



**ASSOCIATION EUROPEENNE DES MEDECINS DES HÔPITAUX
EUROPEAN ASSOCIATION OF SENIOR HOSPITAL PHYSICIANS
EUROPÄISCHE VEREINIGUNG DER LEITENDEN KRANKENHAUSÄRZTE
EUROPESE VERENIGING VAN STAFARTSEN
DEN EUROPÆISKE OVERLÆGEFORENING
ΕΥΡΩΠΑΪΚΟΣ ΣΥΛΛΟΓΟΣ ΝΟΣΟΚΟΜΕΙΑΚΩΝ ΙΑΤΡΩΝ ΔΙΕΥΘΥΝΤΩΝ
ASSOCIAZIONE EUROPEA DEI MEDICI OSPEDALIERI
DEN EUROPEISKE OVERLEGEFORENING
ASSOCIAÇÃO EUROPEIA DOS MÉDICOS HOSPITALARES
ASOCIACIÓN EUROPEA DE MÉDICOS DE HOSPITALES
EUROPEISKA ÖVERLÄKARFÖRENINGEN
EVROPSKO ZDRŽENJE BOLNIŠNIČNIH ZDRAVINIKOV
EUROPSKA ASOCIACIA NEMOCNICNÝCH LEKAROV
EUROPSKA UDRUGA BOLNIČKIH LIJEČNIKA
ΕΒΡΟΠΕΪΣΚΑ ΑΣΟCΙΑCΙΑ ΝΑ ΣΤΑΡCΗΤΕ ΒΟΛΝΗCΗΝΗ ΛΕΚΑΡΗ
ASOCIATIA EUROPEANA A MEDICILOR DIN SPITALE**

Document :	AEMH 16-027
Title:	National Report - Italy
Author :	Dr Sergio Bovenga, FNOMCEO
Purpose :	Information
Distribution :	AEMH Member Delegations
Date :	28-05-2016

**COUNTRY REPORT: ITALY
FNOMCEO**

(FEDERAZIONE NAZIONALE DEGLI ORDINI DEI MEDICI CHIRURGICI E DEGLI ODONTOIATRI)

The FNOMCeO report is focused on the following main issues:

1) Block of hospital doctors' contracts (since 2009)

The block of hospital doctors' contracts - in force since 2009 – is yet persisting in 2016, with severe consequences due to block of careers, salaries standstill and block of turnover. These are likely to negatively affect healthcare services' quality and safety.

2) Reform of Professional Responsibility

The Italian health system experienced a strong growth in medical litigations, resulting in more complex problems both for the sustainability of the system itself (defensive medicine is likely to become more and more a source of inappropriate spending for the NHS), and for health workers. The latter - and in particular high risk professional categories (gynecologists, orthopedic, surgeons) - are forced to pay insurance fees up to 28,000 € per year, an unsustainable cost for young workers especially.

According to ANIA (National Association of Insurance Companies), in 2013 criminal complaints against doctors registered a 200% increase, when compared to 1994 data. The vast majority of ~~criminal~~ complaints were closed without any follow-up action, and 80% of adverse events were attributed to system failures.

The reform of professional liability is therefore an increasingly urgent issue. In January 2014 Dr. Amedeo Bianco, Senator of the Italian Republic and FNOMCeO Past-President, has officially introduced a bill about healthcare safety and healthcare professionals responsibility". The bill, currently being discussed in the Parliament with Federico Gelli in charge as a coordinator, is based on four Pillars:

- a) The introduction – in the Italian Healthcare system - of special Units dedicated to clinical risk prevention and management, and of Observatories charged with litigations' assessment;
- b) A re-definition of wrongful conduct of criminal relevance, limiting it to cases resulting into death or serious bodily injuries;
- c) Direct responsibility (termed '*contract*') to be viewed as a charge of health institutions only, with

vicarious liability (so-called '*non-contractual*') only to be charged to professionals. This means that the hospital can be requested to prove having acted correctly (with prescription of legal actions 10 years after damage having become recognized), whereas the patient has to prove wrong-doing by a doctor (with prescription occurring within 5 years). In recent weeks, with the proposed law going through the parliamentary process, a hypothesis is advancing: to charge the hospital with the burden of directly compensating the patient; afterwards – depending on several possible conditions – the hospital itself will be able to claim for damage against its own employees.

d) The extension of the insurance coverage to every healthcare professional and structure, both public and private (the insurance will be a prerequisite for the accreditation of private hospitals).

3) Task Shifting

In recent months an intense debate has been ongoing regarding the issue of nursing skills needed in the territorial emergencies (118) sector. It had large resonance in the "media", especially in relation to the approach taken by one Order of Physicians and Dentists of the Emilia-Romagna Region: they sanctioned those colleagues who had participated into the drafting of some care protocols regarding this sector (118).

These protocols, in fact, allow the nursing staff on board of rescue ambulances to perform procedures – such as diagnosis and therapy – which pertain to the medical profession only.

Some of these protocols also involve an assumption of responsibility by a doctor acting in remote (charged with emergency care/care continuity), who ends up with being the real weak point in this system.

Doctors are not "a priori" against the possibility to authorize professional nurses to perform medical tasks in emergency situations, in order to safeguard the vital functions of the patient; or to perform medical acts included into pre-defined protocols which the doctor in charge of the emergency service decides to apply: this – in fact – is already legal (Art. 10 DL 27 March 1992); but they deem it essential to objectively and transparently define the professional liability of those involved in these areas.

4) Working Time

Since november 25th, 2015 European regulations governing working time of doctors and health professions in general finally came into force in Italy. From the same date, national and corporate contractual provisions inconsistent with European Directives concerning working hours and resting time became obsolete (lost any effect).

Such rules include:

- Compliance with a maximum of 12 hours and 50 minutes of daily work.
- Compliance with a maximum of 48 hours of average weekly working time, including overtime.

- Compliance with a minimum of 11 hours of un-interrupted rest in a day.

Any derogation to the minimum duration of daily rest periods, to the length of breaks, to how to calculate average weekly working time and night work can be introduced only by resorting to a national collective agreement or national agreements. Any agreements signed with regional authorities or at company level which do not comply with the European regulations are therefore null and void.

5) Impact of the Transatlantic Trade and Investment Partnership (TTIP) on health and the medical profession.

The FNOMCEO recently agreed with - and signed - the CEOM document (European Council of Medical Orders) here below:

“The CEOM calls for caution on TTIP negotiators about its potential consequences for public health, healthcare, medicine, education, the environment and the recognition of professional qualifications. It addresses the following recommendations to the European Commission, the governments of the EU Member States and the medical regulatory organizations: - Trade agreements cannot in any way interfere with the ability of governments to legislate on public health and regulate healthcare. The right to receive care and public health protection are above the interests of any trade agreement. - The agreements promoting and protecting public health and health services take precedence over commercial interests. The CEOM recommends opposing any provision that would jeopardize regulation of healthcare and access to public health. TTIP cannot restrict the right to health and Member States’ obligation to ensure a high level of health protection as enshrined in the Treaty on the Functioning of the European Union and the Charter of Fundamental Rights of the European Union. - TTIP should provide significant exclusions in order to protect health services and public health. Trade and liberalization imposed by TTIP could compel Member States to privatize their national health systems, which could lead to inequalities in health benefits and a decrease in the quality of healthcare and of the number of health professionals. The consequences would be disastrous for many citizens, especially the most vulnerable, and for national solidarity. The CEOM calls on negotiators to make transparent the debate on trade agreements that have an impact on public health by providing all the necessary documents in accordance with the Regulation 1049/2001 regarding public access to European Parliament, Council and Commission documents. The CEOM emphasizes that, in the interest of patients, access to health and the independence of health professionals must imperatively be preserved, in a quality of care objective. Therefore, it is of the utmost necessity to exclude from TTIP anything that could have an impact on public health, especially health services, the medical profession and access to medicines”.