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QUALITY ASSURANCE IN OCCUPATIONAL MEDICINE

Abstract: *According to World Health Organization's definition, quality healthcare is one meeting agreed-upon criteria, using all current knowledge and available funds to meet expectations regarding improving the well-being of a patient and reducing health risks they are exposed to. Quality healthcare uses effective healthcare procedures, treats the right people and does so in an efficient manner, of course considering the circumstances. Due to specifics that arise in the field, occupational medicine is one of the fields where appropriate implementation of a quality assurance system could greatly improve the quality of work. Medical errors should be accepted as everyday companions of our work and as a source of valuable experience, which will help us ensure greater safety for our patients as well as ourselves. Discovery and elimination of deviations should thus become primarily a means of quality improvement as we try to establish our priorities.*

Key words: quality,occupational medicine, supervision

INTRODUCTION

We know all too well that our patients include such individuals who suffer from our errors. Thankfully, the great majority of these errors is such that the patients' health had not suffered significantly; however, the mere realization that what we do sometimes hurt our patients is one of the greatest trials of our profession. Among our colleagues, there are individuals who had already faced judicial proceedings due to their medical errors. However, a number of these proceedings could have been avoided, if the doctors' reaction to others' errors had been different than we are used to, just as a number of patients could have been spared the harm to their health, if we knew how to act in case of a medical error [14]. **Due to specifics that arise in the field, occupational medicine is one of the fields where appropriate implementation of a quality assurance system could greatly improve the quality of work. Medical errors should be accepted as everyday companions of our work and as a source of valuable experience, which will help us ensure greater safety for our patients as well as ourselves. A method wherein the resolution of mistakes is only attempted through disciplinary measures against the individual medical professional and the errors are not used as examples in the attempt to increase healthcare quality is** sure to achieve nothing less than further complications [14]. **From the Medical Practitioners Act (Zakon o zdravniški službi), we surmise that the doctor is free to come to his own professional decisions. In the conduct of his profession, he must follow scientific findings and scientifically tested methods. He must inform the patient of any planned diagnostic procedures. However, the medical practitioner is not responsible for the course of the treatment if the patient gives false information regarding his condition, fails to follow the doctor's orders and does not contribute to the preservation and restoration of his own health. A physician directly involved in the treatment of patients must have liability insurance for the potential harm caused by his work.**

To summarize the Slovenian Code of Medical Deontology (Kodeks medicinske deontologije Slovenije), a medical practitioner is, in the conduct of his profession and as long as he remains within the context of his professional training, autonomous and independent, responsible to his own conscience, to the patients and to society. The doctor is not allowed to initiate treatments with which he had insufficient experience. He must carry out his work in a manner that is responsible, professional, conscientious and meticulous towards all his patients. He must follow the latest findings of medical science and the principles of professional action.

As follows from the Health Services Act (Zakon o zdravstveni dejavnosti), everybody has the right, under the same conditions and in accordance with the Act, to gain access to the medical files pertaining to his condition, the right to request medical professionals and assistants not to disclose information regarding his medical condition without his express permission, the right to appeal to the competent supervisory authority, should he consider his treatment to have been carried out using insufficiently effective means or ethical principles to have been violated, the right to be informed of the costs of his treatment and the right to demand compensation for inappropriate treatment. A healthcare professional may independently carry out any treatment which he is adequately educated and trained to perform and for which he has the appropriate equipment. He takes ethical, professional, criminal and material liability for his actions.

To summarize the Criminal Code of the RS (Kazenski zakonik RS), a medical practitioner who, in the course of his profession, acts in negligence, violating the rules

of medical science and of the profession, and causes significant harm to a patient's health, is punished with up to a year in prison.

Healthcare is a complex service that operates in an unpredictable environment. Regarding its factors, socio-economic changes are most significantly accompanied by the conflicting influence of medical scientific and technological development that calls for ever increasing resources and the pressure of healthcare policy-makers, who must manage the healthcare system using the limited funds accorded to it by the society. The practitioner is primarily influenced by the constant inflow of new data from studies in the medical and other related fields. The medical field is governed by regulations coming from broader environment. These regulations specify the medical services regarding their extent, some elements of their quality, their accessibility, availability and weighing. Thanks to increased knowledge and awareness on the part of the patients and the general public, they are increasingly able to intervene in the decisions regarding healthcare. The public healthcare system is certainly mostly dependent on the capacities of the economic environment, and particularly on the willingness of those in power to finance the system. However, a practitioner's personal decisions regarding adoption of new treatments and provision of an appropriate level of quality are important as well [1]. An **error** is a divergence or deviation that is harmful and larger than expected, that has caused harm and could have been avoided with the knowledge currently available in the field. Harm has been caused either intentionally or because of an undue high-risk treatment the patient had not agreed to or because of a deviation in the provision of care due to a failure to act in accordance with the current level of knowledge, and it has been proven that there is a causal relationship between the divergence or deviation and the resulting harm. A **medical error** is thus a deviation from the expected manner of treatment and/or an implementation of the wrong treatment and/or an omission of the expected treatment and/or an implementation of the treatment on the wrong patient (or wrong body part) and/or delayed or premature implementation of treatment resulting in an unfavorable outcome with reduced medical benefit and/or increased harm that causes the patient to suffer significant bodily and/or financial harm. Not every deviation from the standards of professional action thus represents a medical error; rather, for an action to be considered a medical error, the patient in question must have suffered significant bodily or financial harm and the action must legally be defined as an error due to the manner of its occurrence. Medical errors represent only a part of medical actions that deviate from the expected level of quality. Regarding any other deviations that cause significant harm but are not found to be thus connected, meaning that the unfavorable outcome was incidental, one cannot speak of a treatment mishap (treatment is here used to mean care in general). In addition to these obvious deviations, unseen deviations occur every day, to every doctor who had ever committed a fateful mistake.

A doctor's work is always accompanied by decisions between different options that point to similar outcomes. Work often takes place in special circumstances, pressured by lack of time, insufficient data on the patient's condition due to unavailability of additional know-how, skills or equipment, and accompanied by significant ethical quandaries. **Errors that occur at the individual level may be curtailed and sometimes even prevented by reducing the reliance on an individual's memory, encouraging the use and accessibility of information regarding the patient and his care, by standardizing procedures, educating the employees and identifying the ones who work best, and by establishing a system of risk reduction and safety precautions. The features that contribute to the reliability of a healthcare institution are as follows: appropriate selection and training of staff, sufficient amounts of required tools and equipment, fostering a trusting environment and discussions within the formal framework of the division of responsibility, encouraging collaboration and commitment to joint efforts.**

With regard to their culture of safety, organizations can be placed into three categories: pathological, opportunist and advanced organizations. In organizations with a pathological culture of safety, the leadership obstructs those who call attention to deviations, while downplaying or even hiding unfavorable outcomes. Organizations with an advanced culture of safety encourage individuals and teams to gather data on exceptional events and analyze unfavorable outcomes and keep them apprised of the findings. We should distance ourselves from the tradition of looking for someone to blame and punish for a proven medical error and instead perform a systematic analysis of its causes [4], [11], [12].

The features that increase the safety of procedures and decrease the number of adverse events in a healthcare organization are as follows [4], [12]:

- a patient is handled only by a small number of employees, departments and services;
- high percentage of those involved in care are identifiable by name;
- there are detailed protocols for the use of complex medical technology;
- there are protocols for as many commonplace procedures as possible;
- clinical pathways drafted for as many diseases as possible;
- there are designated formal channels for the exchange of information regarding the patients' treatment;
- encouragement of informal communication between various professions dealing with the same patient;
- staff activities: motivational activities, awards for success and encouragement of professional growth;

- efforts to limit the influence of external factors on the achievement of business goals;
- efforts to maintain a stable inflow of funds from the payers and healthcare authorities;
- constant education and training of all employees;
- impeccable measuring devices and equipment;
- safety assurance, risk management, discovery of exceptional events and a complaints system as part of the organisation's quality assurance scheme.

The discovery and elimination of incongruities and deviations is thus part of the self-corrective activities of all quality assurance systems. However, as the discovery is often primarily punitive, the only distinctions and deviations that remain relevant are those that had caused harm to a patient and had been perceived as harmful and caused by a deviation from the expected level of service by the patient himself. We usually don't know what share of the harm may be ascribed to coincidence and what share to the deviations from the usual quality level of the procedure. Prompt discovery, prevention and elimination of numerous small deviations are much more beneficial to the health of the users of healthcare services than the moral and material vindication of an individual who had managed to prove that the harm in his case had been caused by deviations in the context of his treatment.

Discovery and elimination of deviations should thus become primarily a means of quality improvement as we try to establish our priorities.

A system of error identification should ensure that the patients receive moral and material redress in all cases where it is found that the harm was caused by deviations due to lack of education, inappropriate equipment, lack of organization of work or another reason that could have, in the given circumstances been avoided given the current level of know-how [3], [10], [11], [12], [13].

Quality is an essential element of the provision of healthcare and should be, together with the extent of work and its costs, the focus of any care-related procedure. Every patient and every community is entitled to quality healthcare, regardless of the limited funds accorded to healthcare by society.

According to World Health Organization's definition, quality healthcare is one meeting agreed-upon criteria, using all current knowledge and available funds to meet expectations regarding improving the well-being of a patient and reducing health risks they are exposed to. Quality healthcare uses effective healthcare procedures, treats the right people and does so in an efficient manner, of course considering the circumstances. It is best described as having all the characteristics allowing it to achieve the aims of everybody involved. A quality indicator is the measurable part (element) of healthcare that is scientifically proven (through studies) or commonly considered to reflect the quality of healthcare conditions or procedures, making it useful for quality assessment and thus the assessment of any changes in quality. The indicator can either be an important factor in the success of a treatment (friendly staff, implementation of procedures ...) or the desired outcome of therapy in itself (the patient's satisfaction, his condition ...). The indicator should be definable or measurable (percentage of satisfied patients, percentage of patients with controlled blood pressure) and changeable through quality improvement [4], [11]. **Quality** in healthcare is the use of effective healthcare procedures to efficiently treat the right people in the obtaining circumstances [3], [4], [5].

There are three types of quality-related deviations: overuse, underuse and misuse of healthcare procedures. Overuse involves those procedures where the risk (intentional) is greater than the possible benefit. In this case, harm is done due to intentional high-risk actions or due to the procedure being performed on a high-risk patient. Underuse involves procedures where benefits would have outweighed the possible risks. In this case, an achievable benefit is unduly forgone. And misuse involves procedures that are selected appropriately but inadequately performed in such a way that the patient does not achieve all the possible benefits. These deviations preclude us from achieving the expected benefits of a medical procedure and may result in various forms of harm.

Quality improvement is a dynamic process that consists of the following tasks [6], [7], [9]:

- identification and use of best outcomes to achieve excellence, feedback, explicit identification of quality targets, choice of quality indicators, constant process of prioritization, appropriate resources for quality, a system of incentives, quality-related education, an appropriate information system, constant self-evaluation, professional peer-supervision, willing management, inclusion of patients.

Quality improvement is a professional duty, a long-term activity that encompasses all aspects of care for the selected population, it is a part of everyday work, treats the patient comprehensively as an individual, employee and citizen, encourages efficient provision of healthcare, considers the special features of the specialization in question - e.g. of occupational, traffic and sports medicine - allows for professional guideline-based decision and should not be used for supervision or punitively.

When prioritizing for the improvement of quality, there are several general principles that promote success.

We use questions to identify potential shortcomings of our care: what is it that we are doing wrong or badly, what can we improve, what are we already doing well and should keep it that way, what's new in the field, what do we want to achieve?

We give priority to issues that appear frequently, cause discontent among patients and practitioners and contribute to poor results [3], [5]:

- the issue must be acceptable - of interest for everybody involved;
- it should be observable, there should be a way to gather measurable data and evaluate it based on available knowledge;
- the healthcare issue must be identified as such by at least one participant in the provision of healthcare;
- it should be common enough to have a noticeable impact on the outcomes of a significant number of patients;
- it should be possible to fix identified deviations - i.e. to improve the procedure in question;
- it should be possible to establish standards or quality benchmarks to be reached;
- it should be determined what kind of change would result in improvement;
- there should be criteria for the evaluation of improvement;
- the issue under observation should be defined as clearly as possible using measurable elements of procedures and outcomes, and there should be clear goals regarding quality...

Quality is a process, not an end.

Even after we establish a system of comprehensive quality management or constant improvement, we should not rest on our laurels, as quality should become part of our professional activities such as prevention, diagnostics, treatment, rehabilitation and reinforcement of health, and because systems themselves, such as accreditation or ISO standards, adapt to new developments.

The areas of quality that should be considered fall under the following six principles of quality [3], [6], [7], [9], [12], [15] **:**

1. *Effectiveness* - effectiveness of healthcare is defined as success in achieving favourable treatment outcomes (do our activities improve the patient's condition?)

2. *Safety* - reduction of safety-related complications in patients during diagnostics, treatment, protection and rehabilitation and avoidance, prevention and correction of safety-related complications (are we going to harm the patient?)

3. *Timeliness* - timely healthcare is provided as soon as possible, taking into account the needs of the patient (how long does the patient have to wait?)

4. *Efficiency* - efficient healthcare is defined by its favourable ratio of treatment outcomes and expended resources (can we achieve the same outcome with fewer resources?)

5. *Equality* - healthcare is equal if there is no discrimination between patients (are any patients being discriminated against because of their gender, age, social status ...?)

6. *Focus on the patient* - ensures respect for the patient's values and observance of his stated needs, gives the patient the option to choose, provides palliative care, coordination, consistency and regularity of care, information, a comfortable environment, contact with immediate family as well as friends and other persons, allows for the presence of a companion if this would not be counter to the interests of treatment (are we treating the patient as we would treat our parents or children?)

Comprehensive quality management as the most inclusive form of quality improvement stands on five principles [3], [4], [5], [9]:

1. The essence of continuous quality improvement in using the most valuable care- related accomplishments in an uninterrupted process that consists of: setting quality-related goals, quality evaluation and identification of best outcomes, quality improvement through analysis, using all available knowledge to achieve best results, and monitoring to ensure that the process is not interrupted.

2. The process should also include the active participation of patients.

3. First level activities form the foundation of constant improvement of quality and should be part of everyday tasks of all employees.

4. The most important role in this regard is played by medical practitioners themselves. Every individual in healthcare is responsible for the correct performance of his own tasks, however, final responsibility lies primarily with the management.

5. The effectiveness of continuous quality improvement depends more on self-evaluation and autonomous goal setting than on supervision and regulation.

Because comprehensive quality management is intended to change the character, organization and system of the healthcare institution in question, it requires careful and precise planning. Comprehensive quality management should also enlist patients and practitioners from the outside.

Key areas of continuous quality improvement [3], [5], [9], [12]:

1. Outcome indicators and other indicators of quality, clinical guidelines, clinical pathways, standards: we use the continuous circle of improvements: we detect a problem with the quality of care, gather data, analyse the data and plan an adjustment, carry out the adjustment, verify whether the adjustment has resulted in an improvement, and if so, implement it within the process (the plan- execute-verify-implement circle). We constantly monitor whether the care for the patient meets healthcare standards. Our decisions are based on data rather than assumptions or opinions of the management or other individuals or professional groupings.

2. Evaluation of medical technology - in order to achieve improvements in healthcare, we have to use methods based on evidence-supported medical science. Evaluation should include both new and existing technologies.

3. Information system - we should establish a medical information system that supports and is based on the use of appropriate healthcare indicators, live data displays and feedback and allows for reliable data comparison. Monitoring and continuous quality improvement uses data that are collected daily. When reviewing analyses we shouldclearly describe the variance and identify its general and specific sources.

4. The patient's perspective - data regarding patients' needs, priorities, experiences and expectations are collected at all levels of healthcare, using appropriate methods that ensure the patients' active involvement. Surveys should focus on concrete experiences rather than patients' satisfaction - we don't ask the patient whether they were satisfied with the doctor but rather whether the doctor had explained to them the significance of his findings, examinations, results ... data of this kind provide us with a starting point for improvements, as they help us determine in detail where the problems are.

5. Change management: a quality system should include effective provision of healthcare and strategies for a planned and guided execution of necessary changes, as well as the involvement of all interested parties in the context of treatment and decision-making, including the patients. The planning of changes will almost always encounter resistance. Those who would be affected by the change should know why the change is necessary and what are its benefits. Those who resist change should be enlisted in the planning stage, as well as in the implementation and impact evaluation, so that they may begin to own the implemented changes. The strategy for the implementation of changes thus requires planning, implementation, evaluation and effective communication.

Aims of the implementation of quality [3], [4], [5], [8]:

1. Creation of institution-level structures: CEO, quality board and its head, department heads

2. Activities at the level of medical practitioners:

a) **expanded college of specialists (specialist council):** plans outcome indicators and other quality indicators, formulates standards for individual diseases, prioritises the order in which to formulate clinical guidelines and following their authorisation by the Health Council or another body forms teams for the elaboration of these guidelines ..., plans other nationally important quality-related activities and activities related to patients' safety;

b) **medical practitioners:** introduction of comprehensive quality management, establishment of national and international clinical guidelines, elaboration of clinical pathways, written formulation of important processes and their implementation in routine work, involvement in a national programme for quality indicators, use of indicators for theimprovement of various systems, clinical pathways and processes (business indicators, safety indicators, clinical indicators, experience and satisfaction indicators for patients, other users and employees ...), use of special quality standards for individual diseases provided by evidence-based medical science and based on standards already adopted by the relevant expanded college of specialists, self-evaluation based on healthcare standards and quality indicators prepared by the national body for quality and regular and special internal supervision as demanded by legislation, preliminary activities connected with accreditation and involvement with its processes, establishment of procedures for the reporting and learning from safety complications involving patients with the focus on systemic and procedural causes of the complications rather than on the individual, except in cases of suspected wrongdoing, proactive reduction of safety-related complications through risk management and the establishment of a registry of safety-related complications involving patients and of sentinel events, proposal and implementation of improvement measures, regular internal instruction regarding quality and the safety of patients, non-compliance management, not only as a retroactive analysis of safety complications involving patients and a proactive approach to risk management in the area of patient safety, but also as management of other instances of non-compliance, e.g. deviations from agreements, standards, processes ... , communication of quality- and patient safety-related achievements to the expert and general public, evaluation of performance in the area of quality and patient safety, creation of responsible teams, individuals, departments, activities and whole institutions based on quality indicators;

c) **professional associations** are concerned with the improvement of quality and patient safety, they identify areas of priority, organise educational activities, facilitate collaboration between experts, design databases ... furthermore, they make proposals to healthcare officials and experts on how to increase quality and safety, propose applied research on quality and patient safety, actively contribute to the elaboration of clinical guidelines and other professional documentation on quality and patient safety, provide multidisciplinary and cross-professional treatment of issues related to quality and patient safety ... ;

d) **health insurance companies** draft their contracts with medical practitioners to include quality- and safety related requirements and provide financial incentive to those who advance their constant improvement of quality and patient safety;

e) **educational institutions** in healthcare complement their programmes with education regarding quality in healthcare, its methods and mechanisms. Study programmes deal with patient safety, methods of analysis of safety-related complications and development-focused approaches to the prevention of such complications through risk management.

(Current) quality control in healthcare [8]

Quality control is based on the assumption that there are certain mechanisms that can be used to identify and

eliminate deviations and discrepancies. This is supposed to result in appropriate quality.

Quality control is required by legislation. There are various types of quality control: internal supervision, peer review, quality circles, professional supervision, committee supervision in case of a suspected medical error. This is mostly subsequent control of the quality of work - i.e. supervision carried out after the treatment. Quality control can be performed continuously, periodically or occasionally. There are three types of continuous control: self- supervision, joint quality management and the use of regulations, rules, norms, standards, etc. Self- supervision is based on the values of the individual practitioner as well as on the culture of the institution and the society. Effectiveness of self-supervision is determined by the counselling and as various forms of individual or joint quality management. A significant part of occasional control consists of patient involvement, analysis of exceptional events and the complaints system. Complaints (or lawsuits) brought by the patients after an inadequate medical procedure had already caused harm, often result only in the investigation whether the incident was an accident or a medical error. Many organizations miss out on an excellent opportunity for an in-depth analysis of its work organization and are content to either discover the culprit or smooth over the issue.

Until recently, the prevailing philosophy was to try to identify weak practitioners and to punish and eliminate them. It was commonly believed that quality could be assured by eliminating practitioners who had participated in identified undesired outcomes and had been proven to have acted inadequately. It was more important to identify the "culprit" rather than the causes that had contributed to the outcome.

The best way to improve the quality of one's own work is certainly to look to those practitioners who can show best results in their field. Using feedback and other incentives, practitioners endeavor to achieve good outcomes. Improving the whole curve of outcomes results in all patients benefiting from better healthcare, as opposed to what happens if we merely remove those who have (once) been caught in the act of performing an inadequate procedure with an undesired outcome.

Quality control is based on the assumption that there are certain mechanisms that can be used to identify and eliminate deviations and discrepancies (calibrated blood pressure monitor - calibration in accordance with written instructions - protocols).

Internal quality control - when data gathered during supervision is intended for the practitioners themselves, we are dealing internal quality control. Internal control is carried out by each practitioner in the form of self- supervision and self-evaluation, by the management of healthcare institutions, by colleagues of the same specialization based in the institution in question or by such individual's knowledge, skills and know-how. Joint quality management is encountered in the form of group control, i.e. peer pressure to ensure leadership conformity. This is most pronounced within the collective, but in healthcare frequently extends beyond the boundaries of the institution. Regulations of various kinds threaten punitive or disciplinary sanctions and thus push the individual to conform his actions to prescribed standards. Deviations thus noted by the individual or pointed out by the group are typically quick to effect the desired development of the manner in which the individual performs his tasks. Periodic control consists of monitoring of work using an information system (e.g. sick leave), internal (top- down) supervision and professional supervision with counselling. Because it is difficult for periodic control to cover all the nuances of various procedures, it is mainly used to identify areas where work is done in a manner that requires further analysis and possible adjustments.

Occasional control is carried out as special internal supervision or special professional supervision with colleagues from elsewhere, if we are members of a professional association whose program includes such activities. What is important is that the results of such activities are only known to the practitioners themselves and are not intended to be used by a third party. Various forms of internal quality control include self-supervision, self-evaluation, peer review or quality circles and top-down quality control. Internal quality control helps us achieve our own goals, the goals of the healthcare institution, the college of practitioners or the professional association ...

Internal quality control is performed routinely to verify whether agreed-upon tasks are being carried out. Its purpose is usually to determine the quality level of care in cases when there is a complaint regarding such activities and represents one of the key measures used to identify areas that need to be improved.

External quality control is carried out by the Medical Chamber of Slovenia, the Health Insurance Institute of Slovenia and the Ministry of Health as well as by some institutes, specialized hospitals, inspection services and other bodies in accordance with supervision programs or as ordered by official bodies. In the case of external quality control, data gathered regarding the quality of work is intended for a certain public beyond the circle of practitioners subject to supervision.

Professional supervision with counselling is focused on the review of working conditions, including the practitioners' qualifications. It may be carried our routinely and according to the schedule provided by regulations or as special professional supervision in case of any issues that might arise in the provision of care. It can be thought of as a method used to identify those areas of care that could benefit from certain adjustments. This is because an important part of supervision with counselling is represented by counselling doctors on how to improve their work. Identification of divergences, deviations and harmful elements is a conservative approach to quality improvement that is based on the assumption that one

can achieve greater quality by identifying and punishing (or even eliminating) poorly performing practitioners (bad apple theory). The theory and practice of quality improvement had outgrown such concepts and now focus on the identification of those who perform best and encourages other practitioners to adopt their methods (good apple theory). Nevertheless, supervision with counselling remains warranted, as it is a common method of identification of deviations with guaranteed funding. A national-level quality assurance system could reasonably include it in its comprehensive quality management of the system of medical care. **Regular professional supervision** is defined as supervision carried out according to an annual schedule. The schedule is drawn up by the Committee for Specialist Medical Issues in collaboration with other committees of the Executive Board as well as with the Education Council, and approved by the Executive Board. The annual schedule is approved by the minister responsible for healthcare.

As a rule, every medical practitioner is subject to one regular professional supervision per license period. The annual schedule is published in the Chamber's journal. **Special professional supervision** is defined as supervision carried out outside the annual schedule. Special professional supervision is carried out by the Chamber of its own accord or upon a suggestion from the relevant minister, payer of healthcare services or another body.

Based on a decision made by the Chairman of the Chamber, the Chamber's Committee for Specialist Medical Issues, the Chamber's Prosecutor or the Chairman of the Chamber's Arbitration Board, special supervision **(professional supervision with assessment)** of a concrete case may be carried out either as part of regular annual schedule or as a special professional supervision.

Based on the findings report of the supervisory board, the Committee for Specialist Medical Issues evaluates the work of the doctor in question. In accordance with the Chamber's bylaws, the Committee can then propose sanctions. In case significant professional shortcomings or errors have been identified in the doctor's work, the competent body of the Chamber can issue a reprimand, order further professional training or set a deadline for the rectification of found shortcomings, temporarily or permanently take away the doctor's license, recommend other measures to the Ministry of Health, propose proceedings in front of the Chamber's Arbitration Board if consideration of the shortcomings falls under its jurisdiction, or imposes other sanctions in accordance with the Chamber's bylaws. In case of minor professional shortcomings or errors, the doctor can receive direction or mandatory instruction. Any appeals against the measures imposed by the Committee for Specialist Medical Issues are handled by the Chamber's Executive Board. **Evaluation of new procedures of care** (introduction of new technologies and treatments) - testing and evaluation carried out by competent institutions. This is usually commissioned by the Ministry of Health. Certification of procedures allows practitioners to work according to tested methods. Certification also reassures the patient that he will be receiving effective and safe care.

Evaluation (certification) of healthcare institutions, i.e. verification, is a formal procedure an institution has to go through to receive permission to carry out healthcare activities in the given facilities.

Administrative supervision is carried out by the Ministry of Health, and its aim is primarily to identify irregularities in the organization of healthcare and provision of services to the citizens. This is about control of the legality of operation of healthcare institutions and private practitioners. The supervision may be regular or special. Regular supervision is planned by the minister responsible for healthcare. Special supervision, on the other hand, is carried out based on a request or appeal by a patient, a patient's relative or caretaker, a healthcare institution, an employer, the relevant chamber, the court or on the minister's own discretion.

Financial supervision is carried out by the Health Insurance Institute of Slovenia or its supervisory doctors. This kind of supervision is focused on the fulfilment of obligation and on possible irregularities connected to the conformance with the Rules on Compulsory Health Insurance.

CONCLUSION

The fundamental goal of professional supervision should be a quality improvement of care received by the patients. If supervision is only used to try and identify negative deviations, it does little to encourage a general increase in quality. It is better if supervisory doctors also look for strengths, which should then be encouraged in the practitioner under supervision and communicated to other practitioners through counselling. In their assessment of a practitioner's professionalism, supervisory doctors must follow relevant regulations, previously adopted doctrine perspectives and guidelines and the chosen supervisory criteria; as much as possible they should avoid using subjective criteria based on "personal" experience. Criteria should be commonly known and evidence-based, some of them should be imperative - what must be - and others desirable - what should be. As we know there are no perfect clinics or doctors, an agreement should be stated in the form of guidelines as to what is the minimum acceptable level of compliance with the requirements.

Some doctors fear the professional supervision with counselling, however, the aim of these supervisory activities is not to intimidate. If a doctor strives to perform in a professional and effective manner and documents the process, this will surely be noted by the members of the supervisory committee who understand doctors aren't perfect machines but simply

human. For those who are not doing their best to improve, professional supervision should provide an incentive to raise the quality of their work (supervision in the preventive sense), not be an impediment.

Every day, a doctor makes dozens of decisions. Medical decisions are not based on mathematically definite figures but rather on estimates and assessments. Even in ideal circumstances, it is impossible for every decision to be optimal. We are often lucky to have guessed correctly or for our decision not to have had negative consequences despite being sub-optimal. However, sometimes things go terribly wrong. This is usually due to a combination of circumstances: an unusual course of the disease, tiredness and lack of time, poor communication with the patient or his relatives, poor transfer of the patient to the team taking over. Idealisation of doctors as infallible is not only unrealistic, it is detrimental to everybody involved: the doctors themselves, the patients and the society as a whole. We are much closer to the truth if we say it with the Bible: let him who is without sin cast the fist stone. Such idealisation presents a huge burden to doctors, as revealing they had committed an error makes the public and even their colleagues treat them as the most wretched of criminals. It is thus understandable why very few doctors report their medical errors - why we have trouble finding a doctor who would be willing to be displayed in the pillory. The fact is that most medical errors remain in a closed circle and never even reach professional analysis, much less an apology to the patient or a public explanation. Concealment of the errors is of course most harmful to patients and the society. We should never treat a doctor's poor decision as self-evident. Every mistake, especially if it has grave or fatal consequences, should be the subject of a serious professional and organisational analysis. However, it is also proper not to immediately proceed from the error to criminal liability. We reject the Slovenian judicial practice that supports insurance companies in their absurd insistence that the patient should only receive compensation if the doctor is criminally responsible. Such judicial practice encourages doctors to cover up their mistakes. While it is true that there are medical errors that lead to criminal liability, the majority should be resolved through professional analysis, an apology to the patient and appropriate compensation [15]. We should appreciate the strengths of our fellow man and caution him about his weaknesses, doing so in a constructive, non-insulting manner. We also need respect in order to recognise the good in ourselves and others and to build on it. However, criticism in many areas is not only disrespectful - there is another anomaly. When anomalous phenomena should be pointed out, criticism is completely absent. Nowadays, nobody is willing to step into the open and publicly denounce the mistakes of his colleagues, point out corruptive practices, etc. There are many who think: if I remain quiet now, others will remain quiet in the face of evidence of an error or anomalous procedure on my part. We are all imperfect, and if we criticise someone and if we are honest with ourselves, we feel a tinge of conscience, as we are flawed and make mistakes as well. It is hard to judge others without first coming to terms with ourselves. However, if we are critical in a constructive and professional manner, if our criticism is not directed against individuals but rather their actions, if we promote the pursuit of common values and virtues, and lead on the way that we believe is correct, we can encourage development despite our own shortcomings. But only if what we do is not too far removed from what we say. It is imperative that we preserve and develop our morals and our humanity, that we are simply human towards our fellow man. This is what we should be working towards, despite our shortcomings and mistakes, as this is vital to our individual and collective self-realisation. In this regard, our lives are extremely important, and if we do good by others, we are doing good by ourselves [2].

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Regulations

1. Medical Practitioners Act (Zakon o zdravniški službi, OJ RS 98/99).
2. Code of Medical Deontology (Kodeks medicinske deontologije, ISIS 1992, 1997).
3. Health Services Act (Zakon o zdravstveni dejavnosti, OJ RS 9/91 as amended).
4. Criminal Code of the RS (Kazenski zakonik RS (KZ-1), OJ RS 55/2008, 50/2012 as amended).
5. Rules on Professional Supervision with Counselling (Pravilnik o strokovnem nadzoru s svetovanjem, OJ RS 35-1651/00)

BIOGRAPHY

Marjan Bilban is professor at the Faculty of Medicine of the Ljubljana University (Head of the Public Health Department) and Head of the Occupational Medicine Unit of the Institute of Occupational Safety. Deals primarily with health and safety in work environments, study of physical and chemical factors of work and residential environments and indicators of negative health, assessment of the working ability of workers and handicapped persons, employment of the elderly and their special needs, etc. Author of essential Slovenian textbooks on occupational medicine, as well as more than 30 articles in indexed international journals, more than 400 articles in Slovenian and international journals, organizer and editor of numerous expert professional meetings and publications compiled from panel discussions, etc.

OBEZBEĐIVANJE KVALITETA U MEDICINI RADA

Marijan Bilban

Rezime: *Po određenju Svetske zdravstvene organizacije, kvalitetna nega je ona koja zadovoljava dogovorene zahteve i uz poštovanje trenutnoga znanja i raspoloživih sredstava ispunjava očekivanja za povećanje koristi i smanjenje rizika za zdravlje i dobro osećanje bolesnika. Radi se o korišćenju efikasnih postupaka zdravstvene nege kod pravih bolesnika u datim uslovima na efikasan način. Zaradi specifičnosti, koje su posledica struke, medicina rada je takođe jedno od onih područja na kojem je moguće uz odgovarajuće uspostavljanje sistema nadzora kvaliteta poboljšati kvalitet rada. Lekarske greške je potrebno prihvatiti kao svakodnevne pratioce našeg rada i izvor dragocenih iskustava uz pomoć kojih ćemo našim bolesnicima i nama samima obezbediti veću sigurnost. Otkrivanje i otklanjanje odstupanja bi zato moralo postati pre svega jedan od mehanizama poboljšanja kvaliteta pri traženju prednosnih zadataka.*

Ključne besede: kvalitet, medicina rada, nadzor