COMITÉ PERMANENT DES MÉDECINS EUROPÉENS
STANDING COMMITTEE OF EUROPEAN DOCTORS

CPME Newsletter

ISSUE
32
June 2020

This issue

SAVE THE DATE! - CPME Meetings 2020—2021

20-21 November 2020 **Berlin (Germany)**	**19-20 March 2021** **Tallinn (Estonia)**	**26-27 November 2021** **Oslo (Norway)**

MESSAGE FROM THE CPME PRESIDENT

Dear Colleagues and friends,

Welcome to the 32nd edition of the CPME Newsletter.

The COVID-19 pandemic has radically changed our lives. Many of us have worked on the front line against the virus, sometimes with insufficient supplies and protection. Too many healthcare professionals have lost their lives or been infected while caring for their patients. Our thoughts are with their loved ones. As President of the European medical community I would like to express my sincere gratitude to all those fighting every day putting their own health at risk. Your tremendous work will never be forgotten.

As the COVID-19 outbreak has become a huge priority on the EU policy agenda, this CPME Newsletter will explore different aspects of the pandemic.

During the past months, CPME has closely monitored the developments at national and European level. In a survey coordinated by our organisation, 38 national medical associations have reported doctors' experiences of the COVID-19 pandemic. This information is updated in weekly status reports. The reports *i. a.* address the availability of the medical workforce, PPE, medicines, and medical devices; testing protocols and infection rates among doctors; as well as the working conditions of the medical workforce, including repercussions such as violence against health professionals. You will find further information on all these over the following pages.

Special emphasis is placed in this newsletter on the medicine shortages emergency. Although this has always been a limiting factor in doctors' ability to provide appropriate treatment, the situation is currently aggravated by the surge in demand due to the treatment of COVID-19 patients and additional disruptions to the supply chain. Since the COVID-19 emergency is not yet over, we urge for immediate action to be taken to prevent European hospitals from running out of essential medicines, but also permanent measures to ensure a stable supply of medicines to European citizens in the future.

The COVID-19 outbreak is having a big impact on healthcare professionals' mental health. Due to unprecedented harsh working conditions, frontline staff are experiencing symptoms of anxiety, depression and insomnia, but also stigmatisation. They are often considered as carriers of the virus and have faced discrimination on the basis of their profession. The global medical community has strongly condemned these attacks and asked for campaigns to stop misinformation related to COVID-19 contamination.

Another interesting aspect analysed over the next pages is related to digital contact tracing applications, which are being deployed as an additional public health measure to track and fight COVID-19. We will analyse the guidance issued by the European Commission and EU data protection authorities for Member States and app developers, briefly explaining the approaches taken by Member States and the challenges regarding cross-border interoperability.

We also take this opportunity to announce that on 20 April 2020, the Coalition for Vaccination launched an advocacy campaign aiming to raise awareness that immunisation through vaccination among healthcare professionals and their patients is the best protection against serious, even deadly, preventable diseases. The timing of the campaign launch is even more important as, during the COVID-19 pandemic, many children are failing to receive measles and rubella vaccinations. We invite you to join the campaign and raise awareness of vaccination uptake.

Furthermore, please check how some European countries are fighting the COVID-19 pandemic. Iceland, Poland, Sweden and the United Kingdom share their experiences and analyse the challenges they have faced over the course of the past months.

Finally, we have invited the European Federation of Nurses Associations, the European Hospital and Healthcare Federation, the European Association of Hospital Pharmacists, and the European Patients' Forum to contribute their opinions on how the health crisis has been faced and what main actions they have undertaken to support their own members.

I hope you will find this edition informative.

Kind regards and stay healthy!

Prof. Dr Frank Ulrich Montgomery

CPME ACTIONS IN SUPPORT OF HEALTHCARE PROFESSIONALS FIGHTING THE VIRUS

- European doctors call for a European response to medicine shortages during the COVID-19 pandemic and beyond, 22 April 2020
- Letter from the CPME President Prof. Dr Montgomery to all doctors in Europe fighting COVID-19, 9 April 2020
- Joint Letter on Healthy COVID-19 Recovery, 26 May 2020
- European Medical Organisations condemn attacks on healthcare professionals fighting COVID-19 pandemic, 14 May 2020
- A Plea to Reform and Finance the World Health Organization Sufficiently, 14 May 2020
- Joint Statement on COVID-19 and Mental Health, 8 May 2020
- COVID-19: Principles for Global Access, Innovation and Cooperation, 23 April 2020
- SFP Coalition Statement on COVID-19 and Tobacco Control, 21 April 2020
- SOS Moria Appeal from European doctors, 9 April 2020
- Healthcare professionals urge authorities to guarantee protection to those in front lines against COVID-19, 27 March 2020
- Joint open letter in support of research and development during the current pandemic, 25 March 2020
- AEMH-FEMS Motion on SARS-CoV-2 (COVID-19) Outbreak, 21 March 2020
- Joint letter to the President of the European Commission von der Leyen and the Commissioner for helath Kyriakides, 18 March 2020

COPING WITH THE COVID-19 PANDEMIC: EUROPEAN DOCTORS SHARE THEIR EXPERIENCE

The COVID-19 pandemic has moved health policy to the top of political agendas. While some countries are still coping with the acute pressure of the pandemic, others are seeing a steady reduction in infections and are able to start an evaluation process. At CPME too, a discussion around the lessons learnt has been launched. This process draws on the extensive collection of status reports from national medical associations CPME coordinated which capture doctors' experiences of the pandemic. These include information on the availability of human and technical resources, testing and treatment protocols, and the impact on doctors' health and professional practice. A first analysis of these reports highlights both short-term measures that must be addressed urgently ahead of a second wave of the pandemic as well as more long-term but equally important tasks to strengthen health systems more generally. Two points are exemplary of these challenges: the lack of personal protective equipment (PPE) and lack of medical workforce.

It was remarkable that the lack of PPE affected almost every country. Urgent procurement efforts saw a global competition for supplies from foreign manufacturers in first instance. Many countries such as Finland, France, Greece or the Netherlands set up national production lines which improved the availability of PPE in later stages. In Italy, domestic manufacturing of masks including the repurposing of facilities from the fashion industry. The National Medical Associations i.a. in the Czech Republic, Lithuania, Latvia and Cyprus were directly involved in procuring or distributing PPE for their members. While supply stabilised over time in most countries, there are still reports of local shortages, for example from Spain, the United Kingdom and Sweden. In some cases these are also caused by concerns as to the quality of PPE.

The lack of PPE resulted in unsafe working conditions. In the United Kingdom, only 12% of doctors surveyed by the British Medical Association in April felt they were fully protected at work. Beyond the obvious infection risks, the lack of PPE has further negative externalities: in Romania, there were reports of doctors being harassed by neighbours who fear the spread of infection and even of doctors resigning from positions due to the lack of adequate PPE.

And even beyond such extreme cases, it soon became obvious that a large majority of countries did not have a medical workforce which was large enough to deal with the unknown extent of a pandemic. Existing shortages such as those reported from Bulgaria and Ireland, became more acute. In other countries, it was only the relatively low numbers of infections that prevented a problematic situation. Where doctors were in quarantine due to exposure to COVID-19 cases or on sick leave, the available workforce further contracted. In Malta for example this affected 10% of the total medical workforce at the height of the pandemic. In Hungary, doctors and nurses above the age of 65 were excluded from frontline practice, which applied to a third of the workforce.

To counterbalance these shortages, there have been various emergency remedies. Several countries have accelerated medical students' access to medical practice, be it on a voluntary basis as in Greece or by changing laws as in Germany. Calls to retired doctors to re-join the workforce or a reserve have proven an effective measure in many countries including in Italy, France, and the Netherlands. A solution in Sweden has been to reorganise the distribution of doctors to different workplaces, while in Cyprus doctors from the private sector are requested to assist in public hospitals. From the Spanish medical workforce, it is reported that doctors are supporting their colleagues across specialties. Among those countries not experiencing shortages, Norway reports that doctors have travelled to Italy to support their local colleagues.

These encouraging signs of solidarity and resilience must now guide future pandemic preparedness. The fact that healthcare systems are still functioning in the most severely affected regions is to a large extent thanks to the efforts of doctors and other health professionals who coped with unknown adversities to continue the best possible care for their patients. No mention of these efforts can be complete without remembering those doctors and other health professionals who have died of COVID-19. Their deaths are a sad reminder of the danger and real risks the health workforce faces every day. It is therefore imperative that the medical profession is involved in the evaluation of lessons learnt at all governance levels to ensure the pandemic preparedness is fit for practice. European doctors are ready to share their experience.

Sarada Das, Deputy Secretary General

IT IS TIME FOR THE EU TO PROPOSE CONCRETE SOLUTIONS TO MEDICINE SHORTAGES

The pandemic is an unprecedented public health crisis affecting all areas and aspects of healthcare delivery, including the availability of medicines. The outbreak has aggravated medicine shortages in the EU by causing additional disruptions of the supply chain and by resulting in increased demand for some medicines in clinical trials for COVID-19 and off-label use.

Media reports have been informing the public about the shortage of sedatives, painkillers, muscle relaxants, antibiotics, antivirals and antimalarials needed to treat COVID-19 patients in several EU countries, while the stocks in others have been running low. This information has also been reflected in the national updates from CPME members gathered over the past months.

The pandemic has brought home the EU's long-existing structural problems and just how fragile and intransparent the supply chains of medicines are. It has also highlighted shortcomings in the current cooperation among Member States and in the coordination at EU level. Medicines shortages were already on the political agenda before the crisis and lessons learned from the outbreak are only reinvigorating calls for identifying and applying concrete, effective solutions. There is political momentum as well as public interest in acting to ensure stable supplies of medicines and equal access to them by all EU citizens.

A number of initiatives are currently being undertaken by different EU institutions that could contribute to achieving this goal. Firstly, a recently published roadmap to the European Commission's Pharmaceutical Strategy recognizes medicine shortages as one of the most important problems to be tackled within the pharmaceutical sector over the next few years. It identifies supply chain complexity, the commercial strategies of pharma companies and weak public service obligations as some of the reasons for shortages.

In addition to this, the Commission will shortly launch a dedicated study on the root causes of medicine shortages. Its scope is planned to be broad as it aims to provide a summary of the number of shortages in the EU and their causes, an assessment of current legal provisions and an outline of the pros and cons of possible future actions.

Actions are also being taken within the European Parliament. Its own-initiative report on the shortage of medicines is currently being discussed and is planned to be voted on in the ENVI committee later this month. Most interestingly, as part of the solution, it proposes bringing part of the production of medicines back to Europe, competence shifts at EU level for the prevention and/or management of medicine shortages, including expanding the role of the European Medicines Agency (EMA), and calls on the Commission and Member States to create one or more non-profit European pharmaceutical undertakings for the production of certain medicines of strategic importance.

Moreover, the EMA is drafting its own concept paper on best practices to prevent shortages along with the Heads of Medicines Agencies. Availability of medicines will also be part of the European Medicines Agency's European Medicines Regulatory Network Strategy to 2025, planned to be published later this year. Medicine shortages are also being discussed by the COST action on medicine shortages, the mandate of which has been prolonged by one year, as well as by the European Commission's Pharmaceutical Committee and the Expert Group on Safe and Timely Access to Medicines for Patients (STAMP).

The variety of the above-mentioned initiatives and fora within which shortages are currently being addressed proves the high sense of urgency for finding solutions to this problem. The scope of actions proposed in their results will be broad and EU policymakers, in consultation with stakeholders, will have to decide which of them provide the best chance of strengthening supply chains and ensuring stable access to medicines in Europe.

CPME, on its part, is continuously involved in these developments to ensure that the European doctors' perspective is taken into account in decisions on actions to tackle the shortages. Based on its recently adopted policy, CPME is meeting with the MEPs proposing additional amendments to the Parliament's draft report and with Commission officials in regard to the forthcoming Pharmaceutical Strategy.

Piotr Kolczynski, Legal Advisor

MENTAL HEALTH OF DOCTORS AND OTHER FRONTLINE STAFF DURING THE COVID-19 CRISIS


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The COVID-19 pandemic is already having a big impact on Europeans' mental health and well-being. People are experiencing fear, worry, stress, confusion, frustration and anxiety. They are facing new realities of teleworking, temporary unemployment, home-schooling of children, and lack of physical contact with other people. All this may be combined with inadequate access to mental health care or early intervention services. The mental health toll of the pandemic may only be fully understood after many months or years.

Doctors and other frontline personnel have been placed under exceptional stress by the COVID-19 pandemic, affecting their mental health and well-being. They are also experiencing symptoms of anxiety, depression and insomnia, but also stigmatisation.

In early May, CPME, together with a number of healthcare organisations, published a joint statement on the COVID-19 pandemic's impact on mental health. It highlights that the unprecedented harsh working conditions of frontline and medical staff must be addressed and supported through proper risk management, ensuring sufficient staffing, encouragement, peer communication and support. Moreover, access to psychosocial services should be enhanced and made possible taking into consideration shifts and working time. Limiting the number of working hours should be considered, not only to reduce the risk of infection, but to ensure a proper work-life balance, thus enabling rest and recuperation. The signatories also underlined that ensuring availability of proper personal protective equipment is important not only for physical but also for mental well-being, as it gives a stronger sense of security.

Doctors and other frontline personnel are also affected by stigmatisation. Often considered as carriers of the virus, they have faced discrimination on the basis of their profession. The World Medical Association (WMA) and the European Medical Organisations have condemned attacks on healthcare professionals and asked for campaigns to stop misinformation related to COVID-19 contamination. Misinformation and disinformation often increase fears and panic in the population. Therefore, it is vital that authorities communicate clearly on the risks and the latest developments related to the outbreak. Moreover, stigma must be addressed, staff protected, and awareness raised of the key role healthcare professionals play in overcoming the outbreak.

Also, the World Health Organization (WHO) has called for healthy, safe and decent working conditions for healthcare professionals. In terms of mental health, this means adequate staffing levels and clinical rotation in healthcare facilities, measures to minimise psychosocial hazards, and provision of access to mental health and psychosocial support.

At the European level, Ms Stella Kyriakides, EU Commissioner for Health and Food Safety, has stated that mental health in this crisis is one of the greatest concerns. Policies and services addressing mental health are the responsibility of the EU member states. However, the European Commission's DG SANTE has recently set up a special space within the EU Health Policy Platform to discuss and share information on the effects of COVID-19 on the mental health of European citizens but also of healthcare professionals. CPME has joined this network, which is led by Mental Health Europe.

The healthcare organisations' joint statement concludes that mental health should be an integral part of any public health response to the current and to future pandemics to avoid preventable psychosocial stress. Prevention of mental health problems, early intervention and access to adequate support should be embedded in any containment and post-pandemic recovery plan, as the risks of experiencing mental ill-health are likely to increase.

Markus Kujawa, EU Policy Adviser

JOIN THE COALITION FOR VACCINATION CAMPAIGN!

LATEST NEWS

On 20 April 2020, the Coalition for Vaccination launched an advocacy campaign aiming to raise awareness that immunisation through vaccination among healthcare professionals and their patients is the best protection against serious, even deadly, preventable diseases.

This campaign was launched online across Europe to coincide with WHO Europe's European Immunization Week and it will run until the end of the year. Both the initiator and the target group are health professionals with knowledge of each other's patient groups, professional environments, and the challenges they meet in their daily work in relation to vaccination.

The timing of the campaign launch is even more important as, at this time of the COVID-19 pandemic, many children are failing to receive measles and rubella vaccinations. According to a WHO statement released in April 2020, more than 117 million children will be exposed to serious and preventable diseases. In some countries hit by the COVID-19 virus, many parents have decided to delay the normal vaccine schedules, waiting for better times, even if the national routine immunisation services are ensured. Once again, the role of healthcare professionals is now fundamental as they will have to champion efforts and reassure people that vaccines are safe, effective and cannot be missed, even during difficult circumstances.

The Coalition for Vaccination brings together European associations of healthcare professionals and relevant student associations in the field and is co-chaired by the European organisations representing doctors, nurses and pharmacists. The three co-chairs have produced various videos addressing many aspects of vaccination. These videos, together with tailor-made pictures and messages, are the main tools used during the campaign.

In particular, CPME created three videos and a communication toolkit with a lot of material that can be easily downloaded and shared online. The first video addresses how medical doctors can promote an increased uptake of vaccines among patients and caretakers, responding to their questions and concerns. The second video addresses how medical doctors can promote an increased uptake of vaccines among medical doctors themselves. Finally, the third video addresses how medical doctors can promote an increased uptake of vaccines among nurses or pharmacists. In order to increase engagement and attract attention on the web, the Coalition for Vaccination campaign is using the following hashtags: **#CoalitionForVaccination** and **#VaccinesWork**.

The Coalition for Vaccination brings together nearly 20 European associations of healthcare professionals and relevant student associations in the field. It was convened by the European Commission in 2019. The Coalition aims to support delivering accurate information to the public, combating myths around vaccines and vaccination, and exchanging best practices on vaccination. It is co-led by the Standing Committee of European Doctors (CPME), the European Federation of Nurses Associations (EFN) and the Pharmaceutical Group of the European Union (PGEU).

Each of us is invited to join the campaign and raise awareness of vaccination uptake among healthcare professionals - in our professional or personal life, at individual or collective level.

Miriam D'Ambrosio, Communication Officer

DIGITAL CONTACT TRACING AND THE IMPACT ON THE MEDICAL PROFESSION

In June 2020, several Member States and other European countries are deploying 'digital contact tracing' (1) applications as a public health measure to fight COVID-19. The objective is to refrain the spread of the virus and monitor the incidence of new infections, making it easier to identify, inform and isolate infected persons early on, even before they are aware of being infected, thus avoiding a second wave. This measure will assume a more prominent role as travel resumes, commerce re-opens and tourism lures us away from home. CPME is making enquiries on the subject in order to understand the impact that this measure could have on the profession, in particular the possible increase in the use of telemedicine. (2)

For CPME, the use of this tool must not undermine other public health measures, in particular wide-scale testing of the population, robust and responsive health systems, maintaining social distancing and hygiene measures and the isolation of sick individuals. Contact tracing apps should also meet the essential requirements issued by the European Commission, the European Data Protection Board (EDPB) and the European Data Protection Supervisor (EDPS) (see box list below), which attempt to ensure a common EU approach, compliance with EU data protection law and cross-border interoperability between them, i.e. ensuring that an Italian app near a Portuguese mobile phone should be able to alert the user to a relevant epidemiological exposure. (3)

For CPME, the apps must also not lead to the discrimination or stigmatisation of users, e.g. making access to certain services conditional upon downloading the app. Ensuring that digital contact tracing is respectful of medical confidentiality, private life and personal data protection implies an active role for national data protection authorities during the development phase and throughout deployment and use. Moreover, considering this novel type of processing of health data using new technology on a large scale, a data protection impact assessment prior to the deployment of each mobile app needs to be conducted. For example, unauthorised access to health data, abuse of data collection, unauthorised sharing of data, repurposing or gradual widening of the use of the app beyond the purpose for which it was originally created (also known as 'function creep'), cybersecurity breaches, inhibition or discouragement of exercising freedoms – these are all risks that need to be identified, analysed and assessed against the likelihood of their occurrence and the severity of their impact. From a user's perspective, information on who has access to which data, for what purposes and for how long are key concerns. Consequently, for reasons of transparency, and in order to build users' trust and increase inclusiveness (4), such impact assessments should be made public.

The discussion at EU level over the past months also focused on two other topics: the approach of European countries concerning storage location and communication protocols – the so-called centralised (5) and decentralised (6) approaches - and a common framework for registering epidemiological relevant contact, which is not the same in all countries. (7) (8)

Many questions are still open, in particular it remains unclear what happens after a user receives an alert. National healthcare systems offer different responses, from contacting the user's family doctor or General Practitioner, to calling a national number or following a testing scheme. Understanding the level of physicians' intervention and supportive role in this regard is something that CPME intends to look into.

1) Contact tracing is the process of identifying an individual who has been in contact with infected persons. It can be done manually (e.g. by in-person interview or by phone) or digitally, via a mobile application. Due to the scale of the pandemic, manual tracing was revealed to be insufficient: it relies on individuals' memories, it is very resource intensive to track the infection chain and can be quite challenging to alert unknown individuals. Digital contact tracing, also known as 'proximity tracing' or 'exposure notification', intends to overcome these gaps. The evolution of the term aims to reflect the type of personal data collected, moving away from the use of geolocation data (GPS/GNSS or cellular location data) to recording only proximity signals using Bluetooth Low Energy (BLE) or equivalent technology.

2) The development of mobile apps is a national competence. The app may have many functionalities: from providing trustworthy information to the public, to a symptom-checker and self-diagnosis, with a contact tracking feature (location-based) or only proximity warnings (Bluetooth low energy-based), the app may also provide information on risk exposure, information on the diffusion of the disease, serve as a channel to communicate with the user's family doctor or General Practitioner, etc. All these functionalities should not be bundled together, meaning that consenting to one functionality does not imply consenting to all others.

3) APPLE and GOOGLE have joined forces to develop an Application Programming Interface (API) – a tool that defines interactions between several software intermediaries – for Android and iOS, allowing for interoperability only in the de-centralised approach. According to these companies the centralised approach does not comply with sufficiently high standards of privacy. Protocols are also being developed by other entities (either publicly or privately funded):for both centralised or decentralised apps (ex. Pan-European Privacy-Preserving Proximity Tracing (PEPP-PT), while some only for decentralised (ex. DP-3T, TCN Coalition).

4) According to the eHealth Network, based on a study by Oxford University and evidence from Singapore, an app needs to be downloaded by at least 60% of a country's population in order to be effective. The eHealth Network is a voluntary network set up under article 14 of Directive 2011/24/EU. It provides a platform for Member States' competent authorities dealing with digital health. The Joint Action supporting the eHealth Network (eHAction) provides scientific and technical support to the Network.

5) The centralised approach means that the user is registered at the central server operated by the public health authorities and the arbitrary ephemeral identifiers generated by the apps are stored therein. In case an individual is confirmed positive for COVID-19, the individual can choose to upload the recorded encounters to the central server, which then matches with the registered users and sends notifications about their risk exposures. In the countries using this approach it will be possible to have a visual map of citizens' encounters. Denmark, Czech Republic, France, Lithuania and Slovakia have adopted this approach. The United Kingdom in the beginning also opted for a centralised approach but as this Article went to printing it changed to the decentralised approach.

6) The majority of EU countries opted for the decentralised approach, which is the approach recommended by the European Commission and EDPB as being more in line with the data minimisation principle. In this approach, the matching of encounters is done on the users' phones. Austria, Cyprus, Estonia, Finland, Germany, Hungary, Ireland, Italy, Latvia, The Netherlands, Poland, Portugal and Switzerland have adopted this approach.

7) The European Commission is recommending that Member States follow the evolving guidance of ECDC concerning epidemiological parameters, in particular distance, duration, contact persons and the environment (in-doors, out-doors, wall protected, use of mask, etc.).

8) For a comprehensive overview of official COVID-19 contact tracing apps per Member State and UK see the European Parliament Briefing on National COVID-10 contact tracing apps European Parliament Briefing on National COVID-10 contact tracing apps,15 May 2020, pages 6-9.

Sara Roda, EU Senior Policy Advisor

Relevant EU guidance on digital contact tracing and data protection:

- European Data Protection Board, Statement on the processing of personal data in the context of the COVID-19 outbreak, 19 March 2020;
- European Data Protection Supervisor, EU Digital Solidarity: a call for a pan-European approach against the pandemic, 6 April 2020;
- European Commission recommendation on a common Union toolbox for the use of technology and data to combat and exit the COVID-19 crisis, in particular concerning mobile applications and the use of anonymised mobility data, 8 April 2020;
- European Data Protection Board, Letter concerning the European Commission's draft Guidance on apps supporting the fight against the COVID-19 pandemic, 14 April 2020;
- eHealth Network, Mobile applications to support contact tracing in the EU's fight against COVID-19 – Common EU Toolbox for Member States, 15 April 2020;
- European Commission, Communication on Guidance on Apps supporting the fight against COVID 19 pandemic in relation to data protection (2020/C 124 I/01), 17 April 2020;
- European Data Protection Board, Guidelines 04/2020 on the use of location data and contact tracing tools in the context of the COVID-19 outbreak, 21 April 2020;
- European Data Protection Supervisor, 'TechDispatch #1/2020: Contact Tracing with Mobile Applications', 7 May 2020, explaining about contact tracing in the area of public health, discussing the practice of proximity tracing and the data protection implications;
- eHealth Network, interoperability guidelines for approved contact tracing apps in the EU, 13 May 2020;
- European Data Protection Board, Statement on data subject rights in connection to the state of emergency in Member States, 2 June 2020.
- the eHealth Network Guidelines to the EU Member States and the European Commission on interoperability specifications for cross-border transmission chains between approved apps - Basic interoperability elements between COVID+ Keys driven solutions V1.0 and Detailed interoperability elements between COVID+ Keys driven solutions V1.0, 16 June 2020
- European Data Protection Board, statement on the interoperability of contact tracing apps and statement on the opening of borders and data protection rights, 16 June 2020.

DIGITAL CONTACT TRACING AND ESSENTIAL REQUIREMENTS FOR NATIONAL APPS

The development of mobile apps is a national competence although EU coordination is required to ensure a common approach. The guidance issued by the European Commission, the European Data Protection Board (EDPB) and the European Data Protection Supervisor (EDPS) provides information on essential minimum requirements to ensure mobile apps compliance with EU data protection law. In this article, we present these requirements in more detail:

- Downloading the app must be a **voluntary action** from the user, based on consent, which must be freely given, explicit, informed and unambiguous, and without any negative consequences in case an individual does not wish to download or use the app;
- The mobile app should also be developed in close coordination and **approved by national health authorities** (or entities carrying out the task of public interest in the field of health), **who should be the data controllers pursuant to the General Data Protection Regulation**;
- It must be **specific to COVID-19 purposes**, excluding in particular for law enforcement or commercial purposes. Exceptions for **scientific research and statistics are allowed if** clearly mentioned to the user before the collection of health data starts;

- **Oversight from national data protection authorities** needs to be ensured, as well as **regular review of technical solutions**;
- **Location data** is not considered to be necessary nor recommended, as the goal of the application is not to follow the movements of individuals or to enforce specific actions from public authorities. EU data protection authorities warn that GPS/location data can provide a detailed picture of an individual daily routine and interactions, which may reveal personal traits (ex. sexual orientation, religious practices, etc.) rendering them more vulnerable and exposed**.** (1) **Proximity tracing, using Bluetooth Low Energy (BLE) signals**, is the technical solution recommended by EU data protection authorities. Moreover, it is not necessary to store the exact time of contact or the place. It is sufficient to store the day of contact.
- **Tracing data generated by the app** should be characterised by **arbitrary, encrypted and temporary identifiers,** this to prevent data linkage and re-identification attacks.

- The **register of the epidemiological relevant contact should be stored on the user's device** and sharing such data with health authorities only after positive confirmation of being infected with COVID-19 and on the condition that the **user authorises such sharing of data. The identity of the infected person should not be disclosed** to the persons to whom he/she has been in contact with;
- Mobile tracing apps must be **limited in time**, defining in advance sunset features/clauses, which stop the collection of personal data and delete personal identifiers from all databases (mobile and servers) when the pandemic is declared to be under control. For example, the apps can foresee automatic uninstallation or send instructions to uninstall or the data controller should deactivate the app, etc. Concerning **data storage during app usage**, personal data should be deleted when no longer necessary. For the European Commission, however, the **timeline** should take into account **medical relevance** and **realistic durations for administrative steps.**

In conclusion, mobile apps should be developed in a way that complies with data protection principles specified in Article 5 of the General Data Protection Regulation, bearing also in mind the principles of data protection by design and by default of article 25. Moreover, as rightly pointed out by ECDC concerning the registration of the user's epidemiological contacts: *'apps should be designed in such a way that allows for updating settings and parameters.'* (2) A dialogue between public health authorities, app developers and data protection authorities should continue to allow continuous understanding of technical limitations and public health needs. The use of the regulatory sandbox framework could have been useful in this regard, as it would allow the possibility to deliver a new product/ service with benefits to the public and the assurance of compliance with data protection principles. (3)

1) On 12 June 2020, the Norwegian Data Protection Authority has ordered a temporary the suspension of the app called Smittestopp due to the collection of location data. The Norwegian public health authorities now have until 23 June to reply.
2) https://www.ecdc.europa.eu/sites/default/files/documents/COVID-19-mobile-applications-contact-tracing.pdf, page 2.
3) For more information on the German regulatory sandbox see https://www.bmwi.de/Redaktion/EN/Dossier/regulatory-test-beds-testing-environments-for-innovation-and-regulation.html; and for the United Kingdom see https://ico.org.uk/for-organisations/the-guide-to-the-sandbox-beta-phase/.

Sara Roda, EU Senior Policy Advisor

LATEST NEWS

UNESCO BIOETHICS CONFERENCE 2020 POSTPONED TO MARCH 2021

We would like to inform you that due to the COVID-19 outbreak, the 14th World Conference on Bioethics, Medical Ethics and Health Law has been postponed and will be held on 8-11 March 2021, at the same venue, Porto Palacio Hotel, under the same conditions and according to the original scientific program.

The fast pace of EU policy-making often leaves little time for in-depth reflection on ethics in health. The World Conference on Bioethics, Medical Ethics & Health Law hosted by the UNESCO Chair in Bioethics is therefore a welcome opportunity for ethics in health to be the focus of attention. At this edition's conference, CPME will present two topics: AI and defensive medicine. In sessions dedicated to each topic, a panel of expert speakers from National Medical Associations and other backgrounds will contemplate the ethical questions raised. On defensive medicine, CPME will present the 'CPME Position Paper on Defensive Medicine', while representatives from national medical associations will present their work on what motivates defensive medicine, what the impact is on patients and health systems, and how to reduce defensive practices.

On AI, CPME will present the 'CPME Policy on AI in Health Care' during the session's discussion on safe and responsible implementation of AI in medical practice. The following debate will cover the ethical, clinical and legal implications of AI-based technology introduction in health care delivery.

CPME looks forward to testing its policies with experts and exploring the implications of its recommendations against the wider context of medical ethics.

Sarada Das, Deputy Secretary General

ICELAND DURING THE COVID-19 EMERGENCY PHASE

LÆKNAFÉLAG ÍSLANDS STOFNAÐ 1918
Icelandic Medical Association

The population of Iceland is 364 000 and it has a national social security system for all inhabitants. Hospitals are government run, but primary health care is composed of a mixture of public and private providers. The objectives and actions of the health authorities have been to ensure that the necessary infrastructure is able to withstand the strain that the COVID-19 pandemic could cause in Iceland. The first case of COVID-19 in Iceland was diagnosed on 28 February 2020. On 5 March the Icelandic authorities declared a National Emergency Phase with immediate effect. It then became compulsory for all Icelanders arriving from high risk areas to be tested for COVID-19 and go into quarantine while waiting for the results. On 25 May this was stepped down to Alert Phase after the infection had been successfully suppressed, but not eliminated, from the population.

During this 90 day period, 10 individuals died due to COVID-19, 1805 were infected, over 20 000 completed quarantine and over 60 000 samples were analysed. By 25 May, 1792 people had recovered (Fig. 1), of which 118 needed hospitalization and 30 were admitted to ICU (1). A COVID outpatient clinic was established. Each patient was followed up daily by a phone call from a nurse or a doctor to monitor disease progression. In cases of worsening symptoms, patients were called in for evaluation and, if necessary, admitted to the COVID hospital wards. At the beginning of April about 1000 patients were under the care of the outpatient clinic. (2)

The main measures implemented in Iceland have been large-scale testing to trace all contacts of infected individuals and assign them to quarantine. Prediction modelling by the University of Iceland turned out to be a reliable resource for strategy implementation and resource allocation (ww.COVID.hi.is) (3). The contact tracing app *Rakning C-19* was launched for mobile devices and is openly available. The app helps to analyse individuals' travel and trace their movements against those of other people when cases of infection or suspected infection arise. (4)

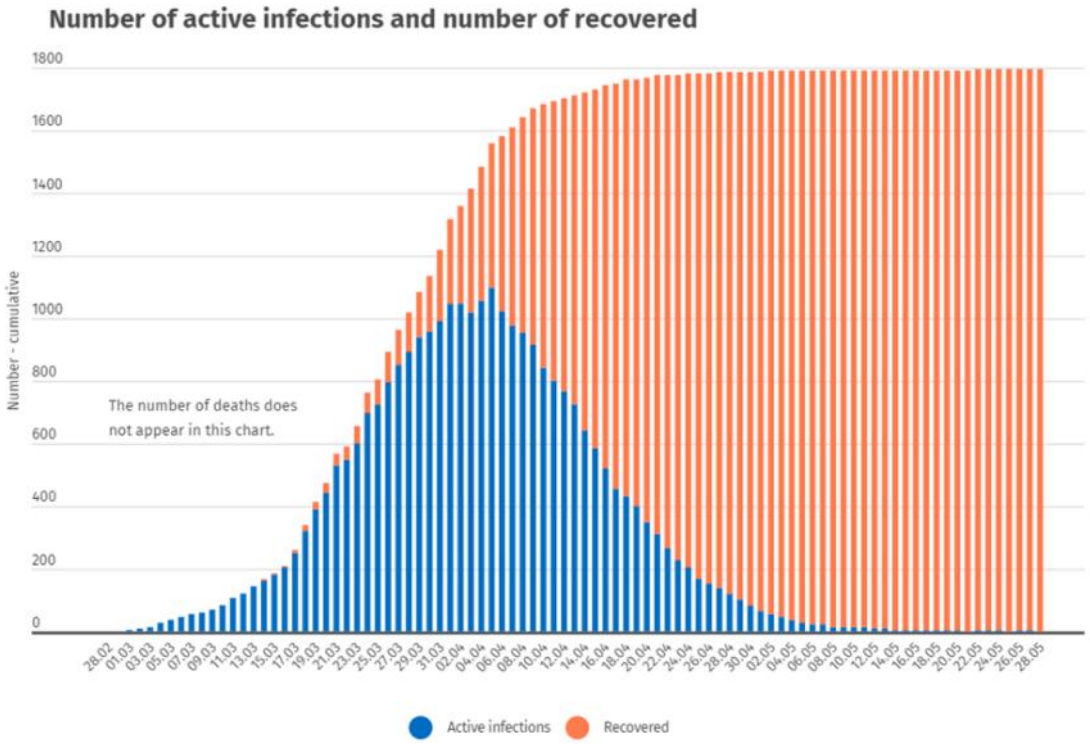


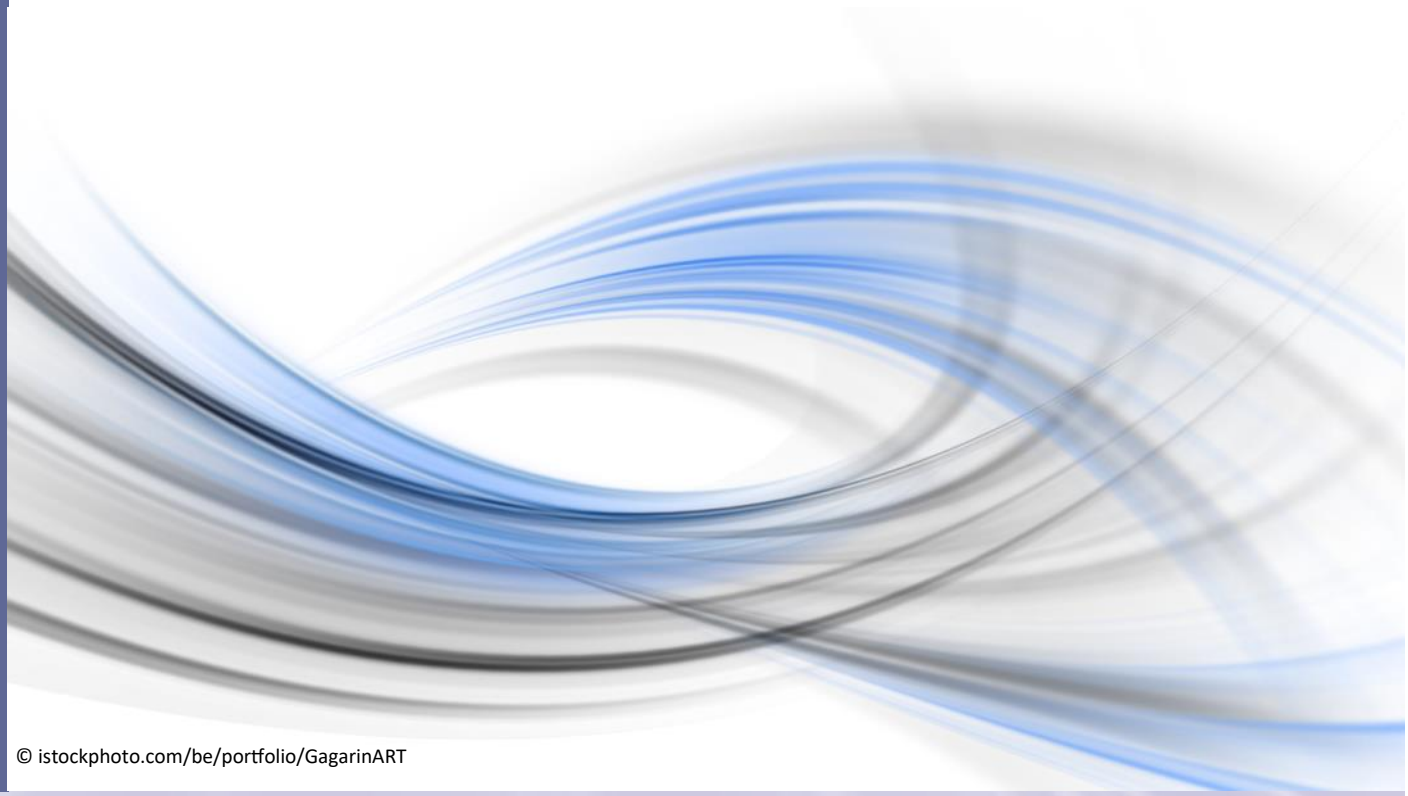
Figure 1. Number of active infections and number of recovered in Iceland

Samples from all symptomatic patients suspected of COVID-19 infection were analysed at the National Hospital. Parallel testing was offered to the general public by Decode genetics and a random population sample was analysed. As of 4 April, 13.3% of those recruited for targeted testing had positive (5) results for infection with SARS-CoV-2, but in the general population only 0.6% of participants in the random screening tested positive. These numbers appear to be more or less constant until today. Preliminary unpublished results from random antibody testing to date by Decode genetics support a low level of population immunity to SARS-CoV-2 of only 0.9%. (6) Interestingly, of those diagnosed so far, 57% were already in quarantine, which was encouraging.

A gradual increase in restrictions started on 16 March and lifting commenced in early May. By now, gatherings of 200 people are permitted. Public services, e.g. gyms and swimming pools, can reopen with 50% restrictions on maximum capacity. Self-quarantine for 14 days is still an obligation when arriving in Iceland. Travel restrictions and border measures will be re-evaluated before 15 June. (7) The government has announced its intention to offer new arrivals the option of either 14 days self-quarantine or undergoing COVID-19 testing upon arrival and compulsory use of the *Rakning C-19* tracking device. This plan is currently under evaluation, but the logistics appear to be very challenging on several levels, e.g. technically with respect to laboratory capacity to deal with large scale screening, airport and harbour facilities and health-care staff availability.

1) https://www.COVID.is/data accessed on 29 May 2020
2) https://www.landspitali.is/default.aspx?pageid=b629a8e0-b262-49e0-b842-0f776cb4241e accessed on 29 May 2020
3) https://COVID.hi.is/english/ accessed on 29 May 2020
4) https://www.COVID.is/app/en accessed on 29 May 2020
5) https://www.nejm.org/doi/full/10.1056/NEJMoa2006100?query=featured_home accessed on 29 May 2020
6) https://www.ruv.is/frett/2020/05/28/mikill-minnihluti-landsmanna-med-motefni-vid-COVID-19 accessed on 29 May 2020
7) https://www.landlaeknir.is/um-embaettid/frettir/frett/item41637/Almannavarnastig-laekkad-nidur-a-haettustig-vegna-COVID-19 accessed on 29 May 2020

Prof. Reynir Arngrímsson, President of the Icelandic Medical Association



SOME ASPECTS OF THE COVID-19 EPIDEMIC IN POLAND FROM THE PHYSICIANS' PERSPECTIVE

The COVID-19 epidemic in Poland – probably just like in other affected countries – is not only a period of particularly exhausting and stressful work for doctors and other healthcare staff, but it is also a time when medical professionals and their organizations face numerous challenges. It is impossible to report on all the important issues and the activities that have been carried out over the past 3 months in a short article such as this. As doctors we have faced many encouraging events and attitudes, but also those which we cannot agree with and which should not take place, especially at such a demanding time.

The epidemic has highlighted two features of the state of healthcare in Poland: negative attitudes towards physicians within a certain part of society and political ignorance regarding healthcare, coupled with restrictive regulations aimed at the medical profession.

Initially, Polish doctors encountered signs of great social sympathy, manifested, for example, in the provision of food free of charge to hospital staff and PPE provided by numerous individual donors. Unfortunately, as the weeks of the epidemic have passed, and with the appearance of SARS-Cov-2 outbreaks in medical facilities, verbal abuse, aggressive gestures and hate speech aimed at healthcare staff have started to take place, with events such as vandalising a nurse's car with paint, or the refusal to admit the children of doctors to kindergartens.

As regards the management of the healthcare system in Poland, one should note the significant tardiness in the introduction of in-hospital procedures regarding the use of PPE (due either to the ubiquitous difficulties in obtaining PPE or the negligence of health facility managers). Hospitals therefore became one of the main centres of outbreaks in the epidemic's initial phase.

At the same time, the authorities decided to impose a ban on doctors employed in the hospitals that had been transformed into infection centres for the sole treatment of COVID-19 patients from exercising their profession elsewhere. This action was unjustified since the vast majority of infections among medical staff were not among the doctors from these hospitals. Doctors were promised compensation for having to work only in one workplace and losing income possibilities. Unfortunately, this additional remuneration has not been paid out so far and administrative procedures are underway to calculate these payments (which are becoming increasingly disadvantageous). In addition, Polish cross-border healthcare workers were unfairly and unequally treated, being the only group of workers who would have to be quarantined after returning from Germany when the border with Germany was reopened.

Finally, perhaps the most painful fact for us was that decision-makers did not allow full testing for SARS-COV-2 among medical personnel, despite repeated requests and calls from the medical profession. On the other hand, when large outbreaks appeared among coal miners in Upper Silesia, screening tests were immediately organized for all employees in the mining sector. Such an example of selective, discriminating attitudes has undermined the morale of many medical professionals in Poland.

Currently, the majority of healthcare facilities are still not providing planned treatments. In most small towns, patients cannot arrange a visit to general practitioners, only teleconsultation is available, and even this is not available in all outpatient clinics. The medical community in Poland is afraid that the healthcare system – which is still up and running only because of the significant amount of overtime work carried out by medical personnel – will completely collapse after the epidemic. And eventually, as a consequence of the coronavirus epidemic, it is likely that far more people will lose their health and lives due to a lack of access to the healthcare system rather than due to the infection itself.

Dr Artur Drobniak

Deputy Secretary of the Supreme Medical Council

Polish Chamber of Physicians and Dentists

SWEDEN'S APPROACH TO THE COVID-19 PANDEMIC

Swedish Medical Association

Sweden's approach to the COVID-19 pandemic has received attention since it is claimed that it differs a great deal from that of other countries. There are certainly differences, but these are not as profound as the impression one might get from the media, and achieving herd immunity has not been part of the strategy. Most of the restrictions that are part of the lock-down strategy in other countries have also been implemented in Sweden, albeit specified as official recommendations by the Government. This approach is, to a great extent, determined by fundamental constitutional constraints - the Swedish constitution lacks a stipulation for the declaration of a state of emergency in peacetime. Thus, the Swedish Government does not have the possibility to suspend citizens' rights and freedoms by declaring a state of emergency. In addition, the Government has no power to interfere with how a governmental agency applies the law or decides in a specific case. The government agencies take decisions independently and report to the ministries. In many other countries, a minister has the power to intervene directly in an agency's day-to-day operations, but this possibility does not exist in Sweden.

This means that most of the decisions taken during the pandemic have been made by expert epidemiologists at the Swedish Public Health Agency (SPHA). The main strategy in Sweden has been to "flatten the curve" so that the outbreak does not overwhelm the capacity of the healthcare system. It has also been important to set a level of restrictions that can be endured by the population for a long period of time. Sweden is not trying to prevent harm to the economy by sacrificing public health, but public health implies a broader scope and responsibility than just fighting COVID-19.

There is, of course, as in most countries, discussion about the choice of strategy within Sweden. Swedish experts and researchers discuss, and partly disagree, on the effectiveness of the chosen strategy. However, the latest public poll shows that 64% of the Swedish people think that the measures implemented in order to limit the spread of the virus are well balanced between public health and the economy. 77% of Swedes have high or very high confidence in the pandemic management of the SPHA.

The Swedish recommendations are quite similar to the restrictions in other countries: the importance of washing hands, keeping 2 meters apart, staying home from work with even the slightest symptoms, no visits allowed to homes for the elderly, no gatherings of more than 50 persons and self-isolation of individuals aged above 70 and at -risk groups. Everyone is expected to work from home if possible and only travel if absolutely necessary. What stands out in Sweden is the fact that pre-schools and primary schools have remained open during the pandemic since there was no solid evidence that school closures would slow down the outbreak, but the effects on the work force – not least on health care professionals – would have been significant.

Four months on from the first detected case in Sweden, it is clear that the SPHA and, most importantly, the local authorities in municipalities who are in charge of care of the elderly, should have worked more actively to stop the spread to and within care homes. The elderly residents of these homes make up more than 50% of all the deceased in Sweden. We can also see that the government should have mobilized increased testing capacity earlier and commenced national coordination of testing, since the healthcare regions in Sweden have different capacities to launch mass testing. The outbreak has revealed deficiencies in Sweden´s preparations for national emergencies, a lack of personal protective equipment and a deficient drug supply. However, even if we are still in the midst of the pandemic, and the work is far from over, there are some positive signs. Sweden has so far managed to scale up its health care facilities, including the important intensive care units, to take care of patients suffering from COVID-19. Sweden´s approach cannot be assessed until we have seen if there will be additional waves and what happens globally when the restrictions – or recommendations – are removed.

Dr Heidi Stensmyren, President of the Swedish Medical Association

COVID-19 AND BREXIT: A TOXIC MIX FOR EUROPE'S HEALTH

For the BMA's (British Medical Association) European Office, 2020 was supposed to be about working with our European partners to ensure that the terms of the future relationship (between the UK and EU) allowed the medical profession to continue treating its patients to the highest possible level beyond the end of the transition period on 31 December 2020.

To recap, the plan was for the UK and EU to use this time to negotiate a new and fair partnership for the future, based on the jointly agreed Political Declaration.

As it took several years to negotiate the much less complex Withdrawal Agreement, this timeline was viewed as optimistic at best.

When the COVID-19 pandemic and attendant lockdown hit both sides of the channel, a dispassionate observer would probably have suggested that the UK government would seek to postpone the negotiations so that both parties could focus their energies on tackling both the public health, and emerging economic, crisis. Such a move would require the UK to request an extension, or accept the same offer from the EU, to the transition period of either 1 or 2 years, before the end of June 2020.

Indeed, and as the COVID-19 pandemic has developed, political heavyweights from both within the EP (European Parliament) and the Irish political establishment have added their support for such a course of action, with Christophe Hansen MEP, negotiator of the post-Brexit agreement within the EP's Committee on International Trade, stating that:

> "*Under these extraordinary circumstances, I cannot see how the UK Government would choose to expose itself to the double whammy of the Coronavirus and the exit from the EU Single Market, which will inevitably add to the disruption, deal or no deal. I can only hope that common sense and substance will prevail over ideology. An extension of the transition period is the only responsible thing to do*".

Despite such pressure, the UK government continues to insist that it will stick to the existing timetable - "The transition period ends on 31 December 2020".

If true, this means that a host of issues directly impacting Europe's doctors and their patients need to be resolved by negotiators working in unprecedented virtual conditions, and under extreme time pressure.

With more than 22,000 EEA (European Economic Area) qualified doctors licensed to work in the UK, and able to practise both there and in other European states due to the mutual recognition of their professional medical qualifications, resolution of this issue is imperative.

Without an ambitious agreement on the recognition of professional qualifications – which is vital to both doctors' professional development and in meeting various workforce requirements across the continent – Europe risks losing many of these highly qualified medical professionals entirely, with Australasia and North America increasingly popular destinations.

Both sides compromised during the first phase of negotiations in order to find the pragmatic solutions necessary to ensure that "doctors working before Brexit can continue to work in their host countries" and that "their professional qualifications will continue to be recognized" during the transition period.

Having spoken to literally hundreds of stakeholders across Europe about this over the last 4 years, not one single person has disputed the importance of securing the future of the medical profession in a post-Brexit Europe.

With COVID-19 putting "health" front and centre of the EU's policy debate, it would be bitterly ironic if its impact on negotiations led to the interests of the European medical profession slipping through the cracks of a "narrow/ shallow" deal on the future relationship.

The CPME helped us to ensure that this wasn't the case with the Withdrawal Agreement, so we look forward (hopefully not by Zoom for much longer) to working with them and the whole European Health Community to do the same for a post-transition Europe.

Paul Laffin, EU Public Affairs Manager

GUEST ARTICLE

HEALTHCARE SYSTEMS COPING WITH COVID-19

The COVID-19 outbreak is having an unforeseen impact across all EU countries and it is affecting all layers of society. COVID-19 is reshaping the EU political priorities and strategies to get the European Union acting as 'one voice'. The European Commission continues to be a stakeholder with whom the nursing profession engages in constant dialogue, but a new area of cooperation has arisen, coordinating actions to tackle the health crisis with EU Member States.

However, the main takeaway of the COVID-19 outbreak is that the European Commission needs to look for formulas to co-design Health Policies that are fit-for-purpose in the context of a health crisis, to ensure that the EU can act in a coordinated manner across all EU countries. This is a need and a demand of nurses at the frontline, as well as of citizens.

The EU institutions should actively co-engage with all EU health stakeholders, especially nurses, to be better prepared at the frontline. That way, all EU countries will be much better prepared for the next pandemic / health emergency.

When health crises occur, the nursing profession is always at the frontline serving citizens and patients. This has been part of European history since the time of Florence Nightingale. In times of war and pandemics, when populations need healing and support, nurses are always at the frontline day and night. For that reason, the European Institutions, Commission, Council and European Parliament, should take concrete and immediate actions to better support and protect European Citizens.

The COVID-19 outbreak and the Ebola crisis have shown significant similarities, which frontline nurses were unprepared cope with: "To be better prepared, we need to be all prepared" (EFN, 2015).

1 - Support the EU health workforce, in particular nurses, to respond to the challenges of Infectious Diseases of High Consequences (IDHC) without compromising its safety and wellbeing, through coordinating and building capacity in the nursing workforce, providing further access to vital education and training that includes opportunities for regular drills on donning and doffing PPE, and assuring the provision of adequate resources and support for a safe working environment.

2 - Explore the causes, mechanisms and consequences of stigmatisation related to the care and treatment of IDHC within the European Health Research Programme and, based on outcomes, take appropriate actions to tackle stigmatisation. Frontline nurses have been unfairly stigmatised by some citizens as dangerous and disease-carriers.

3 - Continue to encourage investment in preparedness, learning from the lessons and knowledge gained so far, and enhancing monitoring and follow up initiatives. Protecting the health workforce, as well as the public, from future health threats should continue to remain a priority for all Member States individually and the European Commission collectively through ensuring that relevant protective equipment, appropriate education and training, and protocols are made available to frontline staff.

4 - Co-creating and co-designing with frontline nurses fit-for-purpose political decision-making processes and policies for IDHC preparedness is a must. This is a challenge for the European Commission as their only counterparts are the Member States and sometimes academics who they ask for advice, but not frontline healthcare professionals. Healthcare professionals and NGOs are often kept out of the decision-making equation, making political actions often unfit-for-purpose. This accounts for the lack of pragmatism in the decisions taken by the European Commission in the handling of the COVID-19 crisis. Past exercises of collecting best practices and fulfilling academic frameworks have not resulted in an EU strategy for supporting the nursing frontline. The new coronavirus outbreak proves that more EU support to the frontline is needed when emergencies emerge. EU citizens need EU policies that protect frontline staff from working overtime and being continuously understaffed.

It will be key to explore how different healthcare systems are responding to this crisis and to monitor and measure the impact of COVID-19 on the nursing workforce. However, we already know for sure that the nursing workforce will need to be better equipped to be able to handle the next pandemic. So, we had better get prepared!

Prof. Dr. Paul De Raeve, RN, MSc, MStat, PhD

EFN Secretary General

GUEST ARTICLE

PATIENTS WITH CHRONIC CONDITIONS NEED ALL THE SUPPORT THEY CAN GET DURING COVID-19

The COVID-19 crisis has exposed and exacerbated existing gaps and weaknesses in our health systems, as well as a lack of resources, tools and harmonisation at EU level to form a single, united European response. Patients with chronic conditions – totalling over 150 million in the EU alone – are among the most vulnerable to a higher risk of health complications and death from COVID-19.

The main challenges for patients with chronic conditions as highlighted by our members, have been treatment delay, discontinuation, general lack of clarity or appropriate guidance, and the lack of patients' involvement in developing solutions and guidance (for example on the ethics of triage). They also mentioned the great social impact all of this will have on vulnerable groups with chronic conditions who are already at a greater risk of poverty and social exclusion.

Being the voice of patients in Europe, it is of utmost importance to EPF to support our members in every possible way. Our members are made up of pan-European disease-specific organisations and national coalitions of patients, and they are the driving force of our daily work. We have therefore strengthened our contacts and have asked our members to highlight the main challenges experienced by the patient community, and to send us regular patient testimonies.

To this end EPF has undertaken a series of actions since the beginning of the pandemic, which have included:

- Issuing to-date four statements addressing a number of issues resulting from the pandemic, including an open letter to EU Commissioner for Health and Food Safety Stella Kyriakides;
- Creating an online COVID-19 Resource Point containing reliable information (credible figures, research articles on medicine development and research, reports on COVID-19, and its effects on the patient and medical community);
- Issuing a designated weekly newsletter containing COVID-19 Resource Point updates, for those interested;
- Showcasing our members' initiatives and other best practices;
- Gathering testimonials from patients across the community;
- Co-writing a call to action with the EU4Health coalition.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EPF also attended a virtual meeting with Commissioner Kyriakides, during which the abovementioned challenges and concerns from the patient community were raised and a much needed discussion was held, including on involving EPF more in the Commission's future work.

There is still a high degree of uncertainty with regard to the resumption of health services and therapies, not to mention COVID-19 vaccine development and therapeutic innovation. However, we believe this also serves as an opportunity to work together and fight to make the patient community stronger than ever.

Our call for patient testimonies, initiatives, challenges and best practices from the patient community is ongoing: if you have anything to share with us please contact dante.diiulio@eu-patient.eu.

More information: https://www.eu-patient.eu/COVID-19/

Emily Bowles, Communications Officer

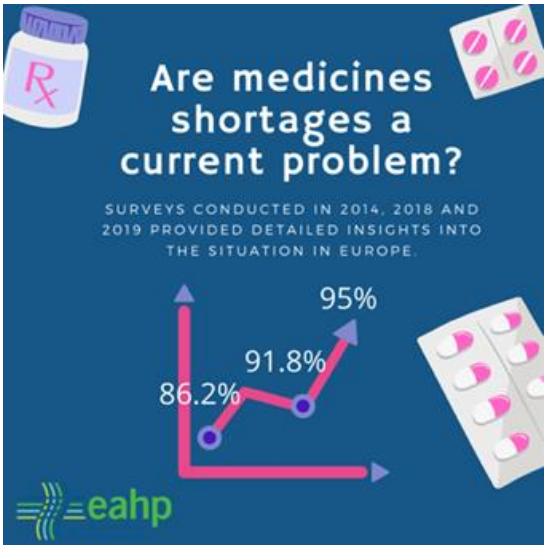
GUEST ARTICLE

HOSPITAL PHARMACY SERVICES IN TIMES OF COVID-19

The COVID-19 pandemic has very much affected the daily working life of hospital pharmacists, but it has not altered the overall aim of their services. The patient and patient safety are and will always be at the centre of all their activities. As outlined in the European Statements of Hospital Pharmacy, hospital pharmacists have many roles ranging from the selection, procurement, distribution and compounding of medicines to clinical pharmacy services. The virus has challenged these activities, but hospital pharmacists are fighting to deliver optimal pharmaceutical care to all patients at all times in spite of it.

Interdisciplinary cooperation is a key element in combatting COVID-19. In these challenging times, hospital pharmacists contribute as part of the team by dispensing medicines, ensuring that all necessary medicines and materials are available in hospitals, compounding medications and disinfectants, as well as gathering, analysing and processing all relevant information and evidence to pharmacotherapeutic guidelines for the treatment of COVID-19. In order to foster understanding about hospital pharmacy interventions during the pandemic, the European Association of Hospital Pharmacists (EAHP) has used social media to share messages from its members throughout the last few weeks. Alongside these positive and encouraging messages outlining the valuable contributions of hospital pharmacists, negative impacts of the virus were also reported.

Frequent shortages of medicines which impact patient outcomes are not a new phenomenon for hospital pharmacists. EAHP has worked on this issue for the past decade. Research by the Association in 2014, 2018 and 2019 showed that the impact that shortages have on patient care and the work of hospital pharmacists has increased. These problems seem to have worsened over the past few weeks with many countries reporting shortages of medicines used in intensive care units triggered by COVID-19. For EAHP and its members, EU action is crucial for addressing the causes of the problem of shortages, which seems to have been aggravated even further during the pandemic. Hospital pharmacists are consequently advocating for concrete measures at EU level to address the growing shortage problem.



These include:

- Investigating and addressing the root causes of medicines shortages and their impact on patients' outcomes;
- Adopting preventive measures across the EU, such as the implementation of a prudent tendering mechanism;
- Facilitating the European-wide uptake of prospective risk assessments;
- Developing a comprehensive European-wide communication strategy on medicines shortages to help improve information exchange, including best practice sharing between authorities, the pharmaceutical industry, supply chain actors and healthcare professionals.

Besides working on medicines shortages, EAHP has set up a resource centre to assist its member associations and individual hospital pharmacists with the provision of the best possible care for patients during the pandemic. Since mid-March, EAHP's COVID-19 Resource Centre has been gathering and making available information on COVID-19 relevant to the hospital pharmacy profession. Also, the Association has teamed up with its clinical pharmacy colleagues from the European Society of Clinical Pharmacy (ESCP) to boost the public's understanding about clinical and hospital pharmacy services during the pandemic. A video campaign is currently being carried out which seeks to showcase how clinical and hospital pharmacists are contributing to improving patient outcomes.

1) The European Statements of Hospital Pharmacy, European Journal of Hospital Pharmacy 2014;21:256-258. Available at: https://ejhp.bmj.com/content/21/5/256.

2) European Association of Hospital Pharmacists. Medicines shortages in European hospitals. The evidence and case for action. Brussels: European Association of Hospital Pharmacists (EAHP), 2014. Available from:

3) http://www.eahp.eu/sites/default/files/shortages_report05online.pdf.

4) European Association of Hospital Pharmacists. EAHP's 2018 Survey on medicines shortages to improve patient outcomes. Brussels: European Association of Hospital Pharmacists (EAHP), 2018. Available from: http://www.eahp.eu/sites/default/files/report_medicines_shortages2018.pdf.

5) European Association of Hospital Pharmacists. 2019 EAHP Medicines Shortages Report, Medicines Shortages in the Hospital Sector: Prevalence, Nature and Impact on Patient Care. Available from: https://www.eahp.eu/sites/default/files/eahp_2019_medicines_shortages_report.pdf.

Emily Bowles, Communications Officer

GUEST ARTICLE

HOPE IN COVID-19

With Europe being the most impacted continent by COVID-19, working for the European Hospital and Healthcare Federation (HOPE) was and still is quite challenging.

Following the situation in China attentively in January and February, and also alerted in late February to the shortages of medical devices produced in China, we first developed a systematic exchange of information and knowledge between members to then customize it to different needs. Contacts were also made in late February with the WHO Regional Office for Europe on the preparation of hospitals in countries with potential issues with handling the COVID-19 crisis.

European countries and regions were at different stages, some on high emergency at hospital level, others getting a limited number of patients, but things were changing fast, and in waves. Feedback from HOPE members (as with the review carried out on a regular basis by CPME) have provided the first lessons, notably the importance of a comprehensive approach that integrates all components of social and health care, from home care, primary care and hospital care, to the connection of the health system and social home care. To avoid putting hospitals in deadlock, measures at community level, social and long-term care are important to avoid the transmission of SARS-CoV-2.

Our role was, of course, also to follow how the European institutions were facing the crisis. Together with CPME, HOPE addressed the European Commission at an early stage, welcoming efforts and measures taken to get out of the crisis. We are now working on evaluating the present role of the EU, not limited to the role of the Commission, and looking at how in particular, on the basis of the treaty (article 168-5), the 2013 Decision on strengthening the EU's capacity to coordinate responses to health emergencies did or did not work well.

Beyond the struggle to tackle COVID-19, the European Union institutions' role in public health, and particularly in the provision of health technology, will certainly be impacted. More specifically concerning pharmaceuticals, medical devices, and protective equipment, COVID-19 has demonstrated very clearly what had already been clear for quite some time: the de-industrialisation of Europe and dependency on China. This is also the case in other fields, like rare minerals and metals, needed especially for IT but also for greening energy production.

Other pressing questions concerning pharmaceuticals have been highlighted by the crisis: do private-sector commercial interests handicap effective responses to health needs? Should the scope of patents (and notably the role of compulsory licensing) be reviewed in this light? Should companies be obliged to share research results? Is it time for different business models, or medicine pricing controls, or mandatory joint procurement? Should requirements be tightened to oblige companies to make their products available? Or are private-sector responses handicapped by inadequate intellectual property, insufficient profits, or excessive regulation?

The pandemic has changed the context for considering what were – until two months ago - burning issues. Among them, artificial intelligence, a field in which there is a lot on-going, as well as for the application of the General Data Protection Regulation... But another worrying topic is back, that of an economic crisis. The previous one severely damaged health in several countries and a lot of lessons have not been learned. Let's work for a restart which links health and the environment.

To conclude, during this on-going crisis tremendous work is being done at all levels by professionals in home care, in social care, in healthcare and in hospital settings. This makes one very proud to work in the health and social sector.

Pascal Garel, Chief Executive

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CPME COMITÉ PERMANENT DES MÉDECINS EUROPÉENS
STANDING COMMITTEE OF EUROPEAN DOCTORS

Guest commentary

For feedback, further information, questions or to express an interest to contribute to future editions, please contact:

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