the Hospital's contentions) a salaried employee medical practitioner with a limited right of private practice had a means of avoiding accountability under the FOI Act for the performance of his/her duties paid for from public funds, which was not available to salaried employee medical practitioners who do not have, or exercise, a limited right of private practice. I do not accept that the consideration referred to in the first sentence of this paragraph supplies a reason for adopting a more expansive interpretation of "professional affairs" in the context of s.45(1)(c). As I said in *Re Pope* at paragraphs 33-34:

> *It is a clear object of the FOI Act to enhance government's accountability (see s.5(1)(a) of the FOI Act), and this must include enhancing the accountability of government employees for the performance of their duties in the public interest. The FOI Act affords no specific exemption for information that might adversely affect an employee of a government agency in respect of his or her employment affairs, and this is only logical since to do so would be inimical to the attainment of one of the major objects of FOI legislation, i.e., enhancing government's accountability and keeping the community informed of government's operations.*

> *Professionals are employed by government agencies, and paid from public funds, to exercise the skills and knowledge attained through their professional training in pursuit of the public interest objectives which comprise the mission of the agency with whom they accept employment. It is difficult to see any reason why professionals employed in government agencies should not be just as accountable to the public they are employed to serve, for the discharge of their employment duties, as other government employees who are not members of a recognised profession.*

29. Since the matter in issue concerns the surgeons' treatment of public patients, it is properly to be characterised as information concerning the performance by the surgeons of their duties of employment as government employees, and not as information concerning their professional affairs, according to the meaning which the term "professional affairs" has in the context of s.45(1)(c) of the FOI Act. Since disclosure of the matter in issue would not disclose information concerning the business, professional, commercial or financial affairs of a person, I find that the matter in issue does not qualify for exemption under s.45(1)(c) of the FOI Act.

30. This finding is sufficient to dispose of the Hospital's claim for exemption under s.45(1)(c). However, since the issues were fully argued by the participants, I am prepared to consider the remaining elements of the test for exemption under s.45(1)(c) on the assumption (contrary to my finding) that the term "professional affairs" extends to the performance of professional services, irrespective of whether the professional is a salaried employee of a government agency or is engaged in running a professional practice on a fee for service basis, and that, accordingly, disclosure of the matter in issue would disclose information concerning the professional affairs of a person. On that assumption, the public interest considerations as to accountability, which are referred to in the passages quoted in paragraph 28 above, would have to be taken into account as public interest considerations favouring disclosure, when it came to apply the public interest balancing test incorporated in s.45(1)(c).

Section 45(1)(c)(ii)

31. Section 45(1)(c)(ii) will be satisfied if either of two prejudicial consequences could reasonably be expected to follow if the matter in issue were disclosed. At pp.339-341 (paragraphs 154-160) of *Re "B" and Brisbane North Regional Health Authority* (1994) 1 QAR 279, I analysed the meaning of the phrase "could reasonably be expected to" by reference to relevant Federal Court decisions interpreting the identical phrase as used in exemption provisions of the *Freedom of Information Act 1982* Cth. In particular, I said in *Re "B"* (at pp.340-341, paragraph 160):

> *The words call for the decision-maker ... to discriminate between unreasonable expectations and reasonable expectations, between what is merely possible (e.g. merely speculative/conjectural "expectations") and expectations which are reasonably based, i.e. expectations for the occurrence of which real and substantial grounds exist.*

The ordinary meaning of the word "expect" which is appropriate to its context in the phrase "could reasonably be expected to" accords with these dictionary meanings: "to regard as probable or likely" (Collins English Dictionary, Third Aust. ed); "regard as likely to happen; anticipate the occurrence ... of" (Macquarie Concise Dictionary, 3rd ed); "Regard as ... likely to happen; ... Believe that it will prove to be the case that ..." (The New Shorter Oxford English Dictionary, 1993).

Adverse effect

32. The Hospital invoked reliance on the 'mosaic theory', sometimes referred to as the 'theory of cumulative prejudice', which holds that information which may appear innocuous when viewed in isolation, can have an entirely different character when considered in conjunction with other information already in the public domain, or already known to the access applicant.

33. The Hospital submitted that the 'mosaic theory' has been recognised by the Commonwealth Administrative Appeals Tribunal, principally in cases involving intelligence information (e.g., *Re McKnight and Australian Archives* (1992) 28 ALD 95) but also more recently in the case of 'commercial-in-confidence' information (e.g., *Re Day and Collector of Customs* (1994) 33 ALD 777). The Hospital submitted that the general principles applied in those cases were capable of applying in the present case, where the applicant is an experienced journalist, skilled in assembling small pieces of information in the course of background investigation and research.

34. The applicant submitted that the Hospital's reliance on the 'mosaic theory' was misplaced, and that the theory is confined to considerations involving the disclosure of highly confidential material in the context of police and security investigations, where such disclosure would adversely affect high-risk operations. The applicant further submitted that a more accurate reading of the decision in *Re Day* shows that the theory was used in a very limited context involving the access and use of the information in issue by the respondent's commercial competitors.

35. I referred to the proper scope and application of the 'mosaic theory' in *Re O'Reilly and Queensland Police Service* (1996) 3 QAR 402, at pp. 410-412 (paragraphs 18-25), where I said (at paragraphs 21-22):

> *21. In my view, references to the possibility of mosaic analysis do no more than draw to the attention of the decision-maker the fact that disclosure of the information in issue in a particular case should not necessarily be viewed in isolation. It points to the possibility that, in certain cases, disclosure of a piece of information in issue, when combined with other available information, could enable the deduction of further information, the disclosure of which would be contrary to one of the public interests which the exemption provisions in the FOI Act are designed to protect.*
>
> *22. It must be borne in mind that the mosaic theory does not give rise to any separate exemption and can only be used to establish a factual basis for satisfaction of one of the exemption provisions within the FOI Act.*

36. In support of the application of the 'mosaic theory', the Hospital submitted that folio 22 (which has been disclosed to the applicant) clearly identifies the five surgeons who were part of the Hospital's Vascular Surgery Unit at the relevant time, and that folio 21 (also disclosed) indicates that one aspect of the lecture given by Dr McGahan was to present the results of a computer audit of the surgical outcomes achieved by the Vascular Surgery Unit, therefore linking the five surgeons identified on folio 22 to the results shown on folio 3. The Hospital conceded that, while folio 3 does not, in isolation, identify any of the surgeons concerned, they are readily identifiable, collectively, from folio 22. The Hospital further

submitted that, given the way in which the information on folio 3 is presented, the surgical outcomes experienced by one surgeon are highlighted, although that surgeon is not specifically identified.

37. In his application for external review, the applicant stated that he had received a tip-off from an informant who had identified a particular surgeon at the Hospital who was alleged to have experienced a high rate of strokes in the patients on whom he had operated, and who had performed less surgery than other surgeons in the Vascular Surgery Unit. The applicant did not identify the particular surgeon in question, but confirmed that he was seeking access to the information in issue in order to confirm or discount the veracity of the information provided by his informant.

38. The information supplied to the applicant by his informant, or at least those parts of it which the applicant has been prepared to disclose to the Hospital or to my office, has not been particularly accurate. For instance, with respect to paragraph 1 of the applicant's FOI access application (reproduced at paragraph 2 above), folio 3 reviews considerably more than 120 cases, and adverse outcomes are not summarised relative to each surgeon. Moreover, the one surgeon whose results are highlighted by the manner of presentation of folio 3, performed twice as many operations as the average number performed by each of his colleagues (at least in respect of the particular surgical procedure, and the particular period of time, covered in folio 3). It is possible that the applicant does not have accurate information as to the identity of the surgeon whose individual results are highlighted by the manner of presentation of folio 3. However, that surgeon's identity would be known to a number of staff at the Hospital, and in a climate where information has been provided to an investigative journalist who is keen to pursue inquiries, I consider it would be more realistic to find, on the balance of probabilities, that the matter in issue, if disclosed, is capable of being related to the performance of a particular surgeon, even though that surgeon is not identified in the matter in issue itself.

39. Having reached a similar view (and in accordance with s.74(1)(b) of the FOI Act), the Deputy Information Commissioner wrote to that surgeon on 8 December 2000 to inform him of my review, and to ascertain whether or not he objected to disclosure of the matter in issue, and whether or not he wished to participate in my review. The surgeon in question contacted the Deputy Information Commissioner by telephone on 12 December 2000 to discuss the matter, and advised that he needed more time to consider his position. Nothing further was heard from the surgeon and so, on 9 January 2001, the Deputy Information Commissioner sent a follow-up letter in which he advised the surgeon that, unless the surgeon's response was received by 29 January 2001, my office would proceed on the basis that he did not wish to be a participant in my review. No response was received from the surgeon, and I have therefore proceeded on the stated basis.

40. In his statutory declaration dated 2 December 1999, Dr McGahan stated that he did not use, or refer to, the statistical information recorded in folio 3 during his public lecture. Dr McGahan further stated:

> *My decision not to include, or to make reference to, slide 00003 in my presentation, was based, in part, on the fact that the comparative statistical information contained on slide 00003 comprised crude data, which did not take into account risk factors for individual patients. In the circumstances and after discussion with all of the surgeons in the PA vascular unit, I considered it inappropriate to present such raw data in a forum such as "PA Week", as I felt that it could be used to draw unwarranted inferences*

> *about the competence of one of the surgeons who had performed the procedures on possibly higher risk patients than the rest of the subjects of my research project.*

41. The Hospital submitted that its primary basis of objection to the disclosure of the matter in issue was that the matter in issue represents raw data which has not been adjusted to take into account operative risk factors, such as the severity of carotid disease and co-existing conditions in the patients in question. The Hospital submitted that its concern was that the figures contained in the matter in issue could be used to draw unwarranted conclusions about surgical competence. The Hospital relied on a Research letter published in the medical journal *Lancet* (Vol 353, No. 9161, 17 April 1999) by P M Rothwell and C P Warlow on behalf of the European Carotid Surgery Trialists' Collaborative Group, of which the following passages are relevant for present purposes:

> *There have been several highly publicised investigations into surgeons with high operative risks. These have led to demands for more rigorous audit of surgical performance. We demonstrated the importance of independent audit of operative risks in a previous study.* [Rothwell PM, Warlow CP, "Is Self-audit reliable?" *Lancet* 1995; 346: 1623] *However, there is a danger that unusually high (or low) risks will be misinterpreted as shown by analysis of the operative risks of the 147 surgeons who took part in the European Carotid Surgery Trial. The overall risk of major stroke and death within 30 days of carotid endarterectomy was 7.0%. … However, there was a considerable variation in operative risk between individual surgeons …. 71 surgeons had no operative strokes or deaths at all, whereas others had risks of 20-50%. Does this reflect genuine differences in surgical skill? Statistical analysis of heterogeneity of operative risk is difficult because many surgeons operated on only a small number of cases. However, two questions can be addressed. Are the 71 surgeons who had no operative strokes or deaths genuinely safer than the rest of the group? Are the surgeons with high operative risks genuinely less safe than the rest of the group?*
>
> …
>
> *Most surgeons with an operative risk of zero had operated on too few patients within the trial (most fewer than five, and none more than 24) to allow a precise risk to be calculated. For a 0% risk to be significantly lower than the overall 7% operative risk of stroke and death, a surgeon would have to have operated on at lest 50 patients (95% CI 0-7.1). There is no good evidence, therefore, that the 0% operative risks among the trial surgeons were due to anything other than chance.*
>
> *The highest operative risks (50% and 33%) were also based on very small numbers of operations (two and three patients, respectively). There is no good evidence that these high risks were due to anything other than chance. …Surgeon X operated on 50 patients and had 11 (22%) operative strokes or deaths. This proportion was significantly greater than the risk in the rest of the group… . Although this comparison is data-derived, it is so highly significant that it is difficult to put down to chance alone. However, the risk of carotid endarterectomy is highly dependent on the clinical case-mix, and it is necessary to correct for this factor before drawing any conclusions about surgical skill. When corrected for independent risk factors for operative*

> *stroke and death, and for other potential confounding factors, in a multiple logistic regression analysis, Surgeon X was no longer associated with a significantly increased operative risk.… .*
>
> *We conclude that although it can sometimes be useful to audit the risk of medical interventions, as with league tables for hospital performance, the interpretation of results must take the effects of chance and variations in clinical case-mix into account. Over-simplistic interpretations of crude results may lead to unjustified criticism of individual clinicians, and are unlikely to lead to improvements in the care of patients.*

42. The Hospital also relied on a series of letters published in the *New England Journal of Medicine*, which raised similar concerns regarding the need to adjust data concerning surgical complication rates, to take into account the severity of carotid disease and co-existing conditions, and also emphasised the difficulty of drawing direct comparisons between the results of clinical trials which use different definitions to classify particular types of post-surgical complications.

43. In response, the applicant argued in his submission dated 12 January 2000:

> *… The Hospital fears that the crude data will be misleading. However, the likelihood of such an extreme adverse effect is limited because of the fact that the average recipient of the information would realise that it is in its crude form and that there would need to be qualifications made to any conclusions drawn from the research.*

44. In paragraph 3 of his statutory declaration, Dr McGahan stated that the complication rate of carotid surgery in published reports in the medical literature was usually less than 6%. The European study quoted in paragraph 41 reported a complication rate for carotid endarterectomy of 7%.

45. Disclosure of the matter in issue would enable a person of average mathematical ability to make calculations that would show that the complication rate experienced by four of the surgeons in the Hospital's vascular surgery unit was well below the range of 6 to 7%, while the complication rate experienced by one of the surgeons was above that range. The figures are not risk-adjusted, and (as the European study, quoted at paragraph 41 above, indicated in its comments on Surgeon X from that study) appropriate adjustment for risk factors might indicate that no adverse inferences could reasonably be drawn about the surgical competence of the individual surgeon whose adverse results are highlighted by the manner of presentation of the information in issue on folio 3.

46. The applicant has argued, in effect, that the average recipient of the information would appreciate that it is in a crude form and could not reasonably be expected to draw adverse conclusions about the comparative surgical competence of the surgeon whose adverse results are highlighted. However, I am not so confident that a significant proportion of 'average recipients' would not merely take the figures at face value as showing that one of the surgeons had a higher complication rate than his colleagues. I consider that there is a reasonable basis for expecting that disclosure of the matter in issue could have an adverse effect on the particular surgeon's reputation for surgical competence, and thereby deter some prospective patients from seeking surgical treatment from that surgeon. Therefore, on the assumption (contrary to my finding) referred to in paragraph 30 above, I consider that disclosure of the matter in issue could reasonably be expected to have an adverse effect on the professional affairs of the particular surgeon whose adverse results are highlighted by the manner of presentation of the information in issue on folio 3.

Prejudice to future supply of information

47. The Hospital submitted that disclosure of the matter in issue could reasonably be expected to prejudice the future supply of such information, either through clinicians being unwilling to undertake projects such as that conducted by Dr McGahan, or through intentionally under-reporting complications, or minimising the seriousness of reported complications, so as to achieve an artificially low rate of operative risk.

48. The only evidence which the Hospital placed before me on this issue was contained in the following parts of Dr McGahan's statutory declaration:

> *3. Such projects are a normal component of research techniques utilised by clinicians to monitor outcomes, as an integral part of ensuring the provision of optimal surgical care to patients. …*
>
> *…*
>
> *10. Had I been aware that my research, performed in the spirit of PA Week (which is to present current local clinical and laboratory research data demonstrating that our hospital is of a world standard), would be the subject of FOI inquiry I would have reconsidered even performing it let alone presenting it. I believe that potential disclosure of research data of the type in issue here could be expected to have a 'chilling effect' on the willingness of clinicians to undertake such projects in the future, or at least lead to research being presented in a more 'sanitised', and thus less useful, form.*

49. In further support of its case, the Hospital urged me to follow the conclusions reached by Deputy President M F Macnamara of the Victorian Civil and Administrative Tribunal in *Re Birnbauer and Anor and Inner and Eastern Health Care Network* (1999) 16 VAR 9. That case involved an application, under the *Freedom of Information Act 1982* Vic (the Victorian FOI Act), for access to documents concerning "adverse medical events", received or created by Quality Improvement Committees and related bodies, for the hospitals covered by the respondent network. Extensive evidence was given by eminent clinicians and hospital administrators, who were cross-examined by counsel on behalf of the applicant, to the effect that, while clinicians would co-operate with the system of quality improvement committees by providing information for confidential peer review processes, that co-operation would be withdrawn if there were a prospect of public disclosure of such information. While Deputy President McNamara voiced skepticism about the evidence, and did not accept it without reservation, he did say (at pp.23-24, paragraph 25):

> *There seems to be every good reason to accept that clinicians …would not be forthcoming with information which would show them as individuals in a bad light. I cannot accept however that release of aggregated data, no matter how far divorced from disclosure by individual clinicians of individual incidents relative to individual patients, will have the alleged adverse effect. Evidence was given by a number of witnesses that material identifying particular small units indirectly has the capacity to identify individual practitioners or patients because of the relatively small number of individuals to whom any anonymous references might apply. One may accept that clinician resistance and apprehension would be significant in those circumstances and sufficient to create the necessary prejudice to*

> *further information gathering which would justify the exemption under section 35(1)(b)* [of the Victorian FOI Act]. *A number of witnesses … were apprehensive in a general sense that data would be misunderstood or misused. I am skeptical that this apprehension would go beyond mere annoyance… to the extent of leading to an actual withdrawal of co-operation in data collection.*

50. In his application for external review, the applicant submitted:

> *It is clear that the Deputy President in this Victorian case did not believe he should automatically accept that the exemption applied merely because clinicians asserted they would not cooperate with data collection. He said* [at p.23]:
>
> > …it seems that members of the medical establishment are given to excessively pessimistic predictions on these sorts of matters. Not only are there grounds for me to treat the evidence in its totality with some skepticism but the actions of the Network demonstrate that its executives bring the same skepticism to bear in making their own judgements.

51. In support of his case that disclosure of the matter in issue could not reasonably be expected to prejudice the future supply to government of such information, the applicant also submitted as follows in his external review application:

> *… We understand from hospital sources that not only is morbidity data generally collected by the Hospital administrative staff and not by the specialist doctors or surgeons, it is an express or implied condition of contract in most Hospitals in Australia that all medical personnel will comply with Quality Assurance procedures. This is an obligation required of staff to ensure that Hospitals can maintain accreditation with the Australian Council of Healthcare Standards.*
>
> *If, as the Hospital suggests, a surgeon refuses to allow his morbidity or mortality data to be entered on to the Hospital computer system, then that doctor is in breach of his legal and ethical obligations to the Hospital and would be answerable not only to the Hospital but his Professional College and the Medical Board. In practice, of course, we understand that could not and does not ever happen because the surgeons have no say-so over whether the Hospital gets the particular type of information we seek in this case.*

52. At paragraph 4 of his statutory declaration, Dr McGahan stated:

> *4. The methodology of my project involved computer searches of the relevant database - the "Hospital Based Computerised Information System" (HBCIS) - to identify patients who had undergone the surgical procedure in question within the relevant time-frame of January 1994 to June 1996. I then examined the individual patient files, collecting data in relation to various criteria (i.e., age, sex and symptomatology), and making an assessment of the surgical outcome for each patient (i.e., death or various types of complications).*

53. The kind of information which Dr McGahan sought from individual patient files (as appears from the parts of folio 3 that have already been disclosed) was in the nature of major adverse events (e.g., death, or a stroke). The information is recorded in folio 3 as a statistical table of the occurrence of such events. I mean no disrespect to Dr McGahan (for whom the compilation of the statistical tables in folio 3 was merely one step in a project with wider purposes, as disclosed in paragraph 3 of his statutory declaration) in saying that the information contained in folio 3 could have been compiled by any hospital administrator with medical qualifications (and probably many without) who followed the same steps to identify (from the HBCIS), and examine, particular patient files. The evidence before me does not establish (and I would have great difficulty in accepting any untested evidence which asserted) that the prospect of disclosure of the matter in issue could reasonably be expected to deter clinicians in Queensland Hospitals from their professional duty (and their legal and ethical duties as public sector employees) to accurately record in patient clinical files the occurrence of major adverse events of the kind that appear on folio 3.

54. Nor do I accept that responsible clinicians (or hospital administrators) could reasonably be expected to be deterred (by disclosure of the matter in issue) from undertaking projects to monitor performance, in rates of adverse outcomes for patients, against accepted national or international standards. (They may be more likely to produce risk-adjusted data to accompany the raw figures, so as to minimise the potential for raw figures to give a misleading impression as to the competence of individual clinicians, but none of the material lodged by the Hospital suggests that that would be undesirable.) It is possible that some individual clinicians might not be prepared to produce surgical outcomes data in a way that was capable of reflecting adversely on a professional colleague. However, hospital administrators responsible for the maintenance of proper standards of medical practice in public hospitals, who monitor performance data in that regard, need not be so constrained, and, as I have indicated above, I do not accept that disclosure of the matter in issue could reasonably be expected to prejudice the availability of such information on individual patient files.

55. Therefore, on the assumption (contrary to my finding) referred to in paragraph 30 above, I find that disclosure of the matter in issue could not reasonably be expected to prejudice the future supply of such information to government.

Public interest balancing test

56. On the assumption (contrary to my finding) referred to in paragraph 30 above, the next step in the application of s.45(1)(c) would require me to assess the relative weight to be accorded to the protection of an individual surgeon's professional affairs from the apprehended adverse effect of disclosure of the matter in issue, plus any identifiable public interest considerations telling against disclosure, and the relative weight to be accorded to any identifiable public interest considerations favoring disclosure of the matter in issue, in order to determine whether disclosure of the matter in issue would, on balance, be in the public interest.

57. In his application for external review, the applicant submitted that:

> *… there is a general trend towards increasing consumer access to hospital-specific and doctor-specific information. The refusal of the Hospital in this case to allow … access to this data runs contrary to the increasing public interest in seeing such information made more freely available to consumers, to enable them to make more informed judgments about their own health care.*

58. By letter dated 27 October 1999 (written at a time when there were still 22 folios in issue), I conveyed to the Hospital my preliminary view on the application of the public interest balancing test in s.45(1)(c), as follows:

> *… I am of the preliminary view that there is a substantial public interest in enhancing the accountability of the Hospital in respect of the surgical results it experiences, and in its monitoring and management of adverse outcomes experienced by patients treated at the Hospital. I consider that disclosure of folios 3, 4 and 5 would further that public interest in accountability. I also consider that there is a strong public interest in enabling the public to have access to information which may enable them to make more fully informed decisions about available medical and surgical treatments, by taking into account the possible risks associated with certain treatments and the types of results experienced. I consider that the availability of data about surgery outcomes would also assist the public to evaluate the performance of public hospitals. Such hospitals exist for the benefit of the public and there is a public interest in allowing the public access to information which will enable them to assess the performance of the hospital.*

59. In a written submission received on 3 December 1999, the Acting Manager of the Hospital responded as follows:

> *I agree with all of the general statements made by the Information Commissioner concerning enhancing accountability of public hospitals through monitoring surgical outcomes, and providing information to assist members of the public in making fully informed decisions about medical and surgical treatment. However, I would submit that patients can only make <u>fully informed</u> decisions regarding surgical treatment if the information presented to them, for the purpose of making such decisions, is complete and accurate. In this case, as has been explained above, the statistical results of Dr McGahan's research project, as shown on folio 3, are unreliable because of the absence of any risk-adjustment. In the circumstances, it is submitted that the results of the research study in question are flawed, and would mislead members of the public about the true position regarding the operative risk which can properly be attributed to the members of the Hospital's Vascular Surgery Unit.*
>
> *Further, I submit that the public interest in enhancing the accountability of hospitals, and surgeons, for the treatment they provide, will only operate to the extent that complete, accurate information concerning the outcomes of treatment is available. Clinicians are well accustomed to the process of peer review, and the frank exchange of views in the course of that process. However, that is very different, in my view, from the potential disclosure of information to the general public with all of the implications for erroneous assumptions regarding competence, and the reduced incidence, or sanitising of clinic audits, which could reasonably be expected to accompany such disclosure. Further, it is submitted that there is a real risk that, if raw data such as that in issue here were to be disclosed, clinicians may well be reluctant to perform surgery on the more high-risk patients, who are appropriate candidates for carotid endarterectomy, in an effort to lower their 'complication rate'.*

> *For all of those reasons, I consider that there is a strong public interest favouring non-disclosure of the matter in issue.*

60. The applicant's case for disclosure of the matter in the public interest was based on two main grounds. The first was the general public interest in hospitals providing information to consumers about their health care standards:

> *… it should be noted that there is a general trend towards increasing consumer access to hospital-specific and doctor-specific information. The refusal of the Hospital in this case to allow SUNDAY access to this data runs contrary to the increasing public interest in seeing such information made more freely available to consumers, to enable them to make more informed judgments about their own health care.*
>
> *Queensland's Health Department co-funded a two year inquiry into health system safety, prepared by the National Expert Advisory Group on Safety and Quality in Australian Health Care (NEAG), which has concluded this year that Hospitals should be required to provide patients with report cards on their performance in a bid to reduce needless harm and death in the health system. Queensland's Health Minister was one of the unanimous meeting of State and Federal Health Ministers who supported changes such as:* 'improving information flow', 'strengthening consumer involvement in healthcare', 'learning from incidents and adverse events', 'improvements to formal quality improvement and accreditation mechanisms' and 'increasing the focus of quality and safety in education and training.'

61. The applicant referred me to the approach taken by Hughes J of the Supreme Court of the State of New York in *Newsday Inc and David Zinman v New York State Department of Health* (RJI No. 0191-ST 3036, 9 August 1991), which held that the public interest compelled a finding in favour of disclosure under New York state FOI laws of a Health Department study of the death rates of cardiac surgery patients based on heart surgery data from operations performed by 126 cardiac surgeons in thirty hospitals. The study reported, *inter alia*, the performance history of each hospital, the performance record of individual surgeons, and the risk of mortality for patients based on their individual risk factors.

62. The applicant also referred me to the judgment in *Public Citizen Health Research Group v Department of Health, Education and Welfare* 477 F.Supp 595 (1979), which concerned a question of access to records maintained by a Professional Standards Review Organisation (PSRO) designated by the respondent agency. The documents in issue were physician profiles on five physicians consisting of "aggregated data in formats which display patterns of health care services over a defined period of time", hospital profiles, medical care evaluation (MCE) studies, and reviews "aimed at effecting specific improvements in health care delivery". The court allowed that: *Disclosure of physician identities in profiles or MCE Studies raises the prospect of misleading publicity, possibly unwarranted professional and public criticism, and damage to professional reputation.* However, the court referred to important public interests that ultimately told in favor of disclosure (at pp.603-605):

> *Foremost is the interest in enabling the consuming public to make more fully informed choices among individual physicians and hospitals rendering Medicare and Medicaid services. The availability of objective comparative data from PSRO profiles and MCE studies would help patients facing a surgical procedure to evaluate the relative performance of providers; it*

> *would also assist physicians from outside the Washington DC area who refer patients within the District. … Moreover, a better informed public may be an added incentive to monitoring efforts by the PSRO's themselves.*
>
> *… The conceivable adverse effect on overall physician participation does not outweigh a clear public interest in increased knowledge concerning the quality of government-funded medical services.*

(I should note that the judgment was reversed on appeal - 668 F.2d 537 (1981) - but only on the issue that the body in possession of the documents, a foundation acting under a contract with the Department of Health, Education and Welfare, was not an agency subject to the application of the US Federal Freedom of Information Act.)

63. The second main ground relied upon by the applicant related to his reasons for seeking the matter in issue, i.e., to attempt to corroborate or reject the allegations made by an informant, to the effect that the study demonstrated a high rate of strokes by one surgeon, and that hospital officials had failed in their duty of care to the public by not acting sooner on concerns about this doctor's outcomes. The applicant referred to details of the "Bristol Royal Infirmary Tragedy", in which an anaesthetist, concerned about abnormally high mortality and complication rates of two surgeons performing paediatric cardiac surgery, eventually became a whistleblower after inaction by hospital authorities. The Professional Conduct Committee of the General Medical Council of the United Kingdom eventually found the two surgeons, and a hospital administrator, guilty of serious professional misconduct relating to 29 deaths, and four cases of brain damage in survivors. From the tenor of his early submissions, it appears that the applicant had sensed the possibility of a comparable story at the Hospital (although the aggregate statistics for all five surgeons in the Vascular Surgery Unit, that have now been disclosed to the applicant, record just one death, and eighteen other adverse outcomes, over the relevant 30 month period).

64. As I said at paragraph 38 above, the information provided to the applicant by his informant about the matter in issue was inaccurate in several significant respects, and considerably exaggerated. Nevertheless, I have also indicated my view that disclosure of the matter in issue could reasonably be expected to have an adverse effect on one surgeon's reputation.

65. The applicant has stressed that he appreciates that raw data on adverse surgical events may be open to misinterpretation:

> *Should we be released the data, we would be very happy to make it a condition of such release that we consult independent experts who advise us on how best to adjust for … risk factors. Indeed, we would be very happy to consult with the Hospital as part of this process.*
>
> …
>
> *… We submit that if it is correct, as our informant alleges, that a doctor at the PA Hospital has a morbidity/mortality outcome that can only be explained (after expert analysis) as a consequence of serious medical negligence, then the public interest balance significantly outweighs the hospital's interest in collecting the data from its clinicians. …*

> *SUNDAY is very happy to concede that it is in the difficult position of not being able to confirm whether the allegations made by our informant are in fact correct. That is why we are doing our job, as journalists to thoroughly check the allegations made to us.*

66. In its submission (received on 21 February 2000) in response to the applicant's submissions, the Hospital argued as follows:

> *Mr Coulthart submits that the Hospital has not afforded sufficient weight to the public interest considerations weighing in favour of disclosure of the matter in issue. Specifically, Mr Coulthart has referred to an increasing public interest in seeing information, such as that in issue in the present case, made more freely available to consumers, to enable them to make informed judgments about their own health care. Mr Coulthart has made reference to a variety of studies from Australian jurisdictions and overseas, in support of his view.*
>
> *However, I would note in this regard that a common thread in the references cited by Mr Coulthart is that information released publicly must be properly risk-adjusted, in order for appropriate conclusions to be drawn from the data. As has been stated previously , Dr McGahan's study involved no such risk adjustment. …*
>
> *In his reasons for decision* [in Re Birnbauer], *Deputy President Macnamara considered at some length the public interest considerations weighing in favour of disclosure of the matter in issue in that case (information concerning "adverse medical events".) Deputy President Macnamara then stated:*
>
> > 36. But these public interest considerations do not stand alone and must be balanced against the public interest issues which arise out of the exemptions relied upon. No-one has suggested that the promotion of the quality assurance movement in public hospitals is other than an unalloyed good. All the public interests relied upon by Mr Dreyfus are directed ultimately to obtaining the optimal quality of health care for the public in its public hospitals. If it is demonstrated that the information necessary to promote quality assurance programs or in a more general sense, manage quality issues within a public hospital will not be forthcoming, the public interest in avoiding that consequence in my view, overrides any of the public interest issues relied upon by Mr Dreyfus. To look at it another way, the applicant's public interest issues assume that information as to adverse medical events will be available. If the release of that information significantly diminishes that flow of information, not only will the quality assurance bodies within the hospitals be deprived of the fullness of the information but so will the public and the entire exercise in the long run will be self defeating.

In applying that analysis to the matter in issue in Re Birnbauer, Deputy President Macnamara consistently upheld the respondent's claims for exemption for matter, the disclosure of which could reasonably be expected to deter full and accurate reporting of adverse incidents, or identify (or enable identification of) clinicians working in small units.

The Hospital adopts the view expressed by Deputy President Macnamara, as quoted above. The Hospital's position is that the potential for disclosure of raw, non risk-adjusted data such as that in issue in the present case, could reasonably be expected to lead to clinicians under-reporting surgical complications, or classifying complications as being less severe than they might otherwise have done, in order to achieve a more favourable 'report card' regarding their surgical performance. Such a result cannot be seen to enhance the efficacy of quality assurance and peer review mechanisms within hospitals, and is clearly not in the public interest. …

Further, it is submitted that Mr Coulthart's stated intention of consulting experts, for the purpose of assisting in determining how to interpret and qualify the data, would be meaningless, as the matter in issue does not contain relevant data from individual patient records (to ascertain the presenting condition, and risk factors, of the patients who underwent the specific procedure to which Dr McGahan's study related).

67. In *Re Birnbauer*, Deputy President McNamara had to consider whether, under the public interest override provision (s.50(4) of the Victorian FOI Act), disclosure of the matter in issue that satisfied the test for exemption under s.35(1)(b) of the Victorian FOI Act, was nevertheless required in the public interest. He made the following observations in respect of that issue (at pp.26-27, paragraphs 30, 32-35):

> *30. I accept Mr Dreyfus' submission that there is a public interest in public hospitals being open to public scrutiny of their management and further that enhanced accountability of such hospitals is in the public interest. It is also in the public interest to promote consumer rights amongst users of health care services and there is an interest in permitting the public to be informed as to the occurrence of adverse medical events and programmes such as quality improvement programmes in the institutions which their taxes pay for public confidence is likely to be enhanced in hospitals and medical practitioners for whom they are seen to be candid and forthcoming rather than secretive.*
>
> *…*
>
> *32. Mr McLean on behalf of the respondent submits that the information here in dispute does not represent comprehensive, aggregated risk adjusted data whose release is advocated by Professor Duckett and co-authors in their work,* Health Services Policy Review Discussion Paper, *Ch 11, prepared as part of the Victorian government's implementation of national competition policy. Mr McLean observes that the "raw" material whether in narrative or statistical form would not achieve the public benefits asserted either in permitting informed public debate or allowing members of the public as health care consumers to make informed comparisons between health care providers. It may be*

necessary to say more as to the detail of these arguments when I turn to the documents themselves. For the moment it is appropriate to consider these arguments at a general level. Dr Coglin said that experience in the United States showed that where material was published in the State of Pennsylvania to enable consumers to make critical judgments between health care providers, only two per cent of a sample of consumers surveyed said that they had consulted and been influenced by this published material. Mr McLean submitted and I did not understand Mr Dreyfus to deny, that the raw nature of the data and information in these documents, devoid of risk adjustment, did not render them fit for easy or reliable interpretation even by informed and discriminating lay people.

33. *These submissions have a superficial attraction but they are based upon an underlying fallacy. According to this analysis the importance in constitutional government and participatory democracy of the Office of the Auditor-General could be judged by the percentage of the population who bought or read his reports. With the infinite complexity of society, its institutions and the scientific and technological expertise involved in their operation, ordinary citizens cannot by their own direct and unaided perusal of available public information keep abreast of all important public issues or subject the workings of government to adequate scrutiny. No individual citizen has the technical expertise to have a full understanding of all major public issues. This is as true for highly qualified expert professionals as for unskilled workers. A lawyer may have a good grasp of the legal issues arising in government but be unable to come to terms with biological or engineering issues. A qualified doctor may understand medical issues but not economic issues. Even if an individual citizen were possessed of all necessary technical expertise, the necessity for him to lead his own life would leave him without the necessary time to analyse all available government information on a range of public issues.*

34. *In practice, democratic society operates upon the assumption that there are specialist and generalist institutions in society which devote themselves to scrutinising and analysing available data and making their analyses more widely available whether amongst academic communities or the wider public. These institutions include most notably universities and media organisations and we now have the more recent and American-inspired phenomenon of the "think tank". Therefore the release of information may enable those with special expertise to analyse and study it and provide commentaries couched in ordinary language which can be the subject of discussion and debate throughout society. When budget papers are published at either the State or Commonwealth level, the wider citizenry never reads them but financial journalists, academic economists and politicians do and ordinary members of society may have some confidence that any egregious issues arising in the budget papers will be raised for debate by one of these groups.*

35. *In a general sense I accept that the public interest issues raised by Mr Dreyfus, viewed alone, do require this class of material to be released.*

68. However, when weighed against his finding that the information necessary to promote quality assurance programs would not be forthcoming from clinicians, Deputy President McNamara reached the conclusion (at paragraph 36 of his decision) which has been relied upon by the Hospital and is set out in its submission reproduced in paragraph 66 above. The matter in issue in *Re Birnbauer* was considerably more extensive, and (for the most part) materially different in character, to the matter in issue in folio 3 in the present case. Deputy President McNamara found that the s.35(1)(b) exemption in the Victorian FOI Act applied to much (but not all) of the information in issue before him. That exemption provision required him to be satisfied that information had been communicated in confidence by a person to an agency, and that disclosure would be reasonably likely to impair the ability of an agency to obtain similar information in the future. As I have explained in paragraph 53 above, the statistical information in issue in folio 3 in the present case is not information of that kind. Therefore, in the absence of a finding like the one referred to in the first sentence of this paragraph (which in *Re Birnbauer* weighed heavily against disclosure), Deputy President McNamara's approach to weighing the competing public interest considerations would appear to tell in favour of disclosure of the matter in issue in folio 3 in the present case. However, the issue is not quite so straightforward, for reasons explained below.

69. I am in general agreement with the views of Deputy President McNamara which are quoted in paragraph 67 above. I note that in *Re Kenmatt Projects Pty Ltd and Qld Building Services Authority* (1999) 5 QAR 161 at p.179 (paragraph 48), I recognised a significant public interest in consumers having information about the performance of builders to enable them to make informed choices about the builder they engage. Deputy President McNamara has acknowledged a similar public interest in consumers being able to make informed choices about health care providers. In my view, it is obviously in the public interest that consumers should be able to make informed choices about services or products they might wish to purchase. There is no reason why professional services should require differential treatment in that regard from other services such as building services. Where a government agency is a provider of professional services to the public, this public interest consideration will weigh in favour of disclosure of agency records that would further it. Of course, the Hospital's primary counter-argument is that consumers will not be enabled to make informed choices about health care providers from raw statistical data, rather than data that has been properly risk adjusted. I will say more about that argument below.

70. I have also previously applied principles similar to those stated by Deputy President McNamara in paragraphs 33-34 of *Re Birnbauer*. In *Re Community Newspapers Pty Ltd v Redlands Shire Council* (1998) 4 QAR 262, I said (at pp.279-280, paragraphs 46-47):

> *46. I note the arguments made on behalf of Civic Projects regarding the technical content of the Report and the alleged inability of lay persons to fully comprehend it. I do not accept those arguments as valid reasons for denying the public access to the Report. If the problems experienced with revetment stability at the Raby Bay Canal Estate are technical in nature, and to describe the nature of the problems and methods of dealing with them requires technical explanations, then interested members of the public can only be properly informed by disclosure of technical information. The authors of the Report have indicated (in the second paragraph on p.12 of the main report) that they have endeavoured to make some concessions for an anticipated non-technical readership. Any interested member of the public having difficulty in understanding technical aspects of the Report is free to seek expert assistance. I see no justification for withholding that opportunity from*

> *interested members of the public, because Civic Projects believes it is in a position to judge what technical information should be withheld from the public for fear of confusing it.*
>
> *47. I can see no manageable standard that could be applied, if contentions of the kind advanced on behalf of Civic Projects were accepted as valid. Much technical, and indeed non-technical, information that is published by governments is confusing and difficult to comprehend for substantial segments of the community. (Anyone who has attempted to read unabridged Commonwealth or State government Budget Papers will understand what I mean.) The democratic values of open government are nevertheless served by making such information available to interested members of the public, including those who might need to seek assistance in interpreting it. I do not accept that the fact that even a vast majority of the public may find a technical document confusing or difficult to comprehend is sufficient reason, in itself, to indicate that disclosure of the document would be contrary to the public interest, or to indicate that its disclosure would not be in the public interest.*

71. In the present case, the Hospital argues that disclosure of the raw figures on adverse surgical outcomes, without risk adjustment, would mislead the public by giving a misleading impression of the surgical competence of a particular surgeon, and would be unfair to that surgeon. The difficulty in transposing the approach in the passage set out above (and in *Re Birnbauer* at paragraphs 46-47) is that, as the Hospital correctly observed in the last paragraph of its submission quoted at paragraph 66 above, it is not possible for any expert assistance to interpret the matter in issue in accordance with proper risk-adjustment principles, without access to the medical records of the patients involved. Those records could not ordinarily be made available having regard to considerations of privacy and patient confidentiality (although it may be arguable that disclosure of pertinent information, in an anonymised form, would, on balance, be in the public interest).

72. It would be open to the Hospital to have qualified staff examine the relevant patient records and undertake the risk adjustment process, so as to disclose a set of risk-adjusted figures to accompany the matter in issue in folio 3, and which might mitigate or dispel the potentially misleading and unfair impression that could be gained from the matter in issue in folio 3. (In view of my finding at paragraph 29 above, the Hospital may consider it proper to commit resources to this task, in fairness to the surgeon whose adverse results are highlighted by the manner of presentation of the information in folio 3.) I have no information as to the resource costs of such an exercise, which would involve expert examination of the relevant patient records, but it would be surprising if it involved a greater resource cost than has been expended in opposing disclosure of the matter in issue under the FOI Act.

73. For an agency to rely on the potentially misleading nature of information as a reason for opposing its disclosure under the FOI Act has been treated with (in my view, justified) skepticism. In the joint Australian Law Reform Commission/Administrative Review Council report: *Open government: a review of the federal Freedom of Information Act 1982*, it was recommended (at p.97) that guidelines should be issued to Commonwealth agencies on how to apply a public interest test in FOI exemption provisions, and that the following factors (among others) should be listed as irrelevant to the public interest:

- *that disclosure would confuse the public or that there is a possibility that the public might not readily understand any tentative quality of the information*
- *that disclosure may cause the applicant to misinterpret or misunderstand the information contained in the document because of an omission from the document or for any other reason.*

74. The last-mentioned factor corresponds to s.59A(b) of the *Freedom of Information Act 1989* NSW (the NSW FOI Act) which provides:

> *59.A For the purposes of determining under this Act whether the disclosure of a document would be contrary to the public interest, it is irrelevant that the disclosure may:*
>
> …
>
> *(b) cause the applicant to misinterpret or misunderstand the information contained in the document because of an omission from the document or for any other reason.*

75. In my view, there are at least two reasonable bases for this disinclination to accept agency assertions that information should not be disclosed because it would confuse or mislead the public. The first applies where it is open to a citizen who has been interested enough to seek out the information, to seek assistance in understanding it: see the passages quoted at paragraphs 67 and 70 above.

76. The second applies where it is open to the agency, by the provision of further information, to avoid the potential for misleading or confusing the public. I should first note in that regard that the right of access conferred by the FOI Act is a right of access to documents which already exist in the possession or control of the relevant agency, not a right to have a new document created containing information which the access applicant seeks (except in the circumstances provided for by s.30(1)(e) of the FOI Act): see *Re Pearce and Queensland Rural Adjustment Authority* (1999) 5 QAR 242 at pp.247-248, paragraphs 4-7. Of course, in the present case, the applicant has not asked for the creation of a new document containing risk adjusted data; he seeks an existing document. But the tenor of the case put forward by the Hospital is such that it ought to have no objection to disclosure of the matter in issue in folio 3, if it were accompanied by a document containing a proper risk-adjustment analysis of the statistical information in folio 3.

77. Although the Queensland FOI Act contains no provision equivalent to s.59A(b) of the NSW FOI Act, it may well be appropriate, in the application of a public interest balancing test, to discount any weight to be accorded to an agency argument that disclosure of information would confuse or mislead the public, when it is within the power of the agency, without otherwise causing undue harm to the public interest, to disclose additional or clarifying information that could mitigate, or avoid, the potential for misleading or confusing the public. In the present case, the tenor of the Hospital's submissions indicates an acceptance of the proposition that disclosure of risk-adjusted statistical data would be in the public interest, and it is within the power of the Hospital to arrange for the preparation and disclosure of risk-adjusted statistical data. I note in this regard the provisions of s.14 of the FOI Act:

> ***14.*** *This Act is not intended to prevent or discourage—*
>
> *(a) the publication of information; or*
>
> *(b) the giving of access to documents (including documents containing exempt matter and exempt documents); or*
>
> *(c) the amendment of documents relating to the personal affairs of persons;*
>
> *otherwise than under this Act if that can properly be done or is permitted or required to be done by law.*

78. While I consider that there is a respectable argument for discounting any weight to be accorded to the Hospital's contention summarised in the first sentence of paragraph 71 above, on my analysis it is unnecessary to resort to discounting the weight of the Hospital's contention on the basis explained above, because there are public interest considerations favouring disclosure which outweigh the Hospital's contention in any event.

79. Firstly, I do not accept the Hospital's contention that the raw statistics in folio 3 are of no value in assisting interested members of the public to make informed decisions about available surgical treatments and service providers, or in enhancing the accountability of the Hospital in respect of the surgical results it experiences, and its monitoring and management of adverse outcomes experienced by patients treated at the Hospital. The statistics in folio 3 are not misleading in themselves (rather the potential vice in their disclosure is that disclosure could reasonably be expected to create an adverse impression as to the surgical competence of one surgeon that is potentially misleading, and if so, would be unfair to that surgeon) - they are accurate figures as to the number (and percentage) of adverse outcomes recorded in the relevant period. They enable straightforward comparisons with the complication rates reported for this particular surgical procedure in studies published in the medical literature. I note, for example, that disclosure of the matter in issue in folio 3 would show that the rate of adverse outcomes in the aggregated results of four of the surgeons in the Hospital's vascular surgery unit were significantly below the complication rate of 6-7% referred to in the medical literature, and this is information that would be valuable for potential patients.

80. Moreover, such comparisons with reported complication rates should enable hospital administrators, responsible for the maintenance of proper standards of medical practice in public hospitals, to undertake a basic performance audit which could alert them to potential problems that required further investigation. Thus, if statistics on adverse outcomes for a particular surgeon or surgical unit were significantly higher than accepted complication rates, it might indicate that a risk-adjustment analysis, and/or some other relevant investigation, ought to be undertaken to ascertain whether or not there was any cause for concern, or further action, in terms of the hospital's responsibility to maintain proper standards of medical practice and surgical competence. In my view, the matter in issue in folio 3 should have raised a preliminary alert of this kind. A need for some inquiries should have been indicated, and perhaps a proper risk adjustment analysis should have been ordered. If that had occurred, it might well have confirmed that there was no cause for concern with the surgical competence of the particular surgeon. But if a risk adjustment analysis was undertaken by the Hospital, that has not been disclosed in the material before me. I consider that there is a public interest in the Hospital being accountable for its action or inaction in that regard, and in members of the community being able to make an informed

assessment of whether the Hospital acted appropriately in terms of its responsibility to maintain proper standards of medical practice and surgical competence. Disclosure of the matter in issue in folio 3 would enable an interested member of the public to ask:

- whether that statistical information prompted hospital administrators to make relevant inquiries and/or order a proper risk adjustment analysis?
- If not, why not?
- And if so, did the steps taken confirm that there was no cause for concern as to the surgical competence of the particular surgeon?

81. It may be preferable in the public interest, and to avoid unfair damage to the professional reputation of particular medical practitioners, that statistical information of the kind in folio 3 should be disclosed together with a document explaining the factors applied in a risk adjustment analysis, and the results obtained. However, on the arguments pressed by the Hospital, basic statistical information as to the performance of publicly funded medical services would not be disclosed (except perhaps in circumstances where a risk adjustment analysis of that data had already been prepared and had also been requested under the FOI Act), if disclosure could reasonably be expected to have an adverse effect on the professional affairs of a medical practitioner. Yet the existence of performance information that is potentially damaging to the professional reputation of a medical practitioner, employed by a government agency to provide professional services to the public, more acutely enlivens the public interest in accountability of the agency to maintain proper standards of medical practice and surgical competence. 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.

82. Towards the end of the passage quoted at paragraph 59 above, the Hospital argued that disclosure of 'raw data' may make clinicians more reluctant to perform surgery on the more high-risk patients, in an effort to lower their complication rate. It is possible that some surgeons could react in the manner suggested by the Hospital, but I have sufficient faith in the professional standards (and dedication to helping the sick) of our specialist medical practitioners, that I am not prepared to accept that a majority of surgeons would decline to assist a high risk patient who needed this surgical procedure. In his telephone discussion with the Deputy Information Commissioner, the surgeon (whose adverse results are highlighted by the manner of presentation of the information in folio 3) stated that his surgical outcomes reflected the fact that he was more inclined than his colleagues to take problem cases into the operating theatre. It may well be just as much in the public interest (especially if there were a tendency of the kind suggested by the Hospital) that patients, who are in significant danger of death or stroke in any event, have access to information about surgeons who are willing to operate on high-risk patients.

83. On the assumption (contrary to my finding) stated at paragraph 30 above, in weighing the apprehended adverse effect of disclosure of the matter in issue on one surgeon's professional affairs and the other public interest considerations claimed by the Hospital to favour non-disclosure of the matter in issue, against the public interest considerations favouring disclosure referred to in paragraphs 28, 58, 69 and 79-80 above, I consider that disclosure of the matter in issue would, on balance, be in the public interest. This is an additional basis (to my finding at paragraph 29 above) for finding that the matter in issue does not qualify for exemption under s.45(1)(c) of the FOI Act.

Application of s.45(3) of the FOI Act to the matter in issue

84. Section 45(3) of the FOI Act provides:

> ***45.(3)*** *Matter is exempt matter if—*
>
> *(a) it would disclose the purpose or results of research (including research that is yet to be started or finished); and*
>
> *(b) its disclosure could reasonably be expected to have an adverse effect on the agency or other person by or on whose behalf the research is being, or is intended to be, carried out.*

85. Section 45(3) exempts matter which would disclose the purpose or results of research, in certain circumstances. In *Re O'Dwyer and The Workers' Compensation Board of Queensland* (1995) 3 QAR 97, I said (at pp.105-106, paragraph 23):

> *There are many dictionary definitions of the term "research". I will confine myself to reproducing two which I consider most closely reflect the meaning of the word "research" which is appropriate in the context of s.45(3) of the FOI Act. The New Shorter Oxford Dictionary defines research as* "a search or investigation undertaken to discover facts and reach new conclusions by the critical study of a subject or by a course of scientific enquiry". *The Macquarie Dictionary defines it* as "diligent and systematic enquiry or investigation into a subject in order to discover facts or principles".

86. The matter in issue in this review was described by Dr McGahan (in paragraph 9 of his statutory declaration) as *"comparative statistical information"* or *"crude data"* or *"raw data"*. I refer to paragraph 52 above, where I set out Dr McGahan's explanation of the steps he took to extract information from Hospital records for his project.

87. The Hospital submitted that, on the basis of the definition of "research" quoted in *Re O'Dwyer*, Dr McGahan's project qualifies as research for the purposes of s.45(3). The Hospital submitted that, after initial computer searches to identify patients who had undergone carotid endarterectomy in the relevant time period, Dr McGahan then assessed the hospital files for each patient, making clinical judgments about the appropriate category of post-surgical complication, and calculating the outcomes in terms of percentages. (The applicant did not make any submissions in relation to whether or not the matter in issue comprised the "results of research" such as to fall within the terms of s.45(3).)

88. I am not satisfied that disclosure of the matter in issue in folio 3 would disclose the purpose or results of "research", in the sense that word is used in the context of s.45(3). The particular matter in issue merely categorises information extracted from computerised statistical data and patient records, ordinarily kept by the Hospital, and in that sense, is more akin to performance audit information than to the results of a research project undertaken to discover new facts or principles. On that basis, I find that the matter in issue does not qualify for exemption under s.45(3) of the FOI Act.

89. Even on the assumption (contrary to my finding) that s.45(3)(a) is satisfied, the matter in issue cannot satisfy the (admittedly peculiar) wording of the test imposed by s.45(3)(b). In *Re Spilsbury and Brisbane City Council & Ors* (Information Commissioner Qld, Decision No. 99011, 21 December 1999, unreported) at paragraph 56, I expressed the view that s.45(3) is a clumsily drafted provision (it was added to the *Freedom of Information Bill* only in the Committee stage of debate on the Bill in the Legislative Assembly and there was no discussion of the provision at that time) which requires reconsideration by Parliament, and amendments to clarify its intended sphere of application.

90. In *Re Spilsbury*, I said (at paragraph 58):

> *58. One* [issue arising in the application of s.45(3) of the FOI Act] *concerns the use of the words "research is being, or is intended to be, carried out". The use of these words indicates that s.45(3) only applies at a time when research is proposed to be, or is being, conducted, i.e., it does not extend to research which has been completed.(I note that the use of the word "including" in s.45(3)(a) tends to suggest that s.45(3)(a) extends more broadly than just to research that is yet to be started or finished. However, the operative test for exemption of matter that answers the description in s.45(3)(a) is imposed by s.45(3)(b), which refers only to adverse effects on an agency or person by or on whose behalf research is being, or is intended to be, carried out.) This is the way corresponding (although differently worded) provisions are applied in Victoria (s.34(4)(b)(ii) and (iii)* Freedom of Information Act 1982 *Vic) and the Commonwealth (s.43A* Freedom of Information Act 1982 *Cth). I consider that to be the correct interpretation of s.45(3) of the Queensland FOI Act.*

91. Clearly, in this case, the alleged "research" has been completed by Dr McGahan (see paragraph 6 above). In accordance with my comments in *Re Spilsbury*, the applicant submitted that I should find that s.45(3) does not apply to research that has been completed, as in this case. The Hospital, however, submitted that it is only possible to have "results of research" (the term used in s.45(3)(a)) once that research has been completed. I do not accept the Hospital's submission in this regard. A research project may extend over months or years, with many stages, and with interim or preliminary results being achieved at those various stages. I consider that s.45(3) was intended to protect such interim or preliminary results from disclosure before the whole project is completed, and before final results are reviewed, analysed and assessed, and findings are made, based on those overall results. Accordingly, I am not persuaded to depart from the view I expressed in *Re Spilsbury* that s.45(3) does not apply to the results of research, if the research in question has been finalised, as in this case. This is an additional basis for finding that the matter in issue does not qualify for exemption under s.45(3) of the FOI Act.

92. Moreover, under the terms of s.45(3)(b), there must be a reasonable basis for expecting that disclosure of the matter in issue could have an adverse effect on the agency or other person by or on whose behalf the research is carried out. In this case, the alleged "research" was carried out on behalf of the Hospital by its agent, Dr McGahan. However, the material before me affords no reasonable basis for expecting that disclosure of the matter in issue in folio 3 could have any adverse effect on the Hospital, or on Dr McGahan. The particular surgeon whose adverse outcomes are highlighted by the manner of presentation of the information in folio 3 was not a person by or on whose behalf the alleged "research" was carried out. For these reasons too, I find that the matter in issue does not qualify for exemption under s.45(3) of the FOI Act.

Conclusion

93. I set aside the decision under review (being the decision made on behalf of the Hospital on 26 July 1999 by Mr L Pyne). In substitution for it, I decide that the matter remaining in issue on folio 3 does not qualify for exemption under s.45(1)(c) or s.45(3) of the FOI Act, and that the applicant is therefore entitled to be given access to it under the FOI Act.

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F N ALBIETZ
INFORMATION COMMISSIONER