

## FROM THE EDITOR'S DESK

When Auckland Orthopaedic Surgeon Bruce Twaddle was threatened with censure and then actually censured for speaking out about perceived threats to services, he was amazed by the support he received from doctors outside New Zealand, including the USA and UK (stuff.co.nz, 2003, Health Board lifts surgeon's censure notice). The sense that a doctor should be able to advocate for patients by making fears known directly to the public seems to be widely shared.

Twaddle received censure from the Hospital Management for remarks he made in the press and on Television concerning the provision of beds for orthopaedic patients in the brand new Auckland City Hospital. He claimed that the number of beds available for acute orthopaedic services had fallen by 4 to 50 at a time when these services were already limited and insufficient (Johnston, M., 2003a). His comments came just as the new hospital was about to be opened. The management of the hospital responded in two ways, first by denying Twaddle's claims, and second by calling him to meet the Manager of hospital to account for his comments (NZ Herald, 2003, Hospital defends number of beds).

Twaddle received strong support for his right to speak out as he had from within NZ from the Association of Salaried Medical Specialists (Mr Twaddle's union). His Orthopaedic colleagues also strongly backed him, writing to the Hospital Management that if Twaddle was censured, then they would consider that they all had been (Johnston, M., 2003c). It was further reported that the Health and Disability Services Commissioner (Ron Paterson) had spoken in support of a doctor's right to advocate for patients' interests, and was said to have called along with many others for the withdrawal of the letter of censure which Twaddle had received from the Hospital Management

(stuff.co.nz, 2003, Health Board lifts surgeon's censure notice).

As is often the case in such instances, there were a number of complications in the detail of the story. For example, the Hospital Management claimed that the number of beds did seem to have fallen, but that the appearance was misleading, as it reflected a new working environment which would be more flexible in the face of fluctuating demands, and in which the apparent fall in bed numbers would be offset by increased efficiencies, more day-care, and availability of beds in other hospitals in the Auckland area (NZ Herald, 2003, Hospital defends number of beds). Furthermore, as background, it emerged that there had been some ill-feeling between Twaddle and the District Health Board in the previous year; Twaddle's concerns in fact turned out to date back a number of years (stuff.co.nz, 2003, Hospital disputes Twaddle claims).

The hospital management also sought to distance itself from the charge that it was trying to curtail a doctor's right to advocate for patients by drawing public attention to potential threats to their interests. They claimed to support the right of doctors to speak out about such threats, but argued that in this case the problem lay in Twaddle's failing to go through the correct channels to do so (stuff.co.nz, 2003, Health Board reprimands Twaddle over comments).

The censure was in the event short lived, as the Auckland District Health Board interim head, Garry Smith, stepped in to get the letter of censure Twaddle had received withdrawn. A degree of harmony was returned, with Twaddle and the DHB agreeing to work together to deal with his worries concerning the level of orthopaedic services (stuff.co.nz, 2003, Hospital Board lifts surgeon's censure notice).

The principle to which Twaddle and his supporters were appealing, and which the DHB and the Hospital Management also approved, is an interesting one. Its source might appear to be the general duty a Doctor has to care for patients. The argument would be that the right to take concerns directly to the public can be invoked when doctors perceive a threat to their ability to care for their patients.

The duty to care for patients is, however, a complex idea in application. How does this become a duty to advocate? To advocate on behalf of a patient or patients is presumably to speak on their behalf in their interests. It presupposes a forum in which the advocating takes place, and somebody, or some body to which the advocacy can be addressed. Thus patient advocacy immediately places the doctor and patient in some wider context. The wider context, particularly when it comes to resources in the form of beds or services, is a particularly complex one. It includes forums within institutions – doctors advocating on behalf of patients to hospital managers, for example. It also clearly includes the possibility of a wider context, broadly speaking the political, governmental context – that is the context of society in general.

Which patients should be advocated for? Clearly, the one in front of a doctor should be: but the patient right in front of a doctor is not the only patient a doctor has. An agreement which had been signed by the Auckland City Hospital and its senior clinicians and surgeons referred to the right of the doctors to speak out about threats related to their specialty (Johnston, M., 2003b). In effect, this means speaking up on behalf of a group of patients united by the kind of help they need. Twaddle, for example, was concerned that the number of beds available specifically for Orthopaedic care was being reduced. But similarly, this group of patients is not the only group, even if it is the only group which a specialist sees on a regular basis. Doctors may also speak out on behalf of those who are not yet patients – those with a future need of a service whose needs will not be met if the service is reduced. And there may be a sense in which a doctor's patients are all those who use the hospital or other health organisation the doctor works in, be this a publicly or privately funded service.

It can be seen why the right is so carefully guarded. In particular, where there is increased managerial influence in the running of the public health service, it would seem more important than ever to have voices which draw attention to the effects of policy decisions. Moreover, institutionally and politically speaking, the voice of the medical profession is a powerful one. Where it is taken to be speaking on behalf of patients, as in patient advocacy, it is perhaps doubly powerful. This may represent an important check in the system where management is making decisions which may affect people's fundamental well-being and lives. It does not, of course, follow that the decisions made by management are incapable of justification: but it would seem vital that decisions which have an adverse impact upon the care of a patient or of groups of patients should be justified, rather than simply allowed to be put into practice without being challenged.

#### References

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