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Legal aspects of substituting healthcare workers

Pravni vidiki nadomeščanja v zdravstvu

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Abstract

The absence of healthcare workers from work represents a serious issue within the Slovenian public healthcare system, especially in light of the well-known low standards regarding the numbers of employed personnel. Authors address distinct legal aspects and possibilities of substituting absent workers, especially doctors. They approach the issue mainly from the viewpoint of patients' rights or rights arising from compulsory health insurance. Next to a brief analysis of the relationship between the Health Insurance Institute of Slovenia and healthcare providers, they also address selected ethical and legal dilemmas concerning doctors' responsibilities in substitution cases.

Izvleček

Odsotnost zdravstvenih delavcev z delovnega mesta ob splošno znanih nizkih kadrovskih normativnih v slovenski javni zdravstveni mreži je velik problem. Avtorji v prispevku obravnavajo različne pravne vidike in pravne oblike nadomeščanja zdravstvenih delavcev, predvsem zdravnikov, pri čemer v prvi vrsti izhajajo iz položaja bolnika oziroma osebe z obveznim zdravstvenim zavarovanjem. Ob obravnavi razmerja med Zavodom za zdravstveno zavarovanje Slovenije (ZZZS) in izvajalci zdravstvene dejavnosti obravnavajo tudi izbrane etične in pravne dileme, povezane z zdravnikovo odgovornostjo v primeru nadomeščanja.

1 Introduction

Substitution of a physician (or another medical worker) occurs or should occur based on one of the legal bases listed below, when the employee is on a shorter or longer temporary absence from work. Regardless of the reason for the absence, the position must be filled in order to ensure that there is no interruption to the work process and the protection of the rights of the patients or compulsory insured persons, as well as with the

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performance of contractual or general agreements, and with the individual contracts for agreed plans. In a narrower sense, substitution means replacing an individual, a specific employee in a specific position (the same work and tasks) with another employee (1). According to the ruling of the Higher Labour and Social Court (HLSC) (Pdp 1483/2014 of 14 May 2015): "an employment contract for substituting a temporarily absent worker is concluded legally, because it specifically names the employee whom the plaintiff substituted for, and its validity is defined with the period of absence of the absent employee. The ruling of the court of first instance that when concluding a fixed term employment contract for substituting a temporary absent employee it is essential it is concluded for the same position […] and that the plaintiff who was substituting had performed the tasks and work as defined for this position, with the fact that she did not perform exactly the same work as the absent employee not being essential."

From the perspective of labour, social and healthcare law it is important that substitution is appropriately resolved, and also that any inappropriate substitution can result in civil and criminal liability of the public institution, concessionaire, physician or another medical worker. Substitution is also important with regard to the relations between the Health Insurance Institute of Slovenia (hereinafter: ZZZS), since it is responsible for paying for the services and items from compulsory health insurance, and either public or private healthcare providers in the public healthcare network. The absence of substitution can also lead to plans not being met, which can generally result in a violation of a provider's contractual obligations, as well as longer waiting periods in healthcare.

This paper focuses on two types of substitution, namely horizontal substitution by equally qualified physicians, and vertical substitution by physicians and other healthcare workers with different qualifications, especially when replacing a specialist with a speciality trainee. Both types of substitution are discussed from the perspective of a patient's right to access to a physician, as detailed by Article 6 of the Patients' Rights Act (ZPacP, Official Gazette of the RS, no. 15/08 to 55/17) in connection with Articles 9 and 10, and some other patient rights, while the question of horizontal substitution is also discussed in the light of the rules on working time.

The paper is focused on substitutions in the event of a physician's absence from work; however, it does not discuss the indirectly related question of absence from a job position, e.g. a physician being employed at several departments, operating rooms, etc., at the same time or during a narrow time period. Because of frequent issues with substitutions for personal physicians (family medicine specialists), the paper also focuses on planning the number of family medicine physicians and available positions, namely the issues and the reasons for a lack of human resources. Some ethical aspects are also briefly discussed through a practical example.

It should be added that work on the draft of this paper, which is focused on the general state of affairs and extends beyond individual crisis situations in healthcare, started before the SARS-CoV-2 epidemic. The sudden changes to the needs of the population and the care for public health have made the challenges related to the lack of properly qualified personnel, and consequently also the challenges of substitutions in healthcare, all the more palpable and also more pressing. This especially holds for the second "wave" of the epidemic in Slovenia, where some healthcare practitioners were facing a significantly increased number of patients compared to the first wave, while both patients and healthcare practitioners were again facing limitations to some healthcare services and preventive programmes, indirectly also limiting patient rights (2).

2 Scope of the problem and legal resources

As the Court of Audit established in its audit report on the absences of healthcare employees in 2015, with the lack of appropriate systems for presence at the workplace and annual leave, the institutions lacked formal rules on substitutions of absent public employees, as well as the data on the costs of absences related to overtime, increased scope of work, concluded work contracts and other civil law contracts, and contractual work of students (3). According to the findings of the Court of Audit, which reviewed every physical absence from work, either paid or non-paid, absenteeism in healthcare presents a major financial as well as organizational problem (3). Both – and the latter especially – can be manifested in (lack of) appropriate, quality, safe and timely care for patients or insured persons. Among other things, the court recommended that the institutions evaluate work training both in numbers and financially, to establish records on how the donations are spent on professional training and to adopt an internal act on training, and an electronic method for recording, monitoring and analysing absences due to employees being on sick leave or in training (3).

While on the one hand absenteeism is a major issue in healthcare, it is also surprising how unresponsive the bodies that set the norms are – especially the general one (National Assembly), but also the professional ones

(ZZZS, public institutions, concessionaires) – with regard to preparing more detailed rules on substitutions. Along with general rules on employee substitutions that are detailed in the Employment Relationship Act (ZDR-1, Official Gazette of the RS, no. 21/13 to 81/19), and substitutions of public employees, as detailed by the Public Employees Act (ZJU, Official Gazette of the RS, no. 63/07 to 40/12), Medical Services Act (ZZdrS, Official Gazette of the RS, no. 72/06 to 66/19), Health Services Act (ZZDej Official Gazette of the RS, no. 23/05 to 82/20), Patients' Rights Act (ZPacP), Health Care and Health Insurance Act (ZZVZZ, Official Gazette of the RS, no. 72/06 to 36/19), and the Rules on compulsory health insurance (Official Gazette of the RS, no. 79/94 to 4/20, (hereinafter: OZZ Rules) also include only basic special rules on substitutions, or none at all. The same applies to the General Agreement for 2020 (hereinafter: GA) and both relevant collective agreements (Collective agreement for physicians and dentists in the Republic of Slovenia (Official Gazette of the RS, no. 14/94 to 80/18 (hereinafter: KPZZ), and the Collective agreement for healthcare and social care activities in the Republic of Slovenia (Official Gazette of the RS no. 15/94 to 5/19). Another problem are the frequently perfunctory (or even absent) internal rules for those performing substitutions (e.g. as general rules on the absences or special rules on substitutions that may define the types of absences, manners of keeping records, informing and substituting, for example during training or annual leave. The heteronomous legal acts (e.g. laws) do not proscribe for healthcare practitioners to also lay down such rules; however, a poorly resolved legal basis can for example lead to the aforementioned financial loss and longer waiting lists, thereby resulting in actual access that patients or insured persons have to legally available rights, or contractual ones when they seek services outside the public healthcare network. It does not need to be emphasized that ineffective access to healthcare services can result in poorer health. Even with the lack of a legal requirement, a clear and properly defined method for substitutions can be of key importance for providing a high-quality work environment, both for physicians as well as for other healthcare workers, and also especially for the patients who receive medical services.

The following sections focus in more detail on the legal arrangement of substitution, starting from the perspective of patients' rights, as in spite of the physician's absence from work, they are entitled to receiving appropriate, high-quality, safe and timely medical care (Articles 14 and 14.a of the ZPacP even detail the need to respect the time of patient, including waiting). We are focusing on the obligation of the healthcare practitioner to appropriately resolve and ensure the replacement of an absent physician, and not only their right to absence (e.g. for coordinating their professional and family life, education), even though this aspect is actually and legally important. The starting point is the legal position of the ill person who is also an insured person and who exercises their right to treatment from compulsory healthcare insurance (hereinafter: OZZ), usually with practitioners with the legal nature of public institutions or with concessionaires.

3 Types of absence and legal forms of substitution

The absence of a physician from their job may be short term or long term in nature (e.g. several months, more than a year). It is equally important in both cases that substitutions are appropriately arranged, while with short-term absences – especially when they occur subsequently – generally by different physicians, or even concurrently (e.g. when using annual leave). Absences may be the result of any reason, either justified, e.g. education, illness, injury, parenting, lately also because of quarantine or self-isolation, or unjustified, e.g. departing from work of one's own volition. In the first case, the absence is generally paid, especially when an employee is absent (unpaid absence is detailed by Article 39 of the KPZZ and Article 30 of the Collective agreement for non-economic activities in the Republic of Slovenia, Official Gazette of the RS no. 18/91-I to 97/20), or the employee may receive income replacement benefits from the social insurance system for the duration of their absence. A different set of rules applies to contractual practitioners, whose scope of work is defined by a civil law contract, and its provisions are applied to determine whether an absence is justified or not, and that may result in a violation of contractual provisions.

The following section discusses cases of employees, i.e. those who concluded an employment contract with a provider of healthcare services, and before discussing the provisions on substitution as substituting one worker with another, we discuss the provisions on working time, as one worker's absence may affect the working hours of a worker present, and this may result in an overload of work that in turn affects the actual position of a treated ill person.

3.1 Employment Relationship Act

In order to define the term absence in more detail, we should first define the term presence at work, i.e. the workplace, which is inextricably linked with the term of working time. Under EU law, working time is defined

by Directive 2003/88/EC of the European Parliament and of the Council of 4 November 2003 concerning certain aspects of the organization of working time, which in Article 2 defines working time as "any period during which the worker is working, at the employer's disposal and carrying out his activity or duties, in accordance with national laws and/or practice". The European Court of Justice has ruled in a significant number of cases that out-of-hours-duty, which is performed so that the physician (or another medical worker) is physically present at the workplace, even though they do not perform the work for the whole duration of their presence, is fully counted towards working time, as the employee is available to their employer, and in fact already performs their tasks by their availability. However, the rule of inclusion in working time does not apply to standby time from home (4).

The difference between out-of-hours-duty (presence) and standby (availability) is defined in Slovenian law in Article 69 of the KPZZ, while working time is defined in general in the ZDR-1. In Article 142 it is defined as effective working time and break time, and time of justified absence from work in accordance with the law and the collective agreement or the employer's general act. Effective working time is defined as any time during which the worker works, meaning that they are available to the employer and fulfilling their obligations from their employment contract. The provision as to whether the employment contract is concluded for full-time or part-time work, and the provision on daily or weekly working time and the allocation of working time with regard to Article 31 of the ZDR-1 are compulsory integral parts of the employment contract, as only arranged and predictable working time allows a worker to effectively coordinate their professional and private (family) life, and thereby also to enjoy freedom of lifestyle. However, surpassing both of these perspectives is the duty to prevent danger to the health of people, where the ZZDej does not clearly differentiate between a physician, a healthcare worker and a healthcare colleague; however, in Article 52 it does state that healthcare workers and contractors should not vacate their position after working time until their substitute arrives, if this could result in danger to persons' health.

It is important in general that when an employer defines working time, rearranges it and defines overtime, as well as substitutions for absent employees that may by their nature affect the working time of those employees who are present, they should adhere to legal provisions, keep appropriate records (the obligation for this is defined in Articles 18 and 19 of the Labour and Social Security Registers Act (ZEPDSV), Official Gazette of the RS, no. 40/06), and for the requirement of predictability, when the law permits, define special rules in which it sets in more detail how rights and obligations related to working time and presence are applied. In accordance with Article 148 of the ZDR-1, the employer is obligated to set a yearly schedule of working time before the calendar year begins, and to inform the employees and unions of this in writing.

In the context of this paper, absence from work is defined as any absence during working time other than absence during break or absence during rest between two consecutive working days or during weekly rest. Absence for annual leave deserves a separate discussion. In these cases, with respect to the rights and obligations agreed with the employment contract, the employee is generally supposed to be working; however, they are absent. As the introductory definition stands, substitution should occur when the normal course of the work process is jeopardized, and which cannot occur because of rest during working time, two consecutive working days or during weekly rest, as work is being performed by other physicians according to schedule and the organization of the work process.

Especially for short-term absences it applies that a physician's absence can be substituted (substitution in the broader sense, not by substituting one employee with another) by temporarily rearranging working time (Article 148, ZDR-1), in accordance with the conditions defined in the employment contract in accordance with the law and the collective agreement, while the institute of unequal allocation of working time (Article 148, ZDR-1) is according to its purpose generally reserved for industries where the scope of work depends on increased scope of work for a longer period, generally during the so-called season (e.g. tourism, farming). In healthcare in some specialist areas (departments) unequal allocation of working time could certainly be planned for the periods of seasonal diseases, e.g. influenza. Since unequal allocation of working time must be defined at the level of the business or calendar year, it certainly cannot be considered when substituting an absent employee. The provisions on rearranging working time are also included in Article 34 of the KPZZ, which defines that when conditions or work process demand under exceptional circumstances – and we can establish that a physician's absence is one such exceptional case – working time may be rearranged in such a way that the average weekly workload of an individual physician in the scope of three months is achieved. However, the KPZZ does not expressly detail the substitution of a personal physician.

The wording of the act (temporary) and the wording of the KPZZ (in exceptional cases) both entail that a change to the regular allocation of working time means not abiding by the rules. Some collective agreements define the conditions that are equal to the conditions for unequal allocation of working time, while others emphasise the exceptional and temporary nature of these measures or the existence of special circumstances that arose during the year (5).

Exceptionally, for example during a physician's sudden unannounced absence, they may also be replaced through overtime (Article 144, ZDR-1), for example, when such absence means that the life and health of people may be in danger, necessitating overtime in spite of the additional burden. Overtime may be in the financial interest of especially highly qualified categories of employees whose work is physically not especially tasking, and should be an exception to the regular organization of the work process. Unlike with temporary reallocation and unequal use of working time, at the yearly level overtime does not lead to a balance of hours, but instead an employee performs more hours than planned for the calendar or business year, consequently receiving higher pay for their work.

Along with the above-mentioned reason of endangered life and health of people, the Act also permits overtime work in cases of exceptionally increased scope of work and in other, exceptional, urgent and unpredictable cases, defined by law or the collective agreement for the industry, with the KPZZ not strictly detailing the performance of overtime, but it does include provisions on working beyond full working time and the payment for a physician's performance, e.g. in the event of above-average burdens (see Articles 73 and 74), and on bonuses resulting from the re-allocated working time (see Articles 66, 67 and 68). The wording of Article 144 of the ZDR-1 clearly states the exceptional application of overtime, which may lead to the conclusion that this institute is not aimed at "substituting a physician") for a long-term absence, as they certainly no longer present an unpredictable or urgent position. An employee may only require overtime in exceptional, urgent and unpredictable cases. In Article 144 the ZDR-1 also limits overtime to up to eight hours per week, up to 20 per month, and up to 170 hours per year, with a single working day lasting no longer 10 hours. However, the daily, weekly and monthly time load of interruptions should not exceed six months, and should be applied as the average temporal limitation that may take into account both the average limit in the legally or collectively prescribed period which should be shorter than six months. Exceptionally and when the employee provides a written statement, overtime may exceed 230 hours per year, with this higher limit being favoured by employers, as they frequently face unpredictable situations, which can certainly also apply to employers in healthcare. However, the increased scope of work in healthcare must also be unexpected and unusual (6). When the increased scope of work is usual, the employer should respond by appropriately organizing the work process and employing sufficient numbers of personnel.

In the above cases the substitution types are not proper forms of substitution or substitution in the narrow sense, in the scope of which one employee in a specific job position (same work and tasks) could replace another specific employee, but for cases when an employee performs work in a changed, i.e. increased scope during an urgent situation, but in a position that is equal to their own position, or to be more specific, is based on the same kind of an employment contract. However, the question for this type of substitution is also relevant for the present discussion. The employer or another responsible person (e.g. head of department) must in such a significant work area as healthcare, and especially when providing emergency or urgent healthcare, be especially diligent. The working time of physicians and other medical workers (especially overtime, night shifts) must not only be allocated in accordance with the law, but also with responsibility and with a focus on the safety of the treated patients, while also adhering to healthcare norms. As Article 11 of the ZPacP states, the patient has the right to primary, high-quality and safe medical treatment in accordance with the medical doctrine. This question is also inextricably linked with physicians' contractual work outside the working time, agreed in their employment contracts, which this paper does not focus on.

With all the above cases of substitution during a physician's short-term absence it should be mentioned that all of such absences are not unexpected and exceptional, and that during planned (short-term) absences, e.g. for using up vacation days or education, it is possible (for example in family medicine clinics) to organise work ahead of time in such a way that there is no need for temporary reallocation of working time or overtime. This is exactly what the above-mentioned yearly working time schedule is for: planning vacation leave, collective leave and similar, so that both employees and their representatives are informed in time, and that the employer can arrange organization of work, including rules on substitutions, with a general act that must be sent to the union, the workers council or their representatives, and all employees must be notified (see Article

10, ZDR-1). The KPZZ has similar provisions. Article 8 defines that the physician must be informed on the annual allocation and occasional reallocations of working time. Theoretically, even for short-term absences, an employment contract can be concluded with a new worker, as the ZDR-1 does not define the minimum duration of a fixed-term employment contract, nor a minimum number of work hours for which the contract is concluded, while in Article 54 it determines that a fixed-term employment contract, which is an exception to the employment contract for an indefinite time, can also be concluded for substituting a temporary absent employee, where, according to Article 55 of this Act, the contract is concluded for the duration required for the work to be performed. The Act does not define the duration of this temporary arrangement, which means it can either be short or longer, but not permanent substitution (1). Concluding employment contracts for short-term absences, e.g. for mild illnesses or a shorter education sabbatical, is impractical and arduous for the employer and even more so for the worker.

For longer absences, e.g. a more severe illness, a longer educational sabbatical or maternity leave, concluding a fixed-time employment contract is the rule, as the need for work is there and permanent, and the employee that performed said work is not available to the employer. ZDR-1 also allows for the employer to conclude up to one or several consecutive fixed-term employment contracts for the same work with a total duration of up to two years, and for substituting a temporary absent employee, it should conclude such a contract for a longer duration. This exception does not apply in the case of temporary increased scope of work, as an increased scope of work over a longer period means there is a permanent need for work. Except where the law or the collective agreement states otherwise, an employer may, based on Article 33 of the ZDR-1, temporarily assign an employee substituting a temporary absent employee with other suitable tasks, even when there is a temporary increase in the scope of work in one or a decrease in the scope of work in another job position.

This question is especially relevant in the case of limiting some healthcare services or prevention programmes because of the epidemic or other emergency measures, which results in a smaller scope of work in one job position with a general increase to the scope of work in another position. The ZDR-1 only resolves this issue from the perspective of labour law (employee's rights and obligations), and does not relate to the specific standards of the medical profession that the relevant legislation or professional rules must define for the cases of assigning other work. Appropriate work, as defined by Article 33 of the ZDR-1, means work for which the employee fulfils the conditions and for which the same kind and level of education is required and which is performed during the same working time. This means that an absent physician can only be substituted by a physician who fulfils the same requirements for their job position, i.e. holds the same specialization. According to the provisions of Article 16 of the ZZdrS, a physician before completing their specialization is still deemed a physician, which can lead to the assumption that they may substitute for any position that does not come with additional requirements. According to the provisions of Article 9 of the Act on recognition of professional qualifications for medical doctors, specialist doctors, doctors of dental medicine and specialist doctors of dental medicine (Official Gazette of the RS, no. 107/10 to 40/17), appropriate professional qualification for a physician requires at least a completed six-year, i.e. 5,500-hour university course of study with theoretical and practical courses and training at the Faculty of Medicine, a completed traineeship and a professional examination. A specialist doctor must, in accordance with the conditions listed in Article 9, also perform a specialization.

Appointing a different task according to the ZDR-1 may last up to three months per calendar year, either as one longer or several shorter appointments. If a position is changed permanently, the employment contract must be amended or a new one concluded.

3.2 Public Employees Act

When a physician concludes an employment contract with a public institute, they obtain the status of a public employee according to the ZJU; however, the provisions of the ZDR-1 still mainly apply to them instead of the provisions of the ZJU, as the latter determines in Article 22 that the second (special) part of the Act only applies to public employees in state bodies and local community administrations, which does not include public institutions. For them, only the provisions of the ZJU related to shared principles and shared questions of public employees apply, while for ensuring an uninterrupted work process only the provisions on the principle of legality, principle of professionalism, principle of responsibility for the results and the provisions on human resource records and systematization apply indirectly. Therefore, in order to conclude a fixed-term employment contract for substituting a temporarily absent employee, the provisions of the ZDR-1 apply.

3.3 Civil law contracts

Whether an absent physician can be substituted not by an employee, but by a physician who performs their work based on a civil law contract, depends on the existence of the defining elements of an employment relationship in each specific case. As Article 4 of the ZDR-1 determines, an employment relationship is a relationship between an employee and an employer in which the employee a) voluntarily joins the employer's organized work process, and within it b) for payment, c) personally and d) uninterruptedly performs work according to the employer's e) instructions and supervision. It is evident that a physician substituting for an absent employee based on a civil law contract performs this work b) for payment and c) personally. In general, it holds that a contractor with a contract based on Article 619 of the Code of Obligations (OZ, Official Gazette of the RS no. 97/07 to 20/18) undertakes to perform certain work, and their obligation has the characteristics of an obligation result, which does not mean the development of the same level of mutual trust among the parties as with an employment contract, when the subject of the contract is a one-off performance of an activity (7). In this sense, there should certainly be a differentiation between contracts for cooperation with a one-off performance (e.g. performing a single operation or a series of operations in a narrow time frame) and a multiple, perhaps even permanent performance, which brings this relationship closer to the one between an employee and an employer, while it also points to the existence of the definition element d) uninterrupted work performance, and last but not least also a) inclusion in the work process. The latter has been recently derogating from traditional patterns of production, and with increased worker autonomy, especially for those highly qualified, can even more clearly indicate the need for the existence of an employment relationship (11). Consequently, a differentiation should be made between those cases when a physician who performs their work based on a civil law contract, e.g. provides individual services a few times per week at the practitioner's premises, and those cases when they are regularly available to the latter at their premises over a longer time frame. Especially when their contractual obligations are directly adjusted to or coincide with the regular work at the practitioner, this indicates that the nature of the relationship or the level of integration in the work process is nearing the one between an employer and an employed physician. Similar applies to the definition element e) instructions and supervision of staff, for example when obligations from instructions surpass the obligations, agreed by contract, or when the opposite party (the concealed employer) assigns the physician with work or other obligations that are not included in the contract or a defined in a different scope. It is not important how to refer to the contractual relationship when establishing elements of an employment relationship (8).

Article 13 of the ZDR-1 sets out that when there are elements of an employment relationship, work should not be performed based on a civil law contract, except in cases defined by the law, with Article 13 of the ZDR-1 expressly referring also to Article 54, which lays down the conditions for concluding a fixed-time employment contract. This means that in such a case when employers would most likely lean towards concluding civil law contracts, the legislator has expressly forbidden this option. Article 217 of the ZDR-1 lays down that an employer for whom a worker is performing work based on a civil law contract in opposition to the provisions of Article 13 is penalized with a fine from EUR 3,000 to EUR 20,000. The above holds that especially in the event of a long-term but still temporary absence of a physician, which means an existence of a permanent requirement for work (and not an occasional performance of individual services, e.g. as with the operations above), concluding an employment contract instead of a civil law contract is the norm.

Special conditions under which a public healthcare institution can conclude a civil law contract with a healthcare worker for performing healthcare services following an analysis establishing the economic rationality of doing so is defined in Article 53c of the ZZDej. Concluding a civil law contract is possible when the a) nature of services is occasional or their scope is small, which means an employment contract cannot be concluded, b) for a one-off increase in the programme for requirements of OZZ, and c) when a public institution with existing human resource capacities cannot fulfil its contractual obligations to the ZZZS. Even when these conditions are met, they naturally do not legalize any illegally concealed employment relationship.

4 Obligation for substituting

The obligation for substituting is defined in several legal acts, although, as explained in the introduction, the arrangement is neither extensive nor detailed. Article 41e of the ZZdrS establishes the obligation for concessionaires who have to ensure that during their absence during office hours a substitute physician provides medical services with the same level of professional capacity,

and the concessionaire should not be absent without a substitute physician for more than 14 days per year or no longer than two consecutive days. With regard to the provisions of Article 45b, when a concessionaire is scheduled to provide uninterrupted emergency medical assistance the substitute physician is supplied by the provider. Article 44f of the ZZdej, which defines the minimum content of a concession contract, determines that the granting authority and the concessionaire must agree on the method for ensuring substitution during the concessionaire's absence. Defining the special obligation of ensuring the substitution reflects the obligation of uninterrupted provision of a public service of a private provider, assumed with the concession contract, which combines the private financial interest of the practitioner and the interest of the insured persons, which, when considering the broad scope of such persons, is not only the interest of a group, but actually public interest. The absence of a special legal arrangement for substitutions in public institutions most likely reflects their foundational purpose or the absence of a private financial interest. The obligation of substitution for both the concessionaires and for public institutions stems from Article 35 of the GA, which determines that in activities that are performed by personal physicians, the practitioner must ensure substitution during their office hours in such a way that the physician's tasks are performed by a substitute physician with the same level of professional acumen, with the GA repeating the provisions of the ZZdrS, while also adding the requirement for the personal physician's approval, while on the other hand, substitution should be limited to the activities of their personal physician. The ZZVZZ does not include relevant provisions on substituting, while Article 2 of the OZZ Rules defines the substituting physician as the physician who fulfils the conditions for a personal physician, and who is substituting for them in their absence and with their authority. With regard to the provisions of Article 172 of the OZZ Rules (taxonomically listed disease, business trip, education or training, holiday or vacation, where it is clear that the CHI Rules should also define an open list of justified reasons), a personal physician may ensure task performance in the basic healthcare activity with a substitute physician at the same location or in its direct vicinity. Considering the concisely limited provisions on substitution, either limited to concessionaires or to the activities of personal physicians, the general obligation of substituting a personal physician can be derived from the provisions of the ZPacP which protect patients and, when applying the rules from the OZZ, as well as from the provisions of the ZZVZZ.

5 The patient's rights during the physician's absence

It is important that the patient has access to the same rights in accordance with the ZPacP, ZZVZZ and other regulations even in the event of the physician's absence, either from their job position or within their position.

5.1 Right to free choice

The right of patients to freely choosing a physician represents a basic procedural right, as this is the first step in the process of exercising their material rights, i.e. the rights to healthcare dues, where the scope of the right and its limitations can significantly affect the patient's (i.e. the insured person's) legal position. In Article 9, the ZPacP defines that the patient has the right to freely choose their physician and the healthcare provider to whom they wish to entrust their treatment. In the public healthcare network, i.e. the network of the public healthcare service, the right to free choice is realized in accordance with the provisions on healthcare insurance. The exception to right to free choice is defined by Article 10 of the ZPacP, allowing the physician or healthcare provider to reject the patient's choice in some specially established cases, where treatment could be unsuccessful or impossible. It is possible to imagine cases where the reason for rejection would be the physician's absence. The right to free choice of a physician and a healthcare institution is important only for socially insured persons, as it is the obligation of the selected physician to accept the person who selected them, i.e. it is the contractual obligation of the provider. The case with private patients is different, as they can select without limitation the physician and healthcare institutions that are willing to accept them, and which the patients are also willing to pay, with the private provider also being permitted to refuse the patient, except in cases of emergency treatment (10). The provisions of Article 2 of the Protection Against Discrimination Act (ZvarD, Official Gazette of the RS, no. 33/16 to 21/18), which inter alia prohibits unequal treatment of legal and natural persons in legal transactions, especially in relation to social protection, including social protection and healthcare, and (if we consider healthcare only in the sense of healthcare from public funding, as it is linguistically connected to the term of social protection, which is always at least for the most part public, social and not private, individual protection) with access to goods and services that are available to the public.

With regard to the provisions of the ZPacP, ZZVZZ (see Article 80) and the provisions of the OZZ Rules, the right to free selection of a physician in the public healthcare network encompasses both the free choice of a personal physician as well as the free choice of a specialist doctor and a healthcare institution (10). As Article 160 of the OZZ states, an insured person can freely select a physician and a healthcare institution and a different provider for exercising their rights, while Article 190 defines that they can (also) freely choose the healthcare institution, the specialists employed there or private specialist doctors who provide such services. It is not clear, however, whether an insured person has the right to select a specialist doctor only for clinical specialist therapy or also for stationary therapy, when the time-barred right to free choice can collide with the (directly non-existent) right to request a transfer to a different healthcare institution. When they do not select a specific hospital physician, the insured person can still have the right to freely select a hospital, which then assigns them with any appropriate physician (10).

However, when the selected physician is absent, the right to free choice, either for a personal physician or another specialist, is indirectly limited. The most difficult one is the absence of a personal physician (or a personal obstetrician), as their relationship with the patient is generally long-lasting and especially confidential (*intuitu personae*). Similar can also apply to another specialist, especially with long-lasting diseases and/or therapies, where a special trusting relationship has been established.

Article 68 of the OZZ Rules states that an insured person may replace their chosen personal physician before the end of one year if they had been absent for more than three full months because of an illness, maternity/paternity, education or other reasons. The Rules should also state that short-term breaks in this three-month period, when the person with healthcare insurance does not have the option to effective, timely access to the temporarily present personal physician, should not be taken into account. As Article 191 of the OZZ Rules states, the rules on changing a personal physician may be also applied mutatis mutandis for changing the selected specialist. With regard to the provisions of Article 2 of the ZZVZZ (contribution to healthcare provision, the obligation of taking care of one's own health) and Article 54 of the ZPacP, the insured person must accept the medical treatment of a different physician or another specialist within the first three months of absence after making their selection, after they have agreed to therapy. The question is whether they are obligated to accept the substitute physician, or whether they may, their medical condition permitting, make their choice again. We can assume that the de facto assigned substitute physician may only be rejected in those cases that permit early replacement of a personal physician or selected specialist because of, e.g., (previous) disputes that have led the insured person to lose their trust in the physician.

It should be emphasized that from the perspective of fulfilling special conditions for occupying a specific job position (appropriate qualifications for a physician, the qualification of a specialist doctor required for high-quality and safe medical treatment in accordance with the medical profession with respect to Article 11 of the ZpacP) or from the perspective of appropriate qualification for performing a type of work, the right to freely choose a physician also means that a physician should not be replaced by a different healthcare worker, e.g. a nurse or a registered nurse.

5.2 Respecting the patient's time

In Article 14, the ZpacP lays down that the patient has the right for respect of their time, which means that the public healthcare network provider must ensure the shortest possible waiting time and for a waiting list with reasonable times. Work must be organized in such a way that the patient is provided a medical treatment as soon as possible, with Article 11 of the ZpacP also defining quality medical treatment in terms of timeliness. As Article 14.a states, they must ensure that the work is organized in such a way that the waiting times are as short as possible, i.e. that they do not exceed 30 minutes. As emphasized in the introductory part of the discussion, the question of work organization is inextricably linked with the arrangement of working time and with an appropriate system for substitutions of absent physicians (and other healthcare workers) based on a general act by the employer, e.g. in the form of special rules. Substitution must be resolved in such a way that with regard to the urgency level, i.e. the position on the waiting list (see Article 14.b, ZpacP) it respects the time of the patients who selected or had been treated by a now absent physician, as well as the time of the patients treated by the substitute physician. All of this is certainly most important in practice for personal physicians and other specialists performing clinical therapy. The challenge of prompt access to the personal physician only increases the lack of interest in specializations in family medicine, as discussed below.

5.3 Suitable, high-quality and safe healthcare and the relationship with the ZZZS

The physician's absence must not lead to the position where an insured person is not provided with suitable, quality and secure healthcare. This applies both in the case when an absent physician is substituted by a substitute physician, but they are overtaxed, so that they are unable to adhere to all the norms and standards during care, as well as in the case when the physician substitution is not resolved at all or is not resolved in such a way that healthcare services is able to quickly enough and completely meet the requirements of the medical condition. The valid legal system demands an absent physician is substituted with an appropriately qualified physician with the same authority, and not with a different healthcare worker, e.g. a registered nurse (vertical aspect of substitution). This indirectly stems from the patient's right to freely choose their physician and the healthcare service provider to whom the patient entrusts their treatment and the definition of appropriate, high-quality and safe healthcare as care that is in line with the medical doctrine.

In spite of the fact that the realization of Article 11 of the ZPaP is also affected by the capabilities of the healthcare system (see the definition of appropriate healthcare), after paying contributions for social security that they pay in line with their economic ability to contribute, based on Articles 50 and 51 of the Constitution of the Republic of Slovenia (URS, Official Gazette of the RS, no. 33/91-I to 75/16), the law and the rights and obligations from the social insurance relationship as a bilateral, public law debtor relationship between the insured person and the ZZZS, an insured person is entitled to receive a reciprocal benefit based on the needs of their medical condition in the form of therapy services that, based on a contract with the ZZZS, a specific practitioner can provide within the public healthcare network.

It is of key importance for the protection of a patient's rights that the specific practitioner provides the programme within the agreed scope of assumed obligations and in such a way that with appropriate organization it can still be realized in the event of usual planned absences (e.g. during annual leave) and in the case of other absences. Considering that only exceptionally is a patient rejected by the public institution or a concessionaire (10), in the event of additional costs related to appropriately recorded and cost valuated substitution of an absent physician these are covered by the ZZZS, either based on special contractual provisions or based on an annex to the contract, as the institute in a functionally decentralized social security system assumes the tasks of the state for performing compulsory health insurance. If the ZZZS's costs exceed revenues at the annual level, they should be covered by the state, which, in accordance with Article 50 of the Constitution, has the obligation of ensuring that the social insurance system functions. This also applies to compulsory health insurance, even though the obligation for covering the excess of costs over revenues of the Institute is not defined directly in law, unlike for compulsory pension and disability insurance. If ensuring healthcare services is the core duty of the practitioners, generally in accordance with the above-mentioned contractual obligation, their core right is the right to payment in the scope of the billing legal relationship with the ZZZS (10). Inappropriately arranged cases of substitution, which are not appropriately recorded and evaluated for costs, and thereby not additionally financed by the ZZZS, cannot have a negative impact on the quality of provided care. The most problematic are the cases where problematic substitution cases result in postponed or lower quality healthcare, as well as non-fulfilment of obligations with the ZZZS. In this case the practitioner's actions may be the subject of procedures related to violations of patient rights, and the practitioner may also be liable for damages both to the patient as well as the ZZZS.

6 Planning the number of family medicine physicians and work positions at the state level

The challenges of substitution are especially significant in family medicine. In particular, these are conditioned with structural reasons for organization and staffing in this area, i.e. with the lack of appropriate human resources with regard to the healthcare needs (ageing population). It should once again be emphasized that the relationship between a family medicine physician (hereinafter: FMP) as a personal physician and their patient is especially confidential, and in general permanent, which can make appropriate substitution especially demanding.

6.1 Number of FMPs

The currently best overview of the number of FMPs is provided by the ZZZS as a constantly updated list. It lists the physicians by ZZZS organizational units, by public institutions and concessionaires. The data on the physicians' workloads with regard to current norms have been added, as well as the data on whether the

selected personal physician is accepting new patients. This spreadsheet is useful both for patients as well as for the ZZZS, for when it allocates funds between individual healthcare practitioners. Because good planning requires more data than just a rough geographic location and the number of physicians, more than ten years ago a project was undertaken in Slovenia that visualized the network of physicians at the primary level in the format of an entity-relationship diagram model (11). The network also included the data on the age and sex, different workplaces of an individual physician, distances between individual locations of these workplaces, the population density, licences and specializations. However, such an overview alone was not able to resolve the structural problem of the lack of FMPs, especially because the network in its proposed format was never implemented into regular use.

On the one hand, the problem of the lack of FMPs is connected with the fact that in 1980 a measure was introduced for physicians after completing their practice to accept compulsory work at the primary healthcare level. Even though this measure lasted only a few years, several physicians continued working at this level. They represent a generational group that, after 40 or more years of employment, has been retiring in the past few years. On the other hand, the area of family medicine is marked with above-average participation of female physicians who, during their active career, assume more obligations for raising and caring for their children than men, which is reflected in the higher level of absence and a more frequent need for substitution. The significant lack of human resources has to be taken into account – also in the light of the discussion on substitution – in any relevant staffing for the area. The possibility for FMPs to work on the primary level and their availability is the direct responsibility of the municipalities. However, when in 2019 there was an additional human resource shortage in family medicine due to FMPs being overburdened, the GA partners, which do not include the municipalities, concluded the Annex (no. 1) to the GA (for the contractual year 2019). It also defined that after an FMP reaches the 1,895-patient quota, they may decline to accept new insured persons, with the GA partners reaching an agreement that no person with compulsory insurance should remain without a selected personal physician.

In the light of demographic change in the future the scope of the work of FMPs will certainly continue to increase, making it essential that staffing in this area is carefully planned with good cooperation between the MZ, Medical Chamber, ZZZS and the municipalities.

6.2 Lack of interest in specialization in family medicine

In the past few years, the number of available specializations in family medicine (hereinafter: FM) has been significantly higher than the number of physicians applying for this specialization. The reasons for this have been analyzed in the past, and certainly include the fact that employment contracts often include perfunctory provisions regarding the location performing the work, workloads and working time, with the FMP as a personal physician due to the nature of the work being obligated to perform a broad range of various services or tasks defined in Article 174 of the OZZ Rules. Additional work can also arise from contractual obligations of their employer to the ZZZS, and because an FMP may be stationed across several clinics or several different work processes, which is certainly one of the key factors that make this specialization unattractive to young physicians. Along with better specified provisions in individual employment contracts and general amendments or changes to the rules that would structurally detail the relationships in FM (e.g. taking into account the burdens, rules on working time, substitutions), making it more attractive to young physicians, another possible option is to attract physicians from abroad. However, the so-called import of physicians can be problematic from the perspective of obtaining all the required working permits, recognizing diplomas or specializations obtained abroad, language, and also the fact that the physician is arriving from a different environment, often even from a relatively remote area, which means that they must first familiarize themselves with the area where they are working. It should be added that in the event of emergencies foreign physicians may return to their home environment, making them not available in their country of employment (12).

7 Select legal and ethical aspects of substitution

In the process of therapy as part of the Slovenian healthcare system, substitution for an absent selected or a more seldom attending physician is unavoidable due to the shortage of physicians specialized in some of the most sensitive areas of healthcare. A substituting physician has the legal obligation to adhere to all required and adopted norms that apply for the physician they are substituting, and must, as detailed in the discussion introduction, meet all the conditions for taking the position. First and foremost, the golden rule applies: "primum nil

nocere – first, do no harm". The substituting physician assumes all the criminal, material, tort and especially ethical liability required of every physician when accepting a substitution. Ethically contentious actions and decisions occur especially during substitutions with those physicians who lack sufficient recognized competencies, such as speciality trainees of all categories, and the responsibility for their work should be assumed by their mentor (either the main one, and even more often, one specific to their training).

With regard to the already discussed provision of Article 33 of the ZDR-1 (substituting a temporary absent employee and a written specification of a temporary performance other appropriate work *for which the employee fulfils the conditions and for which the same type and level of education is required*) and the provisions of Articles 9 and 17 of the ZPPKZ in connection with indent 4 of Article 5 of the ZPacP (right to appropriate, high-quality and safe healthcare) a specialist physician can only be substituted by a specialist, and not a speciality trainee. Substitution does not mean an independent performance of the medical profession, but providing medical service under the guidance and with the responsibility of the mentor. Article 20 of the ZPPKZ defines that during their specialization a speciality trainee may independently perform those tasks and services for which they have obtained appropriate knowledge, experience and skills. This is guaranteed by their mentor, while the speciality trainee is responsible – with regard to the provisions of Article 20 – for performing the work and services. Subject to the mentor's assessment, Article 20.a of the ZPPKZ also allows an FM speciality trainee who is in the fourth year of their specialization in FM to work as a selected personal physician. The ZPPKZ does not permit any other exceptions, which means that other types of vertical substitution, e.g. of a physician with a registered nurse, are not possible at all. Systematically conditioned (classification by articles) ambiguity stems from Articles 20 and 20.a of the ZPPKZ, as the former one that details the speciality trainee's provision of the medical service they are specializing in does not expressly define that the speciality trainee must be provided with constant consultation with their mentor, which is only defined in Article 20.a (a speciality trainee who is appointed for a personal physician), whose provisions also apply to speciality trainees in paediatrics and in gynaecology and obstetrics. Otherwise, applying a grammatical and systematic, but not necessarily also a theological interpretation of the ZPPKZ, can lead to establishing that speciality trainees of other specializations are not entitled to constant consultation with their mentor. The absence of the possibility for consultation is only understandable when this is not possible because of general time pressure as a result of the medical condition. However, it is also questionable whether a speciality trainee who is not yet capable of adopting professionally completely founded decisions, especially completely independently, as well as a substituting physician, can actually provide medical services.

From the perspective of liability for damages, it should be emphasized that the Decisions on insuring physicians and dental medicine doctors for damage that might arise from their work for the year 2019 (Official Gazette of the RS, no. 24/19, hereinafter: Decision) defines that the physician (and dental medicine doctor) who works directly with patients should be insured for damage that might arise from their work, for the insurance amount of at least EUR 130,000, which applies for all specializations. With regard to the systematic interpretation of the previously discussed provisions of relevant legislation, the term *physician* also includes a speciality trainee. The obligation of insurance is related to all the types of work with patients, regardless of an individual specialization, and also for all types of work with patients within an individual specialization. The Decision defines that employed physicians (and dental medicine doctors) are insured by the employer, while those on contract by the contracting authority.

7.1 Practical example of problematic substitution: legal review

A younger FM speciality trainee was substituting for a more experience older colleague specialized in FM in a clinic of a retirement home. He was alone in the clinic. When examining an older resident who had been complaining of chest pain for a day or two, he was not able to determine a threatening condition, did not carry out an ECG, and laboratory tests were not conducted. The physician recommended the patient rest and to take a painkiller, suspecting muscle pain the chest area. The person died soon after, and the medical examiner ordered a sanitary autopsy with suspected overlooked acute myocardial heart attack. The autopsy confirmed the presence of an acute myocardial heart attack, and the pathologist performing the autopsy listed heart failure with acute myocardial heart attack as the cause of death, and triple vessel disease as the primary cause. Family members instigated a criminal complaint due to the suspicion of negligence and providing medical services according to Article 179 of the Penal Code (KZ-1, Official Gazette of the RS, no. 50/12 to 91/20). Family members also

submitted a claim for compensation. Considering the liability of the speciality trainee for the work or services provided and the signs of criminality as defined by the KZ-1, and considering the described background to the dispute, judgements of conviction should be expected.

It should be emphasized that Article 55 of the ZZDej defines that a healthcare worker may independently perform any work for which they have appropriate education and appropriate equipment at their disposal, assuming ethical, professional, criminal and material responsibility for their work. With regard to more detailed provisions on appropriate qualifications for physicians, the rules from Article 62 of the ZZDej no longer apply, as the above-mentioned rules of the ZZdrS supersede them. In Article 3 they also define that the physician is free to choose the method of therapy that is the most suitable under the given circumstances. In any case, if selecting a less suitable or even the wrong method of therapy, the responsibility, both criminal and civil (non-business liability for damages), is not established "automatically" (objective responsibility), but with regard to the specific, subjective circumstances of a specific case, where the guilt, if established, can also be shared. With regard to mistakes made in therapy, the prevalent position for assessing the physician's subjective responsibility, i.e. when a physician acts in opposition to the professional rules (objective assessment of the violations of professional rules) however, they cannot be assigned guilt for this, e.g. because of the epidemic, unsuitable organization of the healthcare service (13).

7.2 Practical example of problematic substitution: ethical and other reviews

We can establish that those responsible were irresponsible in putting the young FM speciality trainee into a position where while substituting he had to act independently, without the option of consulting with his area or main mentor, and adopt a decision that proved to be fatal for the ill person. Up until that point, he had never treated acute myocardial heart attack by himself, and was consequently not able to correctly recognize the clinical picture, finally making the wrong professional decision. We can determine that the actions of the mentor who put the speciality trainee in a position where he had to take key decisions that may be disputable from a professional perspective is not responsible. Independently of the fact whether the speciality trainee had been previously recognized as being able to independently perform medical services in his field of specialization, the situation described above actually opens broader ethical questions of shifting responsibility to an individual, even though the causes for the resulting position can also be attributed to his superiors or the architects of the healthcare policy that permits such situations. As the Article 1 of the Code of Medical Ethics posits, the physician takes into account in their work the scientific and professional findings of modern medicine, and is always learning and training and doing everything in their power to provide quality and safety to patient treatment. As a precondition for such treatment Article 1 defines appropriate conditions in human resources, materials, time and space, which are frequently, also when substituting, not fully met, even though the substitute physician is not necessarily free of criminal liability or liability for damages.

In the best-case scenario, the guilt or responsibility is shared when damages were the result of the actions of several subjects. The same kinds of questions can also arise from the positions where, due to the conditions described above not being met, a physician or another healthcare worker is strung between several narrow units of a work process or even between several work processes, even though they should only be working in one narrow unit of an individual work process at a time.

8 Conclusion

Absenteeism in healthcare is present across the board and is a multi-layered issue. It is defined both in the relationship between the rights and obligations of workers, i.e. physicians and their employers with regard to various types of absence (e.g. for using annual leave, education, illness), and rest and working time, as well as and especially with the rights of insured persons to appropriate, high-quality and safe healthcare, which should not depend on the short or long-term absence of their physician (or another healthcare worker) from their job. This reaches both into the field of labour law (working time, rest, permission for concluding civil law contracts, etc.) and in a limited scope also into public employee, social and healthcare law. The aspect of civil liability and even criminal liability can also be added to this. As established, the absence of appropriate substitution can have an effect on contractual relationships between the practitioner and the ZZZS. This also applies to cases of appropriate substitution, which in the event of a physician's absence increase costs and perhaps exceed contractually agreed amounts. Comprehensively resolving this issue would require some normative changes, e.g. at least provisions in relevant healthcare and social security legislation on the obligation of preparing internal acts related to recording and resolving substitution and

recording the related costs. Similar applies to the issue of allocating working time and the general challenges of organizing the work process with an employer's internal acts in such a way that work coincides with professional norms and standards required to fulfil the provisions of the ZPacP. However, we can only guess that actually improving the conditions, both for physicians and for other healthcare workers, as well as for those hospitalized in the public healthcare network again depends in particular on the scope of available funds, at the annual level divided based on the GA and individual contracts between the practitioners and ZZZS, and consequently also the obligations of the state for co-financing compulsory healthcare insurance or finding new financing resources in the current period of an ageing society. This applies in particular to the essential need for sensible staffing, both at the level of an individual employer as well as at the level of the healthcare policy in the country, as conditions in healthcare should be resolved in such a way that young physicians will also opt for the less attractive specializations (e.g. especially the aforementioned specializations in FM). The problem of absence and substitution is much bigger here. This will eventually also ensure suitable, high-quality and safe, while also timely healthcare of insured persons.

Conflict of interest

None declared.

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