ZEVA

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MEDICAL CHAMBER OF SLOVENIA
National report on violence against physicians

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CONTENTS OF PRESENTATION

- Epidemiology of violence in healthcare: what is really happening? Presentation of three real cases
- Existing legislature, strategies and motions
- Examples of good practices from abroad

IN THIS PRESENTATION CERTAIN DATA FROM THE FOLLOWING RESEARCH WILL BE USED:

Martin Pecnik, MD

Violence in general/family practice in Slovenia

Specialist thesis

Ljubljana, September 2016

Ana Sotošek, MD

The incidence and forms of violent events in family medicine

Research paper winning Prešern`s award

Ljubljana, April 2014

CASE 1

- night duty in a prehospital unit
- the technician opens the door (to the waiting room) to call the next patient in
- when the door opens, an unknown perpetrator hits him suddenly with the head in the middle of the face
- the technician`s nose is broken, the blood pouring down his face, we close the door
- an upset doctor on duty wants to clarify the situation
- he opens the door, the scene with the perpetrator repeats itself
- In three minutes, two heavy injuries were sustained by the team at the prehospital unit; the cause and the perpetrator unknown, no previous conflict

CASE 2

- in 2006, a 31- year old patient in Community Health Center of Ljubljana slaughters his dentist with a bayonet from behind while she is treating another patient
- the 33-year old dentist was immediately resuscitated (Emergency unit responded in 5 minutes)
- due to the injuries, open heart massage/resuscitation was administered
- The young female doctor did not survive

CASE 3

- as he was walking down the hall in the regional Izola hospital, after having seen 56 patients that day, a 37-years old urologist was approached by a patient
- the doctor sat down with the patient to talk to him
- from near distance, the patient-a retired policeman- - killed the doctor with a his registered shotgun

MOST FREQUENT REACTIONS TO VIOLENT EVENTS

- disappointment
- feeling threateneded, afraid, vulnerable
- feeling offended
- (personally)hurt feelings
- feeling of injustice
- blaming and condemning the patient
- blaming the security measures at the workplace

RESEARCH ON PATIENT VIOLENCE IN SLOVENIAN FAMILY MEDICINE- A CROSS SECTIONAL STUDY

(FROM 09/2017 TO 06/2008, N=71, PECNIK M.,2016)

- the forms of violence that were included in the study: psychological (verbal), physical, sexual
- 94,4% (67) of the included GP/FPs had been exposed to verbal(psychologica violence
- **all male** participants had had experience with patient violence
- **10 % of the female** participating GP/FPs stated that their patient are completely non-violent
- there media, social networks and via IT in general: a new category should be introduced, **virtual violence** (cyberviolence)

FREQUENCY OF VIOLENCE IN FAMILY MEDICINE

- of 209 participating doctors, 140 (67%) had reported violent encounters with patients in the past
- only 60,7% discuss violent events (WE DO NOT COMPLAIN, WE HURT…)
- 14 doctors sustained physical injuries
- 65,8% try to calm the patient down
- threats with lawyers, cyber bullying and verbal violence are most frequent forms of violence

LOOKING FOR SOLUTIONS IN SLOVENIA

- legislative basis: article 52 of the *Law of patients`s rights* („patients should behave respectfully towards healthcare personnel“)
- declaring zero tolerance against violence
- establishing an interdisciplinary special interest group within **Medical Chamber of Slovenia in 2016,** meetings every two months
- a press conference was organized at MCS in 2016, guidelines for treating violent patients are underway and educational workshops for healthcare professionals are planned
- making the issue public: talk about it, talk about consequences (lost years of work, lost years of life, LOST DOCTORS, practising defensive medicine…)

MEASURES AGAINST VIOLENCE IN HEALTHCARE IN SLOVENIA

- training of communication and de-escalation techniques for healthcare personnel
- the red button (automated emergency alarm) installed predominantly in emergency units
- security officer present very rarely
- video surveillance mostly trained on the entrances, not the waiting rooms

WHAT CAN WE DO? ARE WE REALLY HELPLESS?

SOLUTIONS IN THE USA

- permanent presence of **security officers /police** in the emergency units
- every emergency unit should have an **isolation room** for violent patients
- waiting room as well as the isolation have **video surveillance,** of which the public is notified (primary prevention)
- in examining rooms and in the isolation room **no dangerous objects** should be within the reach of the patient (ie sharp objects, scissors etc.)
- several healthcare units have **an x-ray monitor** at the entrance fot the visitorsas a safety precaution
- zero toleranca against violence is declared

EXAMPLES OF SAFETY PRECAUTIONS IN GREAT BRITAIN

- **data on violent patients** is easily acessable to all healthcare providers in the healthcare network („labelling of violent patients“)
- violent patients are **denied the right to house visits**
- the presonal/chosen doctor can **erase the violent patient** from his list
- community is regularly advised of potentially dangerous individuals residing in the same environment (i.e. pedophiles etc.)

WE CAN ONLY TREAT OUR PATIENTS WITH RESPECT, PROFESSIONALLY AND SAFELY IF WE WORK IN A SAFE ENVIRONMENT.

POSTGRADUATE MEDICAL TRAINING AND CONTINUING MEDICAL EDUCATION IN SLOVENIA

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Head of Postgraduate Medical Training,
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Medical Chamber of Slovenia
Ljubljana, September 15th, 2017

POSTGRADUATE MEDICAL TRAINING

- Since 2000 every doctor has to have a specialization.
- We have **45** different medical specialities (**4-6** yrs) and 6 for dentists (3 yrs).
- Public tender –national selection twice a year-on national level and for a certain healthcare provider (eg. Hospital)
- Residents accepted on the basis of: university degree, completed internship, other (completed specialization or part of specialization)

- Paid **fully by the state**
- Resident has a main tutor, on wards he has trainers
- National examination (part of the exam UEMS exam)
- Resident has to work in public sector or for the healthcare provider 4-6 yrs or
- Has to refund the costs, except salary
- Can be **self funded** if there are training posts available (trainees themselves or their sponsor)
- A full physician’s licence for work in the field of speciality

LICENSING:

In the beginning (till the end of 1999) physicians that were 56 yrs old/older obtained a **permanent licence.**

For everybody else the **7 yrs licensing period** was introduced.

Since 2000 -Every physician, that wants to practice medical profession in Slovenia, has to:

1. have the appropriate qualifications and level of training
2. be entered in the register of physicians
3. hold a license to independently perform medical services in a specific field of expertise (hereinafter: license)

CME

CME are awarded by the Medical Chamber.

In order to extend a licence, physicians must:

- obtain 75 credits in the 7 year period. The credits have to be obtained from the field of his speciality.
- has to work as a physician full-time; if he doesn’t, he may have to take an exam.

OBTAINING THE CREDITS:

CME includes:

1. Active or passive participation at a medical meeting, conference or a workshop
2. Publications in medical journal or book
3. E-learning or Q/A exams
4. Study visits, study travel
5. Medical malpractice reporting system

- Additional options of E-learning
- M&M conferences
- Tutoring

NO. OF AWARDED CREDITS

1. Active* or passive participation at the medical meeting, conference or a workshop -1 credit/hour
2. Publishing in medical journal or book -up to 5 credits
3. E-learning or Q/A exams -0.5 credits per exam
4. Study visits, study travel -5 credits/week
5. Medical malpractice reporting system -0.5 credits/report

* 50% more credits

THANK YOU!

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TREATMENT PROTOCOLS

Zdravniška zbornica Slovenije
Medical Chamber of Slovenia

Dr. Zdenka Čebašek-Travnik

ARE THERE ANY TREATMENT PROTOCOLS IN YOUR COUNTRY OR NOT?

- There are many treatment protocols which are used in every-day practice by the Slovenian physicians.
- Among them the most important are treatment **protocols for oncologic diseases**. They are published on the web side of The Institute of Oncology Slovenia. These protocols included Colon cancer, malignant melanoma, Lymphoma and so on.

- *But not all specialities have their own treatment protocols, or they cover only a part of certain speciality.*

WHO DEFINES THOSE TREATMENT PROTOCOLS? WHAT RULES APPLY WHEN WRITING A PROTOCOL (BASED ON WHICH DOCUMENTS THE PROTOCOLS ARE COMPILED)? ARE THEY MANDATORY?

- These treatment protocols are made by multi-disciplinary teams. Their basis are large research studies published in eminent medicine reviews.
- Specialist who is faced with particular issue or disease should work on these standards.

- In the case that doctor does not follow recommended practises the Medical Chamber can proceed supervision and make decision of further action:
  - from request for additional education to the worst: take away medical licence.

DO YOU DEFINE THE STANDARDS AND NORMS FOR PHYSICIANS, THE CONSUMPTION OF SUPPLIES, ETC. BASED ON THESE PROTOCOLS?

- In some protocols norms are defined and described. For example, pathologist should report in order.
  - The datasets enable pathologists to grade and stage cancers in an accurate, consistent manner in compliance with international standards and provide prognostic information, thereby allowing clinicians to provide a high standard of care for patients and appropriate management for specific clinical circumstances.

- On the other side, there are no official norms yet (e.g. psychiatry).

IS THERE AN ISSUED DEADLINE / CONDITIONS WHEN THE TREATMENT PROTOCOLS ARE CHANGED?

- There are no lists of conditions when protocols can or must be changed.
- We are in the period of changing some protocols and establish another. No deadline is proposed from government or other authoritiy.

IF THERE ARE NO PROTOCOLS, ON WHAT BASIS DO YOU PROVIDE HIGH-QUALITY HEALTH CARE?

- High-quality health care is achieved on the basis of permanent education of physicians. There are seminars, work-shops with credits for participants.

IF THERE ARE NO PROTOCOLS, WHO COMPOSES THE GUIDEBOOKS / GUIDELINES?

- The guidelines are compiled by the most experienced specialists and their societies.

- Of course, time is needed for spreading new practices among colleagues and to take new view into every day medical practice.