COMITÉ PERMANENT DES MÉDECINS EUROPÉENS
STANDING COMMITTEE OF EUROPEAN DOCTORS

CPME Newsletter

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This issue

MESSAGE FROM THE CPME PRESIDENT

Dear Colleagues and friends,

Welcome to the 34th edition of the CPME Newsletter.

We are all closely watching the progress of different vaccines as governments, healthcare professionals and pharmaceutical companies strive to give people the Covid-19 vaccination in order to turn the tide against the coronavirus and its mutations. And we see a successful roll-out of effective vaccines as being key in efforts to reduce the prevalence of the disease and bring back more normality to the lives of healthcare professionals and of everyone. In this respect, we would stress how important it is for everyone to use and pass on accurate information from reliable sources and to help stop the spread of disinformation.

Healthcare professionals have played and continue to play a crucial role in coping with the high numbers of cases across the world. But the strain of coping with the disease has taken a heavy mental and physical toll, with hundreds of colleagues across Europe having lost their lives.

We therefore start this edition with an article summing up a special event to commemorate healthcare professionals. During the ceremony, a commemorative plaque from the Federazione Nazionale degli Ordini dei Medici Chirurghi e Odontoiatri (FNOMCeO) and the CPME was unveiled at Codogno Hospital.

Also in our latest news section, I would like to highlight an article setting out the state of play on the European Commission's plans for a European Health Union, which include establishing a new structure to step up the EU's ability to prepare for and respond to serious cross-border threats to health: the European Health Emergency Preparedness and Response Authority (HERA).

Digitalisation is a big priority for the European Commission during this legislature and the CPME is particularly interested in the debate about the ongoing digital transformation of healthcare systems. Doctors of course need training and that is why, as part of Germany's Presidency of the Council of the EU, the Standing Committee of European Doctors and the German Medical Association (BÄK) held a joint conference entitled 'Doctors go digital' on 20 November. We have an article drawing out the highlights of this event, a short video summary of the conference, an article combining the CPME's policy on digital competences for doctors and a Digital Doc Thematic Network joint statement on 'Training future-proof doctors for the digital society'.

Moving to our section on CPME member associations, we hear from the Doctor's Chamber of North Macedonia, which has been given observer status by the CPME (at the General Assembly in November), as well as from our associate member in Turkey, the Turkish Medical Association, and the Belgian Doctors' Association.

In our guest section, I would like to highlight a statement, written by the European Medical Students' Association, on the involvement of medical students in patient care during the COVID-19 pandemic. In the same section, we have a contribution from the European Commission about the EU's strategy for a safe and effective roll-out of COVID-19 vaccines.

I hope you will find this edition as informative as previous editions.

Kind regards and stay healthy!

Prof. Dr Frank Ulrich Montgomery

CPME President

LATEST NEWS

EUROPEAN DOCTORS STRESS NEED FOR SOLIDARITY AS HEALTHCARE PROFESSIONALS ARE REMEMBERED IN CEREMONY IN ITALY

“Grazie. A chi ha dato la vita per salvare le nostre” [Thanks. To those who gave their lives to save ours.] is how the front cover of the programme announces the event commemorating the loss of lives of healthcare professionals on 20th of February 2021, the first Italian National Day of Healthcare, Social Health, Social Assistance and Volunteer Staff.

The year 2021 has also been designated by the World Health Organisation as the International Year of Health and Care Workers to recognise their dedication to providing care during and despite the COVID-19 pandemic that has challenged health systems worldwide.

The first COVID-19 patient in Europe was treated in Codogno Hospital in Italy. And that made Codogno a fitting place for a commemorative plaque for the doctors and other colleagues who have lost their lives to COVID-19 to be unveiled during a ceremony held in Codogno and in Rome. The ceremony, which was organised by the Italian Federazione Nazionale degli Ordini dei Medici Chirurghi e degli Odontoiatri (FNOMCeO), was accompanied by music, including the European and Italian anthems.

And those giving speeches included Italy’s President of the Republic, Sergio Mattarella, Italy’s President of the Senate of the Republic, Maria Elisabetta Alberti Casellati, Italy’s Minister of Health Roberto Speranza, as well as the President of the Standing Committee of European Doctors (CPME), Frank Ulrich Montgomery, and the FNOMCeO President, Dr Filippo Anelli.

Representing Pope Francesco, Monsignor Vincenzo Paglia, President of the Pontifical Academy for Life, gave a blessing during the unveiling of the commemorative plaque and read a message from Pope Francesco, who spiritually joined those gathered at the ceremony.

“Around 2.5 million people have been cured of Covid thanks also to the key contribution of all the healthcare professionals in a pandemic that has brought the world to a standstill and continues to claim victims among the population and among doctors. Up until today, 326 colleagues have unfortunately died because of the epidemic. Doctors have striven, with a solemn oath at the start of their professional career, to treat everyone without discriminating against anyone, to treat patients in the event of any emergency and to treat them without ever giving up. For us doctors, ‘every live counts’,” said the FNOMCeO President, Dr Filippo Anelli.

“Not only will we remember the service they provided as doctors, dentists and nurses to their patients and to healthcare in Europe with esteem and respect, but we will also remember each of them as the person they were, as a colleague, family member, a mentor or simply a friend.

We will take this message of remembrance across Europe. The feeling of connectedness through our profession is especially strong in moments like these,” said the President of the Standing Committee of European Doctors (CPME), Frank Ulrich Montgomery.

In relation to the ongoing roll-out of vaccines, Dr Fillipo Anelli added that "we have a duty to protect our healthcare professionals as a basis for ensuring safety in medical treatments. For that reason, the vaccination of doctors and healthcare workers is the most effective personal safety protection device".


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The President of the Standing Committee of European Doctors (CPME), Frank Ulrich Montgomery also had some messages for the future and the importance of solidarity:

"To honour our colleagues' memory, we must not shy away from the reasons for this extreme catastrophe. By working across borders in Europe and worldwide, it has been possible to learn from one another on how to provide patients the best possible care despite insufficient supplies and protection. National medical associations have been successful in creating support services to safeguard the mental well-being of doctors. The European Medical Organisations, who are also following today's event, joined forces to call for support and protection of doctors.

And we owe our colleagues hope: Plans for future pandemics have to be adapted. Physician self-administration and governments have to work together in preventing - sure to come - future viral or bacterial attacks.

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Let's have hope: Scientific cooperation has produced vaccines within months of the outbreak which will start to turn the trend on infection rates. Scientific units around the world are racing to detect and combat variants of concern. And governments have learnt that working together and coordinating their response is more effective than trying to cope with the pandemic in national isolation."

Julian Hale, *Communication Consultant*

WHAT DOES THE FUTURE HOLD FOR A EUROPEAN HEALTH UNION?

COULD THE DEVASTATING CRISIS OF THE COVID-19 PANDEMIC SEE THE BEGINNING OF A PERMANENT SHIFT IN THE EU'S PERCEPTION OF HEALTH POLICY?

It would be fair to say that the pandemic has revolutionised the European Commission's thinking on health policy. Over the last year, the Commission has come from placing it as a strand of the European Social Fund Plus, to proposing over €9 billion for a standalone health programme, to agreeing on a historic €5.1 billion – negotiated firmly along with the European Parliament overcoming the Council's resistance (see the newsletter's 33rd issue) – for health over the next seven years. With a strong political mandate and a significant budget, the Commission is eager to seize the opportunity to fully exploit the potential that the Union could have for health policy. In November, this plan was given a name – the European Health Union.

First things first

As this visionary project reflecting the EU's growing ambition was triggered by the ongoing pandemic, its implementation naturally begins with the improvement of the health emergency management framework. This process was kicked off with the release of three flagship legislative proposals to increase crisis coordination and empower key health agencies: the European Medicines Agency (EMA) and the European Centre for Disease Prevention and Control (ECDC).

If adopted, these new and amended regulations would allow the Commission to formally recognise a public health emergency at Union level, the EMA to reinforce and formalise the current ad hoc processes and extend its supervision to medical devices, and the ECDC to issue tailored recommendations for Member States, among other things.

The plan also includes the establishment of a new European Health Emergency Preparedness and Response Authority (HERA) with a mission to strengthen the EU's preparedness and response in terms of medical countermeasures for serious cross-border threats to health, both of natural and intentional origin. Whether it will be just an operational agency, or a body that also includes the EU's centralised manufacturing and innovation infrastructure, or a lead authority that will even take over some of the competences of other EU agencies in the field of medical countermeasures will be discussed over the coming months.

European doctors' view

European doctors welcome this initiative and the reports that CPME is receiving from national medical associations indicate that, in many instances, improved coordination at EU level would allow for better protection of the health of EU citizens. In recently adopted recommendations to the EU, they call for revisiting the existing approaches, from replacing the current "just in time" rationale with a "just in case" model, to guaranteeing permanent funding, and adjusting current policies and mechanisms, like investing in health promotion, strengthening health workforce planning, improving data collection, and providing for supply chain resilience. The forthcoming legislative changes could help the EU to achieve these goals.

Will the concept live up to the high hopes?

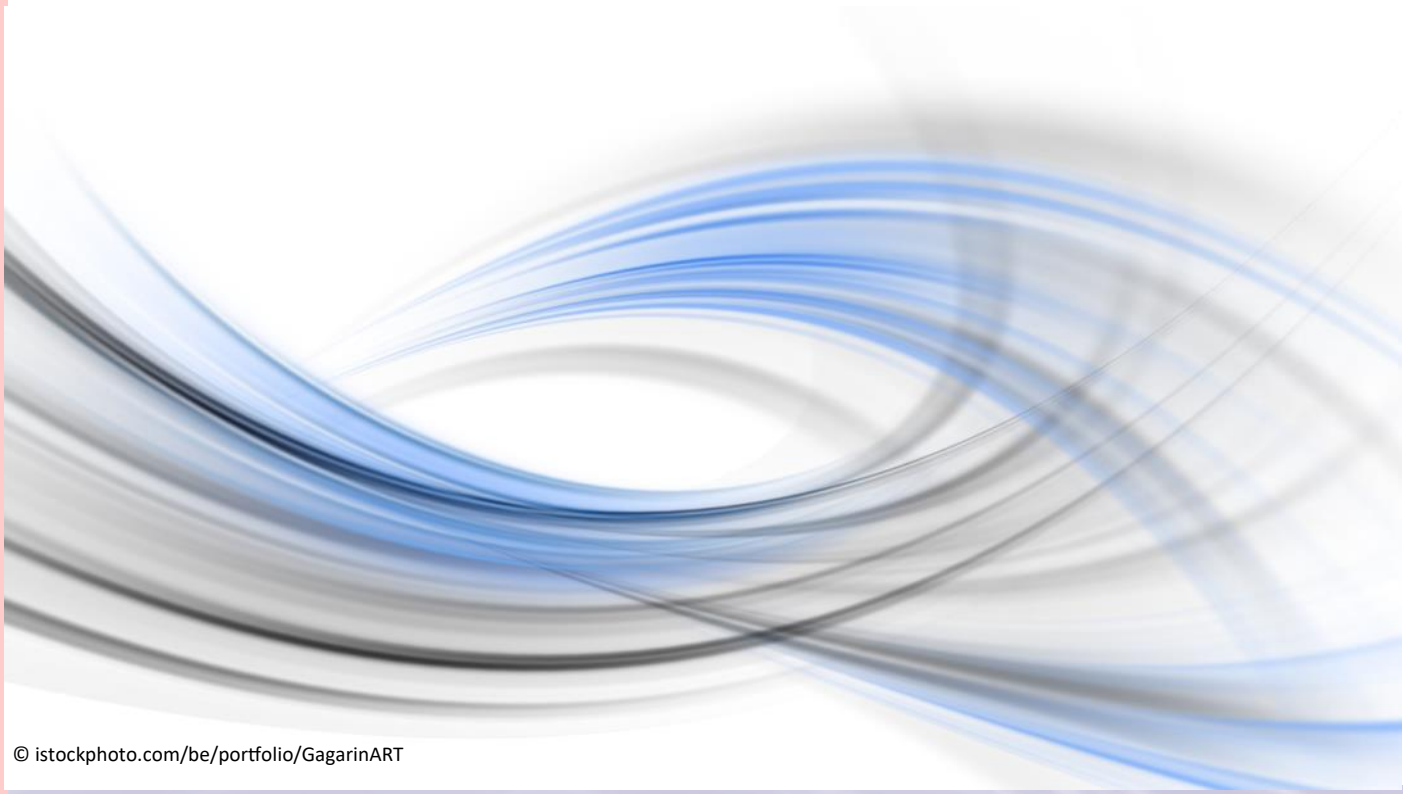
Although the European Health Union is only in the process of taking its first steps – or to use the Commission's metaphor, placing its first pillars – there is a valid question as to whether it can provide much more than coordination of crisis-related actions and, if so, how much it will actually be able to deliver?

For one thing, none of the Commission's proposals indicates changes to the EU's treaties. But if public health stress tests make it clear that the Union is still not sufficiently resilient, will Member States decide that greater coordination and closer cooperation are worth putting the Commission in charge of more competencies? The debate on such a scenario has already started and there is no lack of voices that would like to see it realized, such as the Manifesto for a European Health Union.

Altogether, it remains to be seen whether the pandemic-induced health and economic disaster will change the EU's perception of the importance of health policy as a whole and convince Member States to place it higher on the EU's agenda.

We may not have to wait for the first answers until the pandemic is over. If the Conference on the Future of Europe were, finally, to convene in May this year, as suggested by the Council, the space allocated to discussing the future of EU health policy on its agenda would be the first gauge of whether the European Health Union will be able to live up to the high hopes pinned on it.

Piotr Kolcyński, *Legal Advisor*



EVENT RECAP: "DOCTORS GOING DIGITAL: HOW TO FUTURE-PROOF SKILLS"

On 20 November, CPME and the German Medical Association (BÄK) organised a joint conference to discuss digital knowledge and skills for future doctors. The event was part of the associated programme of Germany's Presidency of the Council of the EU. A video summary is available here. Summary video (10m).

The conference opened with a statement by Jens Spahn, Germany's Federal Minister of Health, on digital medicine and the challenges posed by the Covid-19 epidemic, followed by a keynote speech by Michael Servoz, former Senior Advisor for Robotics, AI and the Future of EU Labour Law at the EC on AI and the digital transformation in healthcare. A moderated panel discussion followed. The main highlights included:

Prof. Dr Sebastian Kuhn, Professor of Digital Medicine at the medical faculty of Bielefeld University and senior orthopaedic and trauma surgeon, stressed that doctors should rethink medicine using digital tools. In his opinion, educating current and future generations of doctors is key to ensuring that technological innovation leads to improvements in patient care and preventing harm.

Ms Lina Mosch, medical student and former Health Policy Director at EMSA (2018-2019), noted the huge gap in current medical students' education. Students wanted to become part of the digitalisation of healthcare and learn more about e-health, but there was a lack of digital education and practical training. She added that there was no need for a doctor who could programme an algorithm or code, or who was able to oversee all health laws. However, there was a need for a doctor to be able to assess the basics of digital technologies, oversee data science and understand the mechanisms of algorithms. A doctor also needs to communicate well, be empathetic to patients, while understanding patient needs. Moreover, a doctor needs to know who to ask for help and be able to communicate and work in multidisciplinary teams with data scientists, engineers, nurses. Mr Servoz added that the task of a doctor would not only be to control what an algorithm is doing, but also to be able to explain to the patient how the AI works and what the conclusions were, and to assume responsibility for

these diagnostic or medical conclusions.

Prof. Vilja Pietiäinen, senior scientist and team leader at the Institute for Molecular Medicine Finland, University of Helsinki, explained that the programme she coordinates at the University has the objective of getting students involved, giving the example of the innovation course where students organise the programme together with companies, bringing up models.

Prof. Dr Jörg Debatin, physician and Chairmanof
the Health Innovation Hub of the German Federal Ministry of Health, discussed governance, noting that first it was necessary to find a way to enable digital technologies to be part of patient care in a 'legally manageable and a safe way'. The role of governments is very important in providing the regulatory basis.

Ms Linda Keane, General Manager at the Irish Computer Society and Health Informatics Society of Ireland, recommended leaders adopt an incremental approach when it comes to digital skills initiatives - starting with small groups and building a momentum of their own. Developing motivation among colleagues and then broadening out to the workforce, bit by bit.

Prof. Dr Claudia Schmidtke, cardiologist and member of the German Bundestag and the Federal Government's Commissioner for Patients' Affairs, commented that patients generally view the digital transformation as something positive and the younger generation demanded such services. Concerning patient data, she first stressed that data belonged to patients. They alone ought to determine how it is used. Secondly, the use of digital services has to be voluntary. If patients decided against their use then this decision must not place them at a disadvantage. Thirdly, the best legal protection against misuse must be ensured. Data protection violations ought to be prosecuted and punished vigorously.

Dr Peter Bobbert, Member of the Executive Board of the BÄK, senior physician and specialist in internal medicine, concluded by noting that physicians needed to improve their own education and qualifications. It is important that physicians have the opportunity to gain experience with digital tools, developing an understanding of basic mechanisms and of the dangers of gathering and processing patients' data. Trust was the key message to hold on to at different levels, trust in technology, in innovation and in the patient-doctor relationship. Trust is the main condition for the successful development of digital medicine in the future.

For the full conference video see here.

Sara Roda, *EU Senior Policy Advisor*

DIGITAL TRAINING FOR DOCTORS: CPME ADOPTS KEY POLICY DOCUMENTS

The CPME has adopted a policy on digital competencies for doctors and Digital Doc Thematic Network Joint Statement on 'Training future-proof doctors for the digital society'

CPME policy on digital competencies for doctors

On 20 November, the CPME Board unanimously adopted a policy on digital competencies for doctors (please see here). The policy acknowledges that digital health technologies are changing the way in which health and care are delivered, reshaping medical practice and the patient-doctor relationship. It stresses that the digital health literacy (DHL) of healthcare professionals is a crucial component for the efficient and effective transformation of health care. The paper highlights that doctors should possess strong digital competencies framed and adapted to their medical specialty. Doctors should also be provided with new possibilities for interdisciplinary and interprofessional collaboration, such as engineering, computer science and law.

CPME divided digital competencies into three main areas: i) general, comprising competencies in data protection and IT safety, problem-solving with IT tools and software, legal and ethical considerations of health data and digital tools; ii) technical, encompassing data analytics, genomics and bioinformatics, 'augmented' intelligence and clinical decision support, mHealth, telemedicine, virtual and augmented reality, and robotics; and iii) patient-doctor relationship, which includes competencies in digital communication with patients, relatives and healthcare teams, digital collaboration and promoting digital literacy.

CPME insisted that digital solutions must be embedded in the doctor's care pathway, taking into account the actual workflow and time management in a doctor's practice. This is key to avoiding an increase in meaningless procedures that take time and resources away from the provision of healthcare. Doctors therefore need to be involved in the early stages of the development of digital solutions. They have to understand technologies' limitations, to form realistic expectations and reduce misconceptions about their role and usefulness. They need to ensure appropriate professional oversight over clinical validation, while remaining cautious of the overreliance on technology.

CPME called on Member States to take on financial responsibility for the digital health transformation, to promote investment in eHealth solutions that improve patient safety, quality of care and efficiency, and to invest in programmes that boost the digital health literacy skills of patients.

Digital Doc Thematic Network Joint Statement on 'Training future-proof doctors for the digital society'

On 6 January 2021, CPME endorsed the Digital Doc Thematic Network Joint Statement on 'Training future-proof doctors for the digital society'. The Joint Statement focused on actions needed to prepare current and future doctors to cope with and contribute to the digital transformation of healthcare by integrating digital competencies in the education and training curricula of medical doctors.

Among other things, the Statement stresses that a general belief in technology and its ability to solve problems should not come at the expense of evidence-based medicine and efficiency research. This implies that medical doctors will not only need to learn about new technologies, but also to critically assess them and make an active contribution to their development. The Statement also highlights the need to critically reassess the already packed medical curricula, suggesting replacing less relevant and outdated content with new content related to digital knowledge, skills and attitudes, including relevant laws and ethics.

Indeed, an overall reflection on the priorities for the medical curriculum is required, without losing sight of two main objectives - acquiring the necessary competences to prevent, treat and diagnose diseases and providing high quality healthcare for every patient. CPME contributed extensively to the Joint Statement with the support of Prof. Dr Sebastian Kuhn, CPME rapporteur on digital competencies. CPME is very grateful for Prof. Dr Kuhn's support.

Sara Roda, *EU Senior Policy Advisor*

LANCET COUNTDOWN: TRACKING THE HEALTH BENEFITS OF THE EU'S EFFORT TO MAKE THE CONTINENT GREENER

The Lancet Countdown, which brings together climate scientists, engineers, energy specialists, economists, political scientists, public health professionals and doctors from all over the world, has been tracking progress in relation to health and climate change since 2016.

The context is that European Union policy-makers have set goals and a trajectory towards achieving a greener continent, including: a plan to further cut emissions by at least 55% by 2030 and the aim, set out in the European Green Deal, of reaching zero emissions by 2050. These goals are underpinned by sector-specific policies such as the new 'Farm to Fork Strategy'.

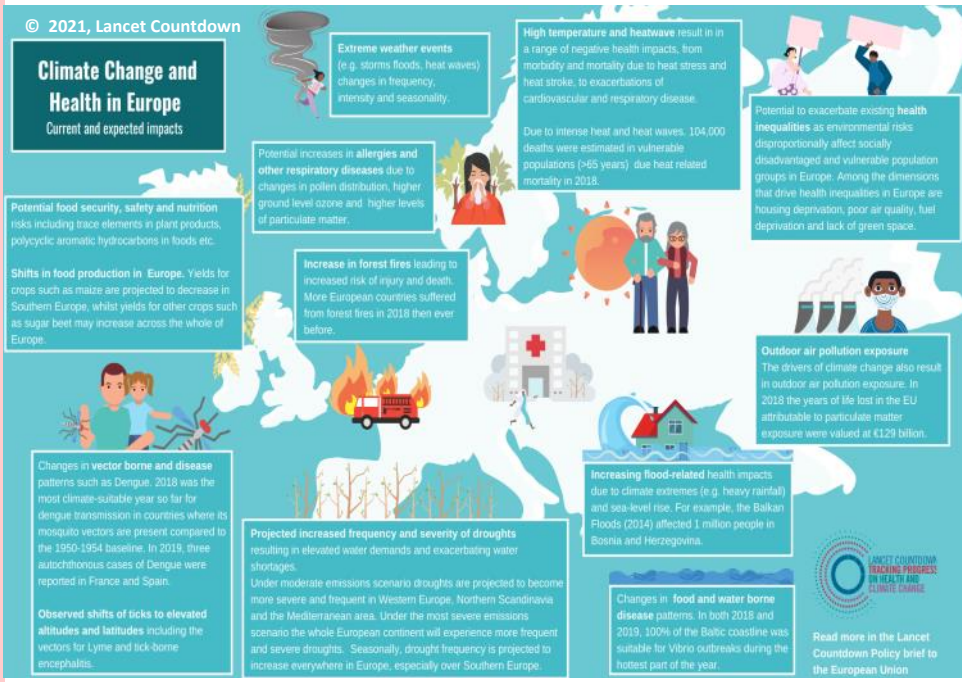
Lancet Countdown reports track these environment-friendly developments from a health perspective, which is of particular interest for European doctors. The 2020 Policy Brief for the EU, co-published by the CPME and the Lancet Countdown in December last year, focusses on infectious disease, city-level climate change and its health-related economic costs.

The 2020 brief recommends implementing policies and investments which preserve the climate, protect public health and promote economic sustainability. Moreover, on a macro level, it advises policy-makers to boost efforts to prevent, prepare for and control infectious disease by implementing holistic strategies that modernise surveillance, early warning systems, data collection, European coordination and health system resilience.

The policy brief also encourages policy-makers to undertake climate risk and vulnerability assessments for all major national urban centres to understand current and future climate hazards, the areas most at risk, and to determine the economic costs and benefits of interventions to inform city-level adaptation and mitigation planning.

At a more micro level, the Lancet Countdown brief looks at the state of play in European cities. Urban areas are already home to almost three quarters of the population of the EU and urbanisation is expected to increase to 80% or more by 2050. The policy brief therefore highlights the importance of boosting city-level climate change adapta-

tion and mitigation measures as well as the importance of boosting mental and physical health by increasing the amount of urban land dedicated to green spaces, facilitating 'active transport' (e.g. putting down bicycle lanes and setting up pedestrian areas) and improving air quality by reducing air pollution.



The CPME has also addressed these points in its own policy papers. Its 2019 policy on air quality and health calls on policy-makers to promote and prioritise measures that will foster clean air, including active mobility such as cycling and walking, as well as affordable public transport based on renewable energy. Moreover, it urges authorities to improve urban and residential planning and to increase the area devoted to green spaces in cities to ensure good air quality and to increase physical activity, particularly among children and lower socio-economic population groups. The 2020 CPME policy on physical activity also calls on policy-makers to continue promoting physical activity and investing in 'active mobility' solutions and in particular to develop safe and accessible infrastructure and environments that support and encourage engagement in physical activities.

As part of the Green Deal, the EU will be revising its air quality standards, specifically the Ambient Air Quality Directives, to align them more closely with the recommendations of the World Health Organisation (WHO). The revised WHO Air Quality Guidelines, anticipated for the first half of 2021, are expected to include updated guideline exposure levels for a number of air pollutants, especially for the most harmful fine particulate matter (PM2.5). The latest air quality report of the European Environment Agency (EEA) indicates that PM2.5 is still responsible for more than 400,000 annual premature deaths across the continent.

The CPME also encourages its members and other healthcare professionals to participate in the discussion on the impacts of climate change and raise awareness among their patients, for example about the risks of air pollution.

More background about the Lancet Countdown

The Lancet Countdown on Health and Climate Change is a multidisciplinary collaboration of over 120 experts from academic institutions and UN agencies across the globe.

It works to ensure that health is at the centre of how governments understand and respond to climate change. Our work ranges from ensuring policymakers have access to high-quality evidence-based guidance, through to providing the health profession with the tools they need to improve public health.

You can read the full report here.

Markus Kujawa, *EU Policy Adviser*

WHAT FUTURE FOR EU-UK MEDICAL MOBILITY?

Since 1 January, medical mobility across the EU-UK border has been recast. With the EU-UK Trade and Cooperation Agreement replacing the EU legislative framework, which continued to bind the UK beyond Brexit, doctors, students, and regulators must tackle new policy options and questions.

In the first instance, the EU-UK Trade and Cooperation Agreement (TCA) seems to tackle the question of recognition of professional qualifications by providing a framework for concluding mutual recognition agreements (MRAs) for individual professions. However, the mechanism foreseen does not allow for immediate application as it requires a feasibility check, the negotiation of new recognition rules, and the ratification of the same by a Partnership Council, which is yet to be formed. CPME, its UK member the British Medical Association, and other European Medical Organisations had highlighted these challenges during negotiations and called instead for clear rules to be set out in the TCA itself. Mutual recognition agreements have, however, become the European Commission's preferred tool, featuring, for example, in the EU-Canada free trade agreement, which entered into force in 2017 – tellingly none have been concluded so far.

For now, therefore, national rules will replace the tried and tested EU framework based on 'automatic recognition'. To mitigate the disruption to medical mobility, national authorities are seeking solutions that ensure safety and legal clarity. On the UK's side, the General Medical Council has announced that for a period of two years, qualifications from the European Economic Area and Switzerland held by nationals of those countries will continue to be recognised in a "timely and streamlined way" referencing existing procedures. At the same time, a 'Health and Care Worker' visa is intended to facilitate migration now that free movement rights no longer apply to the UK. Several EU Member States, for example Ireland, are looking at recognition procedures which similarly acknowledge that UK diplomas were considered equivalent to national qualifications until very recently. However, in the absence of an EU-level framework to address such questions, policies may vary between Member States. The situation of students graduating in the future also requires clarification.

This leaves questions as to if, how and when an EU-UK level solution can be found. The continued relevance of EU-UK mobility on both sides of the channel is clear: according to data published by the General Medical Council in October 2020, there has been a year-on-year increase in registrations of EEA-trained doctors in the UK since 2018. Therefore, CPME is currently considering the potential of a future MRA, but also the situation of doctors and students in the immediate aftermath of the TCA's conclusion. Further discussions on this topic will take place at the CPME meetings in March 2021.

Sarada Das, *Deputy Secretary General*

COVID-19 IN BELGIUM

Belgium has a population of 11.5 million and is divided into three regions: the Flemish Region (6.65 million inhabitants), the Walloon Region (3.65 million inhabitants) and the Brussels Capital Region (1.2 million inhabitants). Belgium also has three communities: the Flemish, French and German communities. Successive state reforms since the 1970s have led to a complicated state structure with one federal government and five regional governments, and an equal number of parliaments. In total, we have as many as 9 ministers who are responsible for public health in one way or another.

Predictably, this complex state structure was not conducive to efficiently dealing with a massive crisis such as the COVID-19 pandemic. BVAS/ABSyM, the country's largest physicians' syndicate, was committed from the beginning of the crisis to adjusting policy where necessary. Dr Philippe Devos, the young and charismatic chairman of BVAS/ABSyM, managed to establish himself as an important spokesman for the medical profession. His calculations, predictions, reservations and criticisms regularly made it into the Belgian and international press.

In the first months after the outbreak of the pandemic, the Belgian authorities were totally unprepared. There was no strategic plan and stocks of masks had been destroyed. Maggie De Block, the Federal Minister of Health and a GP herself, continued to dangerously play down the risks of COVID-19 and all governments were in denial. At a hearing in the Federal Parliament, Dr Devos said he was shocked by the amateurish policy in the first months of 2020.

Dr Devos was extremely critical in parliament of the confusing jumble of powers. Moreover, the many ministries, agencies and cabinets communicated separately and without mutual consultation, while even the virologists appointed as experts by the government regularly disagreed. This led to a confusing and often contradictory flow of information. Belgian doctors and their organizations had to learn about strategies for testing and tracing or about the declaration of new phases in the hospitals' emergency plan through the press.

The tragedy of Belgium is that it was continuously lagging behind events throughout the year of 2020. Ranging from testing and tracing, the Coronalert app to alert citizens, to the measures for returning travelers or the preparation of the vaccination campaign, the slow response time of the government was shocking.

BVAS/ABSyM, as the first point of contact for Belgian doctors during the COVID-19 crisis, was very concerned about their working conditions, well-being and income. We repeatedly insisted on the rapid delivery of FFP2 face masks and other protective equipment and even went so far as to organize block purchases for physicians ourselves. It is also to the credit of BVAS/ABSyM that we pushed for the proper payment of physicians in triage or testing centers, in residential care centers, hospitals and general practices. We also successfully negotiated support measures or replacement income and financial compensation for doctors who had to temporarily close their practices in order to engage in the fight against COVID-19 after retraining.

One achievement of which BVAS/ABSyM is very proud is breakthroughs in tele- and video consultations and their financing with appropriate fees. We have been at the forefront of facilitating this for Belgian physicians.

Bernard Maillet, *Head of the Belgian Delegation to CPME*

THE NORTH MACEDONIA CHAMBER OF DOCTORS ACTIVITIES AND THE COVID-19 PANDEMIC

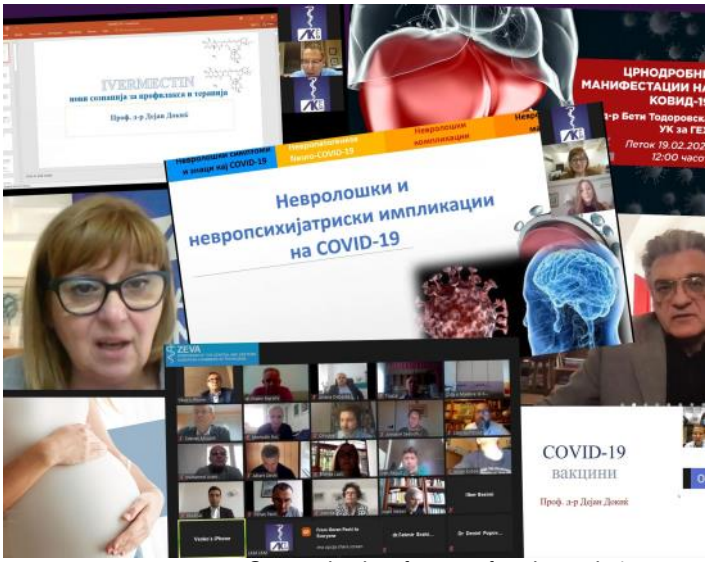
North Macedonia has a population of about 2 million and, until the middle of February, there had been 99,408 reported cases of Covid-19, of which 3,439 (4.8%) were among health care workers. A total of 3,076 Covid-19 deaths have been reported, of which 24 have been among health care workers.

The first case of Covid-19 was reported on 26 February 2020. We have spent a whole year fighting this unpredictable virus, and we are exhausted. Our health care system was not immune to the pressure of the pandemic, on the contrary, its lack of functionality in certain problematic segments has become more obvious. We have faced many challenges, but we will point out only the issues of highest priority, which we have coped with within our remit as a professional medical organization.

A shortage of PPE was the first problem encountered at the beginning of the pandemic. The state was obligated to provide stock for the hospitals, but the speed of delivery was very slow.

GPs were most severely affected since they, as private practitioners, were obligated to buy PPE with their own personal resources. Due to the need for prompt training of doctors in the proper, but also sparing, use of PPE, the Doctors' Chamber, in collaboration with IPH and WHO, organized and accredited training. In addition, all funds earmarked for non-essential activities of the Chamber were reassigned to buying PPE, which was donated to the two biggest Covid-19 hospitals.

Violence against doctors has become a more profound problem. Part of the population has been denying the existence of the virus, refusing testing and treating the illness as if it were a common cold. There have been many deaths due to late hospital admission, and increased incidents of health care workers threatened and physically assaulted by family members who blamed them for the death of their loved ones. The Chamber took the initiative, demanding that institutions start coordinating for establishing and enforcing proper legal regulations and sanctions for these violations. Doctors still constantly feel unsafe in their workplaces since authorities have so far made no substantial effort to protect us. The problem of workforce shortages surfaced during the peak of the second wave, when doctors from various specialties were transferred to work in Covid-19 units. Due to the lack of official treatment algorithms, there was a great need for interim consensus. In order to help doctors coordinate, especially GPs and first-line specialists, we started organizing online Zoom meetings with the main goal to discuss various aspects of Covid-19 and establish best Covid-19 treatment choices. Since November, these ses-



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sions have been held on a regular basis every Friday, with capacity for 500 participants and so far many aspects of Covid-19 have been covered.

In September 2020, the Doctors Chamber of RNM hosted the 27th Zeva Symposium. Due to the restricted mobility, we hosted the event online focusing on "Managing Covid-19". Participants presented and discussed their experiences on the matter, and concluded that all ZEVA countries face the same challenges and that medical professional organizations must be more persistent in insisting on being included in decision making processes regarding Covid-19 in their own countries. Another successful activity for us last year was, of course, becoming a CPME observer member, for which we worked hard, and it is a great honour.

Currently, our country faces uncertainty over whether and when we will get a larger supply of Covid-19 vaccines. The quantity received so far is reserved for first-line health care workers only and is far from sufficient. On the other hand, resistance to vaccination is evident, not just among the general population, but among health care workers as well. The doctors', dental and pharmaceutical chambers already signed a Collaboration Memorandum last year - as soon as vaccines are delivered we plan to launch a vaccination campaign to raise awareness of the need for immunization among both health care workers and the general population.

Dr Kalina Grivcheva Stardelova, *President of Doctor's Chamber of North Macedonia*

THE TURKISH MEDICAL ASSOCIATION DURING THE PANDEMIC

Türk Tabipleri Birliği
Turkish Medical Association

Around 1.2 million health professionals work in Turkey according to Ministry of Health data. Of these, 165 363 are physicians and only two thirds of them are members of the Turkish Medical Association (TMA). The TMA has local chambers in 65 provinces, which enables the organization to closely follow injustices and the needs of physicians nationwide.

The history of the TMA starts with the early years of the Republic, although its organizational background is much older. Forerunners included the Turkish Medical Society, the first professional body for physicians founded under Ottoman rule in 1856, 29 years after the establishment of a modernized medical school. Physicians who opposed autocratic rule were exiled and many of them later joined the ranks of Young Turks and were influential in the declaration of a constitutional monarchy in 1908[1].

Chambers of Medical Professionals, the first local organizations of physicians, were launched in 1929, spreading across Anatolia with no centralised management. Their founder, Tevfik Salim Sağlam, had served as health minister[2].The TMA had to strenuously defend its rights and preserve them in the constitution as a centralised organization, initially in 1953. Founding director Ahmet Rasim Onat authored the first study on the socioeconomic conditions of Turkish doctors. The TMA then set a minimum wage for medical professionals. Turkey's ruling junta banned the TMA's activities and prosecuted members of its central committee after the military coup in 1980. It also amended TMA's legal basis to omit compulsory membership for physicians who serve as civil servants, henceforth weakening the organizational capacity with only physicians who have private practice being compulsory members[3]. Nonetheless, the TMA still has the capacity to represent a majority of physicians.

This short history is needed to understand the position of the TMA during the pandemic. A COVID-19 monitoring committee was promptly established at the beginning of the pandemic and worked under the umbrella of the TMA to spread accurate information to the public.

A lack of transparency on behalf of the government and TMA's efforts to reveal the true situation of the pandemic caused a loss of trust among the population. This tense relationship with the TMA resulted in a threatening approach, with the government's coalition partner asking prosecutors to shut down the TMA, the largest professional body of physicians in the country, on 18 September 2020.

While health professionals in Turkey have had to struggle on two fronts; against the rising number of COVID-19 cases on the one hand, and against government harassment on the other, more than 380 health professionals have lost their lives to COVID-19[4].

The TMA has always been critical in its assessments of the Turkish Governments' health policy and, recently, with its management of the pandemic, which has killed 28,569 people as of 28 February according to data released by the Ministry of Health[5] - while the data collected through municipalities revealing excess deaths increase this figure two-fold[6].

The TMA launched a campaign on 14 September entitled "You can't manage, we are burning out", asking supporters to wear black ribbons to commemorate health workers lost to the virus and demand reduced working hours. In response, politicians from the ruling coalition accused the TMA of being "as dangerous as the coronavirus".

On 30 September, Turkey's Health Minister said that, since 29 July, COVID-19 figures published daily by his office had referred to patients who had COVID-19 symptoms, but had excluded asymptomatic cases, who made up a majority. This met with strong criticism from the public as well as the health professionals' community.

Though the Ministry had been announcing its data on a turquoise-coloured panel each evening, the numbers have lost their relevance. The Health Ministry's scientifically contradictory statements and lack of transparency have resulted in the pandemic being less manageable.

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Dr Sebnem Korur Fincanci, *President of the Turkish Medical Association*

GUEST ARTICLE

THE EU'S STRATEGY FOR SAFE AND EFFECTIVE COVID-19 VACCINES

I wish to begin by thanking our health professionals for their efforts, commitment and their resolve during this difficult year. On our side, the European Commission has invested heavily in vaccine development and access whilst supporting Member States on their road to deployment.

Efforts have also gone into diagnosis, treatment and raising awareness of other preventive measures, such as physical distancing or wearing masks, to reduce the number of cases. Better and faster diagnostic methods such as rapid antigen tests also allow us to intervene sooner and to trace contacts. From the outset, though, it was clear that a safe and effective vaccine against COVID-19 would be the most important part of a sustainable solution.

Facing an urgent need and given adequate financial support from the EU budget to cover upfront costs, pharmaceutical companies and research institutes have been able to respond quickly. No corners have been cut in terms of safety; we have simply moved swiftly, together.

To accelerate the development, manufacturing, and deployment of vaccines against COVID-19, we adopted an EU Vaccine Strategy. We secured production capacity, purchased raw materials at the same time as clinical trials using innovative technologies to cut the timeframe to less than 12 months.

The Commission also negotiated intensively on behalf of Member States with leading pharmaceutical companies and signed agreements with AstraZeneca, Sanofi-GSK, Johnson & Johnson, Pfizer/BioNTech, CureVac and Moderna, which will give Member States access to almost 2 billion doses of potential vaccines,. We have also concluded exploratory talks with Novavax and we are still discussing with other vaccine producers.

We have a broad vaccine portfolio based on several platforms: Moderna, CureVac and Pfizer/BioNTech have developed novel types of vaccines based on messenger RNA (mRNA), while Sanofi/GSK is based on a recombinant protein and others such as Johnson & Johnson or AstraZeneca use methods that have proved effective in the past in overcoming the Zika and Ebola viruses.

The European Medicines Agency (EMA) conducted rolling reviews of data from trials to gain as much time as possible, while fully respecting the EU's high standards in this area. Our patience has now paid off: the European Commission recently granted conditional marketing authorisation for the COVID□19 vaccine developed by BioNTech and Pfizer and to the Moderna vaccine.

Now, Europe needs to gear up for vaccination and we are working with Member States to ensure that everyone is ready to rollout vaccines. To prepare Member States for their vaccination strategies, the Commission published Communications on 15 October and 2 December that lay out the key elements needed for the successful roll out of the vaccine. These include vaccination capacity services to deliver COVID-19 vaccines, easy access to vaccines for target populations such older groups and medical professionals and the deployment of vaccines with different properties, as well as storage and transport needs. Clear communication is also emphasised to build public trust. On their part, the European Centre for Disease Prevention and Control (ECDC) have also laid out their guidelines on the prioritisation of COVID-19 vaccination in order to aid the efforts of Member States when considering their objective, the characteristics of the vaccine and priority groups.

This is why robust and transparent vaccination plans are also needed. Citizens need to understand which priority groups are identified and why. As trusted doctors, you will also play a pivotal role in ensuring public confidence in COVID-19 vaccines. I am confident that through your lead, the power of science will demonstrate the life-saving nature of vaccination and lead to sufficient uptake across our Union.

Sandra Gallina, *Director General for Health and Food Safety*

GUEST ARTICLE

VACCINATE TO PROTECT

In February, the Coalition for Vaccination, convened by the European Commission and co-chaired by CPME, launched a manifesto calling on healthcare professionals to get vaccinated against COVID-19. The Coalition brings together European associations of healthcare professionals and relevant students' associations in the field.

The manifesto underlines three key reasons why all healthcare professionals should get vaccinated against COVID-19 when they have the opportunity to do so and why they should help promote the vaccination against COVID-19 among the general public. Their health is paramount for the functioning of the health systems, even more so in times of crisis.

1. You protect yourself from illness and possible severe or life-threatening complications

As a healthcare professional, you are at greater risk of contracting COVID-19 as you have more exposure to it. Vaccination is your best option to prevent you and your colleagues from contracting the illness and possible severe or life-threatening complications. Moreover, you, for many people, are the main trusted source of advice and information on COVID-19 vaccination.

It is our professional responsibility to protect those we are caring for by encouraging them to get vaccinated. Many of your patients and family members may have underlying health conditions that put them at risk of suffering from a severe form of COVID-19 if they contract it.

2. COVID-19 vaccines are safe and effective

The safety and effectiveness of all authorised vaccines have been studied thoroughly in large, controlled and randomised clinical trials before their approval. These scientific evaluations show that the benefits of the authorised vaccines are, in terms of protecting people against diseases, much greater than any potential risks. Moreover, the safety aspects of COVID-19 vaccines are closely monitored through the EU Pharmacovigilance System and any safety concerns will be promptly known to the public, and dealt with.

The European Medicines Agency (EMA) and the International Coalition of Medicines Regulatory Authorities (ICMRA) statement for healthcare professionals provide more information on the development, evaluation, approval and monitoring of the COVID-19 vaccines and how they are regulated for safety and effectiveness.

3. You help safeguard healthcare capacity

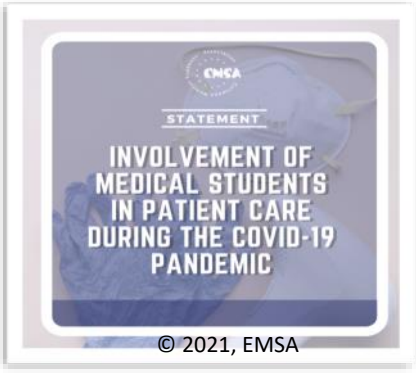
Healthcare services have been under enormous strain for a very long time and the coronavirus has already taken a very high toll on healthcare staff. The COVID-19 vaccine can help alleviate that pressure by ensuring that you and your colleagues have greater immunity, are less likely to catch the virus and are therefore will be able to continue providing key services to your patients.

We call on you to accept a COVID-19 vaccination when it is offered to you and encourage your patients to do the same

GUEST ARTICLE

STATEMENT ON THE INVOLVEMENT OF MEDICAL STUDENTS IN PATIENT CARE DURING THE COVID-19 PANDEMIC

Brussels, 8th March 2021



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The ongoing pandemic is devastating us all. As medical students and future medical professionals, we are more than willing to help in the struggles our respective healthcare systems are facing and want to do so to the best of our abilities. While we see it as our duty as prospective doctors to support our future colleagues where we can in the ongoing pandemic, certain aspects have to be kept in mind. Various distressing reports have reached us, as the European Medical Students' Association, regarding the situation of medical students working in healthcare settings in the fight against the ongoing COVID-19 pandemic. These reports from students across Europe, as well as results from a survey conducted amongst our members working in healthcare, are very worrying to us as an organisation.

We believe that healthcare students and professionals have to work hand in hand to be better able to tackle the various difficulties faced and provide the best patient care possible. Mutual respect of all parties is essential and translates to qualitatively good patient care and better work environments, which are crucial in such straining times.

We are thus calling on all hospitals and university clinics to re-evaluate the treatment of medical students in patient care during the ongoing pandemic to guarantee appropriate safety of staff, medical students and patients alike, vaccination of students exposed to the risk of getting infected with COVID-19, the ethically appropriate treatment of those involved in patient care, as well as respect for the work they do.

Safety concerns regarding medical students working in hospitals

We believe the safety of any healthcare professional to be a vital part of the global fight against the pandemic. This effort has to include medical students working in COVID-19 patient care - whether directly in COVID-19 Intensive Care Units or on general COVID-19 wards, in emergency rooms or in other areas of patient care. There is a fundamental need for all students to be supplied with Personal Protective Equipment (PPE), as suggested by the European Centre for Disease Prevention and Control (ECDC)[1], including FFP2/3 masks, gloves, waterproof and long-sleeved protective coveralls and eyewear/face shields, during their work with potential contact to SARS-CoV-2 positive patients. While it is good to see that some hospitals are already adhering to this definition of PPE and supplying students working there with this equipment, the more considerable number of hospitals providing students with incomplete PPE is all the more worrying. According to our questionnaire amongst our members, the majority of hospitals supply medical students with only face masks for the treatment of COVID-19 patients. All students within a hospital or medical facility, no matter if employed there or still attending classes, have to be supplied with complete PPE when in contact with COVID-19 positive patients or in departments with patients with questionable COVID-19 status (e.g. emergency rooms), without question.

With mutations currently spreading widely with less well-known means of transmission and frequency of infection, FFP2 or 3 masks, having proven to be more effective in limiting transmission as compared to cloth or surgical masks, should be supplied to students in all hospital areas, as is the case in a small number of hospitals already. Enough masks need to be provided so that no student or employee should have to wear the same FFP mask for more than 8 hours at a time or re-use them. The official protective range for these masks being defined by the manufacturers as 8h[2] and there no longer being a shortage of supplies, we believe this to be elementary.

It has furthermore been brought to our attention that students working in hospitals with duties such as drawing blood etc. are being told that they are not required to be in direct patient contact, therefore are not counted as personnel which should be equipped for patient contact. It needs to be underlined that any student working in that capacity is in direct patient contact and thus at risk of being infected or transmitting the infection to others. Such statements are not only incorrect but also disrespectful to medical students working in patient care during the pandemic.

Additionally, students should be provided with introductions to internal hygiene protocols and the proper usage of PPE at the beginning of each placement, to avoid misuse and to ensure efficacy of the materials provided in limiting the spread of the disease.

Furthermore, we want to underline that students recruited for COVID-19 testing need to be properly instructed in how to conduct nasopharyngeal testing, as the technique in fact differs from other cheek swabs students may be familiar with. Testing done by someone unfamiliar with the procedure of nasopharyngeal swabs may result in false negative test results and thus not aid in limiting the transmission of the virus.

Vaccinations of healthcare professionals

Vaccine rollout having begun across Europe and national vaccination schemes being developed, the question quickly arose of when healthcare personnel and healthcare students would be vaccinated. While the vaccination of healthcare personnel was swiftly approached, students working in hospitals have been told that they would not be included in the hospitals' vaccination efforts at the same time as other personnel on the respective wards, as they are not counted as essential workers or official employees. However, we believe that students should be seen as what they are, which is essential, as most wards rely on their work.

Even before the pandemic, although not intended, students were often asked to take on certain duties due more to understaffing than for educational purposes. This has not changed during the pandemic, with healthcare personnel and future healthcare professionals, such as medical students, working together in the fight against COVID-19. Students should be treated with respect and be accredited for the work they do. Inclusion in vaccination schemes is a vital point in this effort.

Furthermore, with students working in close contact with patients, they have the same risk of infection and of becoming a vector for transmission of the disease as healthcare professionals. They should thus be protected in the same way to also protect other patients they come in contact with.

Ethical treatment of medical students

It cannot be disregarded that some students may have reasons for not being able to be included in COVID-19 patient care. Students should be given a choice within their mandatory internships and clinical rotations whether they are open to being included in COVID-19 patient care or not, including tasks such as drawing blood from COVID-19 positive patients, which, despite the potentially short time required, results nonetheless in exposure. According to our survey, this option is not always given.

As indicated by our survey and based on the ethical aspect that accompanies their future profession, most students are offering to be involved in COVID-19 patient care. However, some medical students are in irrevocable contact with at risk people outside of the work environment, from whom isolation is simply not possible. Others may themselves be at risk with severe lung diseases, immunodeficiencies, as cancer survivors or belonging to other groups categorized as at risk by, for example, the ECDC[3].

Additionally, we believe that medical students agreeing to work voluntarily in patient care during this pandemic should be compensated. Students are often dependent on part-time employment, which they will not be able to continue due to the risk of spreading COVID-19 that accompanies working or being in contact with COVID-19 patients. These students may not always qualify for government funding.

We were also made aware of the unethical treatment of medical students and indirect and direct threats being made. We deem it ethically irresponsible, if there are no students volunteering to work on COVID-19 wards, to put pressure on students to decide among themselves who to send into a COVID-19 ward, by setting a minimum num-

ber of people who have to go. This kind of social pressure is devastating for every human relationship and we highly denounce these methods.

Students should in no way be directly or indirectly threatened in case of refusal to work on COVID-19 wards or conduct COVID-19 testing. This includes threats of consequences in the classes of lower year medical students and threats of refusal to sign attendance sheets, to name a few scenarios which were brought to our attention.

Students should not be negatively impacted in their medical education if they choose to not be included in COVID-19 patient care. Additionally, students should not have to suffer consequences of an internship-related quarantine on seminars with compulsory attendance or on scheduled exams. In these cases, it is paramount that solutions for students to continue their studies without quarantine related delays have to be found, as these delays are not based on faults on the students' part.

Working areas of medical students

In addition to safety, vaccinations and ethical concerns, the areas students are working in have to be included. The original purpose of medical internships always was and shall continue to be the education of prospective doctors. While we do realize that this cannot be ensured during a pandemic to the same extent as before, particularly medical students in their final years of studies (e.g. fifth or sixth year medical students) could be an asset for nurses and doctors in patient care. Using students as security staff for temperature measurements at hospital and ward entrances without employing them for that specific purpose not only completely disregards any potential educational purpose, but also prevents them from being able to support the medical staff.

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Alexandra Archodoulakis, *EMSA Vice President of External Affairs 2020/2021*

Oğul Kaplan, *EMSA Secretary General 2020/2021*

GUEST ARTICLE

TOWARDS A EUROPEAN HEALTH UNION

The ongoing COVID-19 crisis in Europe tells a story of collective complacency and the dangers of isolation. Europe´s first instinct was to downplay the threat and delay action, then retreat to its national borders, an every-country-for-itself mentality. The impact has been devastating, resulting in catastrophic loss of life and livelihood, and precipitating an economic crisis as well as an existential crisis about the purpose of the European project.

As we continue to tackle the pandemic and begin charting a recovery course we can, and must, do better – and not only during a pandemic. We believe this crisis calls for "more Europe" - a greater role for the European Union (EU) in health, a renewed concentration on our shared core values, and the commitment to create a legal basis that can empower the EU to protect and secure health across the continent.

Among expert observers and practitioners of EU health policy and law, the pandemic has spurred discussions about what was lacking in the EU response to COVID-19, and which prerequisites are needed to facilitate a strong and united response in the future. These conversations have given additional momentum to the creation of a bottom-up campaign for a European Health Union (EHU), which supports the vision of a EHU presented by the European Commission to strengthen solidarity, jointly address cross-border threats, and provide security for EU citizens. Yet, the EHU Initiative goes further than these goals and looks beyond COVID-19 by addressing longer-term and more comprehensive issues.

The immediate goal of the Initiative is to open the floor to genuine discussion and advocacy efforts around how a greater level of EU engagement in matters of health will become a reality that is both acceptable to individual Member States and meets the requirements of EU policymakers to effectively shape health policy across the region. Through exchange and debates we hope increased knowledge and new actions will finally lead to the creation of a EHU through a revised Treaty on the Functioning of the European Union, incorporating the EHU in Articles 2 and 3 to give the EU explicit competence to take action on health policy. This vision of a EHU seeks to:

- Strive for the health and wellbeing of all Europeans, with no one left behind;
- Strengthen solidarity within and between Member States, based on the principle of progressive universalism, providing support, including universal health coverage for all, but with particular attention to the needs of those who are disadvantaged;
- Ensure environmental sustainability by adopting the European Green Deal and prioritising measures to promote One Health, the concept that links our health with that of the animals and plants with which we share this planet;
- Provide security for all Europeans, protecting them from the major threats to health and from the vulnerability that is created by living a precarious existence;
- Enable everyone's voice to be heard, so that policies that affect their health are created with them and not for them.

As first steps towards realising these goals, a call for signatures for the European Health Union Manifesto has been launched and national and European Members of Parliament have been addressed to push for political discussion of a EHU in the European Council meetings on 25 - 26 March. In addition, a series of webinars and podcasts entitled 'Towards a European Health Union' are scheduled to take place at regular intervals throughout this year. To keep informed of upcoming activities please follow the EHU Initiative Twitter account and to sign the Manifesto please visit the EHU Initiative website.

We hope you are inspired to support us in building a European Health Union!

Written by European Health Forum Gastein as facilitators of the European Health Union Initiative.

GUEST ARTICLE

ARTIFICIAL INTELLIGENCE AND ENHANCED SHARING OF PERSONAL DATA IN HEALTHCARE: THE MOON HAS AN OBSCURE SIDE

Technology is neither bad nor good in itself, but serves humans' ends and purposes. As much as for those ends and purposes, the use of technology raises ethical considerations and dilemmas with respect to its societal impact and the level of acceptable intrusion into the rights and freedoms of individuals. This is particularly true when it comes to the use of Artificial Intelligence (AI) or the development of data sharing technologies in healthcare.

If there is one sector in which the societal benefits of AI are all the more evident it is healthcare. A recent example of the influence of AI in the field of health is a new diagnosis application that is able to detect Covid-19 infections by differentiating between the sounds of coughs with a 70% accuracy rate[1].

Despite the benefits, there is a potential for specific applications to lead to serious, or at least questionable, repercussions: for instance, self-experimentation in medicine, the reading of brain signals or the external control of neural processes. Or, more on the manifest malicious side of using very sensitive personal data, scamming and the malicious use of health data, bioterrorism and evil biohacking, that is the manipulation of the human genome and the introduction of malicious changes into the genetic heritage[2].

There should be no large-scale deployment of AI before it can be shown that the technology has reached a certain level of maturity, and before inter alia a rigorous, holistic impact assessment has taken place[3].

Enhanced data sharing in healthcare can also benefit society. The creation of a European Health Data Space (EHDS) has been set as a high-priority on the political agenda at EU level[4] with a view to boosting the quality of healthcare and supporting scientific research. In this respect, we need a strong data governance mechanism that provides for sufficient assurances of a lawful, responsible, ethical management anchored in EU values, including respect for fundamental rights. This would serve the advancement of society without overlooking fundamental rights, which are essential attributes of the person[5].

Our experience in dealing with the pandemic has clearly indicated the necessity to explore and exploit technological solutions to serve a good cause - to save human lives. But technological evolution in environments so crucial for the individual, such as healthcare, should stay true to the essence and values of the EU legal framework and be ingrained in the ethical values which underpin our societies in order to build public understanding and trust. This consideration should guide and be reflected in the broader societal approach towards any innovative advancement further pushing the technological frontier.

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EDPS
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NB: this article was submitted on 8 December 2020 and therefore covers the state of play with regard to policies up to but not after that date.

Wojciech Wiewiórowski, *European Data Protection Supervisor*

GUEST ARTICLE

MUSCULOSKELETAL DISORDERS IN THE HEALTHCARE SECTOR

This article is based on a Discussion Paper[1] of the same title recently published by EU-OSHA, which reviews the existing literature on MSD risk factors and effective interventions in healthcare workplaces. In this paper it is shown how physical and psychosocial risk factors for MSDs are prevalent in the healthcare sector.

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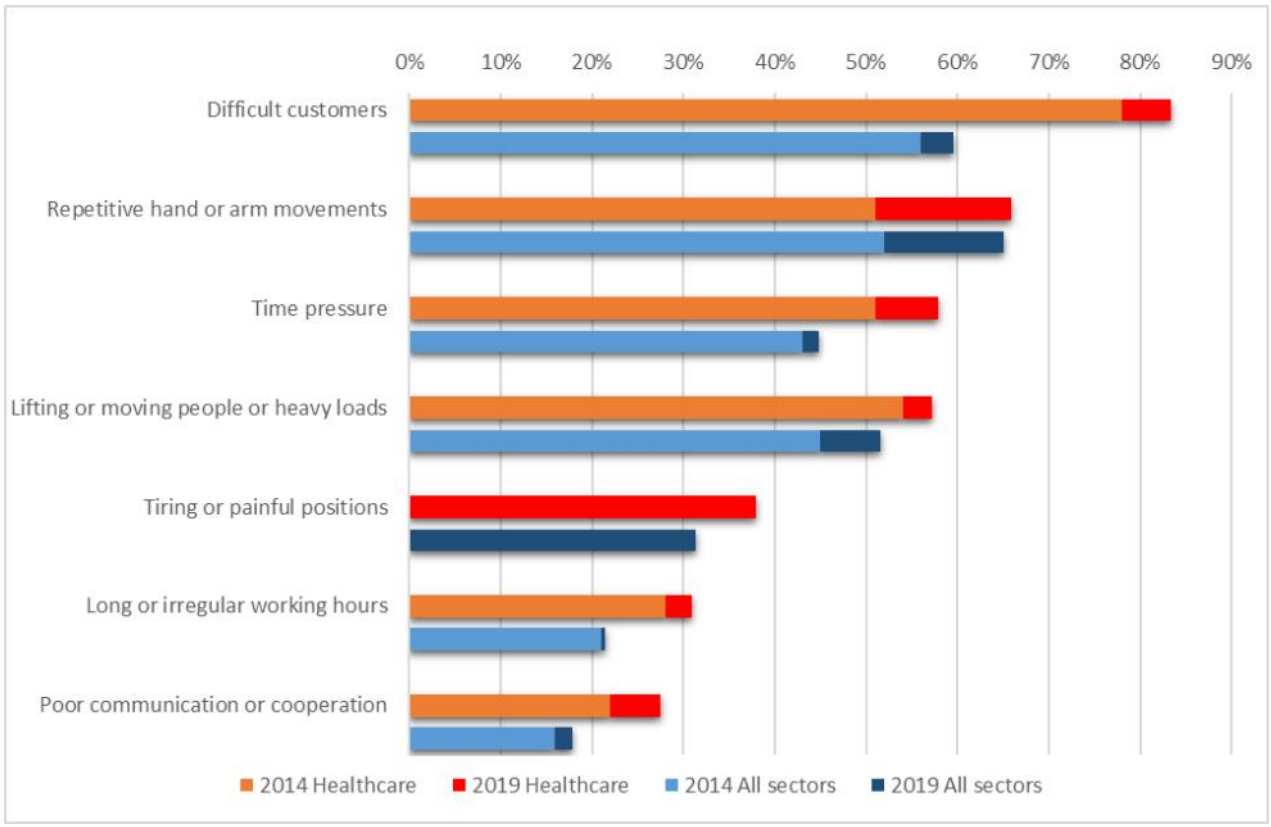
According to the European Survey of Enterprises on New and Emerging Risks (ESENER)[2], risk factors are reported more frequently in the healthcare sector ('Human health and social work activities') than in other sectors as a whole, and the majority of risk factors increased in the healthcare sector from 2014 to 2019 (Figure 1). Lifting or moving people or heavy loads, repetitive hand or arm movements and tiring or painful positions are physical risk factors for MSDs among healthcare workers. Furthermore, psychosocial risk factors — which indirectly influence MSDs — are also reported more frequently in the healthcare sector than in other sectors, in particular in terms of demanding customers, time pressure, long or irregular working hours and poor communication or cooperation.

Figure 1. Risk factors for MSDs present in the healthcare sector ('Human health and social work activities') in 2014 and 2019 compared with all sectors in the EU-27

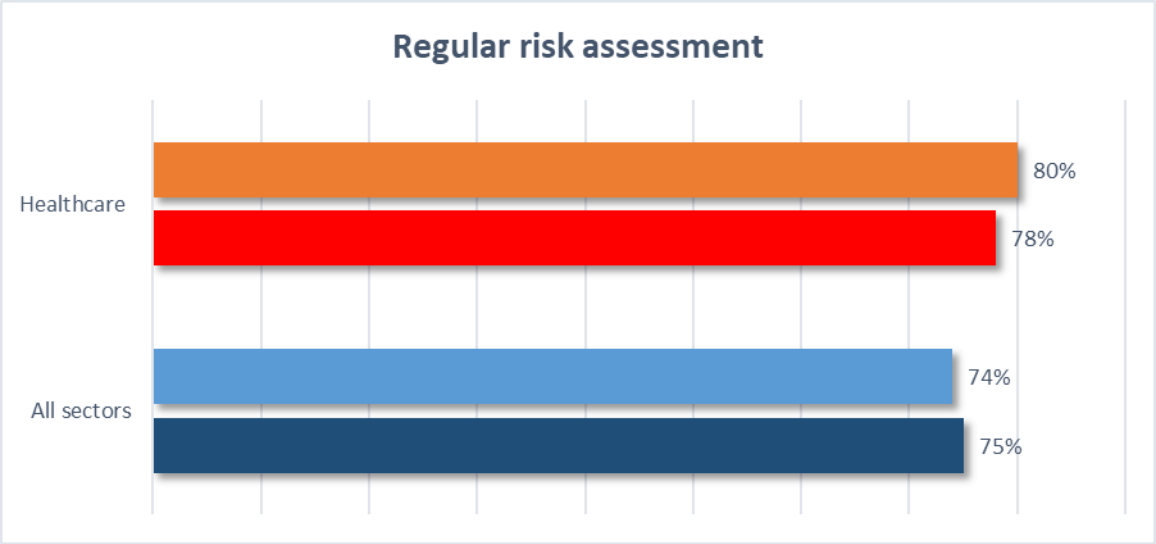


Base: all establishments in the EU-27, ESENER-2 (2014) and ESENER-3 (2019)

Note: 'Tiring or painful positions' was measured differently in 2014 and is therefore included only for 2019.

Although more than three out of four establishments in the healthcare sector of the EU-27 perform regular risk assessments, many experience problems in addressing safety and health. A lack of time and staff is a significant barrier that increased from 29% to 41% between 2014 and 2019. This development highlights the growing pressure in the healthcare sector. The provision of adequate resources is necessary to ensure the safety and health of workers in the sector now and in the future.

Figure 2. Percentage of establishments in the EU-27 that carried out a regular risk assessment in the healthcare sector ('Human health and social work activities') in 2014 (orange) and 2019 (red) compared with all sectors in 2014 (blue) and 2019 (dark blue)



Base: all establishments in the EU-27, ESENER-2 (2014) and ESENER-3 (2019).

Musculoskeletal disorders remain a major challenge in the healthcare sector. Looking into the future, the healthcare sector of the EU is likely to face a triple challenge of an increased care burden, recruitment challenges and an ageing workforce. However, an orchestrated effort focusing on preventing, reducing and managing MSDs may tip the scale in favour of more healthy workplaces, inducing a positive cycle of higher recruitment into the sector and better retainment of the existing workforce.

Last October the EU-OSHA launched the Healthy Workplaces Campaign 2020-2022 'Lighten the load' focusing on the prevention of work-related musculoskeletal disorders. EU-OSHA is very pleased to have the Standing Committee of European Doctors on board as an official campaign partner, as it considers the involvement of the healthcare sector key for the success of the campaign. More information about the campaign is available at: https://healthy-workplaces.eu/

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Stay in contact with CPME!

Rue Guimard 15

B-1040 Brussels, Belgium

Tel: +32 2732 72 02

Fax: +32 2 732 73 44

Mail: secretariat@cpme.eu

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STANDING COMMITTEE OF EUROPEAN DOCTORS

Guest commentary

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

Miriam D'Ambrosio