



OGÓLNOPOLSKI
ZWIĄZEK ZAWODOWY
LEKARZY



Fédération Européenne
des Médecins Salariés
European Federation
of Salaried Doctors

FEMS General Assembly

6th Joint Meeting AEMH – FEMS

Venue: The Bridge Wrocław, Plac Katedralny 8, 50-329 Wrocław, Poland

Meeting Room: Concretum

MINUTES

FRIDAY 8 May, 9:00 – 17:00

9:00 – 13:00 Joint General Assembly AEMH – FEMS; Chair Alessandra Spedicato, FEMS President
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1. Welcome addresses:

- **Alessandra Spedicato (FEMS president)**
- **João de Deus (AEMH president)**

Alessandra Spedicato welcomed participants to the sixth joint AEMH–FEMS meetings, thanked the Polish delegation and local organizers, and emphasized the value of exchanging views and collaborating across European medical organizations to identify shared strategies and projects over the next two days.

João de Deus welcomed delegates and representatives from CPME, CEOM, UEMS and UEMO, thanked Polish colleagues for organizing the meeting, noted availability of translation for multiple languages (speaking allowed in English, French, Spanish, Italian and German; listening only in English), and invited the keynote speaker.

2. Keynote speeches

- **Łukasz Jankowski, President of the Polish Chamber of Physicians and Dentists**

Dr Jankowski welcomed the delegates and expressed appreciation for a productive and constructive meeting.

He further identified three major problems affecting salaried physicians in Polish hospitals: a. Staff shortages: Progressive shortages of doctors and nurses, particularly in public hospitals. Hospital work less attractive for young doctors due to heavy workloads, night and holiday duties, and high liability claim exposure. Resulting vicious cycle: shortages increase workload and further discourage recruits. b. Aggression against doctors: Increase in physical violence and aggression in hospitals; cited the recent

death of a young doctor in a Krakow clinic. Causes include organizational failures, long waiting lists, and blame shifting to physicians. c. Hospital debt: County hospitals in particular are heavily indebted; procedures undervalued and underfunded by the National Health Fund; recent stop to paying for over-performances has worsened the situation, forcing cost-cutting that degrades working conditions.

Dr Jankowski concluded by pointing out that urgent action required to avoid collapse of hospital system was needed and he expressed appreciation that these topics are on the meeting agenda.

Alessandra and João noted these are shared problems across Europe and said discussions during the meeting will address quality of life, attractiveness of hospital practice, and potential solutions.

3. AEMH projects and updates:

a. The European Academy of Clinical Leadership (Pierre Maldague/João de Deus)

- EACL relaunch and objectives: certification and assessment at European level, educational support, and promotion of certified clinicians.
- Three-level framework: Fellowship (experienced clinicians), Master (postgraduate leadership training), Junior level (early-career leadership competence).
- Fellowship details: assessment based on curriculum (including ~200 hours training over 10 years preferred), educational capacity, leadership skills, and a capstone project (management of a medical department/service/clinic). Current status: 17 fellows mentioned earlier; corrected in discussion to nearly 70–80 candidates from ~11 countries.
- Master program: in development; postgraduate program of six modules, ~200 hours (online and on-site), recognition of prior learning up to 30%, certification via capstone and oral assessment. Target to complete/gather next developments by spring 2027.
- Junior pathway: voluntary recognition aligned with UEMS postgraduate certification; collaboration with EJD noted.
- Administrative/financial proposal: create a European pool of clinicians with leadership skills; fee structure example provided for the fellowship — €600 candidate fee to be split 1/3 AEMH, 1/3 EACL, 1/3 National Medical Associations. Benefits for national associations include revenue share and potential to host in-country assessments (jury travel) to reduce candidate travel.

Discussion highlights:

- Support for stronger recognition, wider scale participation, and university partnerships to increase formal recognition and value of the certification (Rudolf, Pierre).
- Existing and prospective university collaborations (Germany, Romania) noted; need for more jury members and external experts.

Decisions/actions:

- Continue development of master program with university partners; involve national associations where possible.
- Pierre informed on the next EACL assessment session (Paris, 26 November 2026, ahead of the AEMH general assembly).

b. Strategic Management of Hospital Crises (Clarisse Joachim)

- Rationale: Hospitals face increasing crisis scenarios — public health emergencies, cyber-attacks, natural disasters, supply and energy disruptions, strikes, and conflict-related challenges — requiring dedicated crisis-management competencies and simulation training.
- Workshops: interactive simulation-based workshops designed to immerse participants in realistic scenarios and test coordination and decision-making. Examples: a. Natural disaster scenario requiring partial hospital evacuation and resource coordination. b. Cyber-attack scenario causing loss of IT systems and medical information; tested coordination without electronic systems, highlighting reliance on paper processes and human adaptability. c. Explosion/mass casualty scenario: complex multi-source emergency response, surge flows and uncertainty about causation.
- Outcomes: Participants motivated; workshops improve crisis response skills, coordination, communication, and cross-border cooperation. Suggested expansion to more scenarios, including attacks on hospitals and contexts of war for some European countries. Decisions/actions:
- Continue and expand crisis-simulation workshops; involve European-level structures to harmonize coordination approaches.

4. FEMS projects and updates:

- *Update on FEMS activities*
- *Progress Report on Recognition of Medical profession as an arduous job*

[F26-012](#)

Alessandra Spedicato informed on her activities since the last FEMS general assembly:

- Post-General Assembly activities: FEMS policy paper on recognition of the medical profession as an arduous job circulated to stakeholders and EU institutions.
 - Stakeholder engagement: meetings with European Public Service Union, WHO Europe contacts via EJD/WHO Academy, and head of EU Health and Safety Unit
 - January: FEMS second conference in the European Parliament (hosted by MEP Raffaele Topo) addressed recognition of the medical profession as an arduous job; participants included hospitals (public/private), other EMOs and occupational safety stakeholders.
 - Media and external visibility: coverage including Medscape references; strengthened relationships with DG Employment and other stakeholders. Occupational Strain Index proposal:
 - Alessandra proposed development of an evidence-based Occupational Strain Index to quantify physical and mental fatigue for doctors and healthcare workers using measurable, comparable indicators (examples: number of night shifts per month, ED/psychiatric/OR duties, compliance with EWTD, number of on-call/standby duties). Indicators would be weighted based on international evidence to classify activities into high/medium/low occupational strain. The idea would be to use the index to propose national/European frameworks for compensation or protections and to seek recognition/promotion via EU-OSHA (goal: inclusion on EU-OSHA Wiki as a tool). Initial pilot planned in Italy (or any interested country), with iterative refinement.
- *EWTD - FEMS Position Paper and future actions – open discussion*

[F26-014](#)

Background:

- Alessandra informed she had met with Adam Pokorny, head of unit, DG Employment and Social Affairs / European Commission. She shared FEMS position paper on non-compliance with EWTD and proposed organizational and compensatory solutions (examples: mandatory rest compensation, tying staffing/funding to EWTD compliance, enhanced monitoring of member states, maximum overtime limits, and inclusion of GPs/family physicians under protections). Key points from meeting:
- The European Commission acknowledges widespread infringements but observes low numbers of formal infringement procedures filed by individual doctors; their enforcement and follow-up rely on formal complaints.
- Reopening/revising the directive is not a politically viable option at present due to risk of worse protections (policy momentum currently towards stricter protections).
- Acknowledgement that health impacts from EWTD breaches are relevant to DG Employment / occupational safety; Alessandra was put in contact with EU-OSHA contacts to explore practical tools (hence the Occupational Strain Index).

Discussion and interventions:

- Several delegates emphasized the need for greater flexibility in how working time is organized to reflect doctors' needs and new workforce expectations (Ole Johan Bakke/CPME).
- Concerns raised about misuse/exploitation of standby duties and inconsistent valuation/counting of on-call/standby time; reference to ECJ jurisprudence noted (participant cited C-373/24 in discussion regarding standby duties and definition of working time) (Renata Culinovic-Caic/FEMS). She emphasized the intensity element is not relevant per the judgment: presence on standby counts as working time regardless of call frequency.
- Suggestions to escalate the issue collectively: consider coordinated infringement procedures across multiple countries, media campaigns, or visible actions (e.g., demonstrations) to create political momentum and prompt enforcement.
- Emphasis on need for professional self-awareness and cultural change to reduce self-exploitation of young doctors, and for clinical leadership to include onboarding and awareness about rights and safe working conditions (Rudolf Knapp/Austrian Medical Chamber).

5. The quality of life for hospital doctors – a common working group – AEMH – FEMS – introduction and rationale (Pierre Maldague/AEMH, Joana Savva/FEMS):

Joana Savva explained the aims of the working group as follows:

- Define “quality of life” specifically for hospital doctors, develop common metrics, and consider a European survey to produce evidence-based recommendations to hospital managers and department chiefs. Key content from Joanna's presentation:
- Burnout is a central component; defined as chronic workplace stress syndrome (emotional exhaustion, depersonalization, reduced efficacy). Prevalence estimates vary 30–60%; examples: Portugal residents show 25% diagnosed burnout, 50% at risk.
- Primary drivers: workload, administrative burden, emotional strain; impacts include depression, anxiety, suicidal ideation, sleep disorders, cardiovascular risk, reduced empathy, higher medical error rates, and lower patient satisfaction.
- Quality of life framed in three domains: psychological, physical, and social. WHO definition and subjectivity across cultures noted; lack of a uniform definition and evaluation instruments across Europe. Objectives for the working group:

- Agree a practical, operational definition of quality of life for doctors.
- Design a survey instrument or data collection approach to map current status across Europe.
- Derive practical recommendations for employers and health systems (workload reduction, organizational reform, peer support, training programs, and structural changes to support work-life balance).

15:00 – 18:00 FEMS General Assembly
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PART I: Procedural issues

Roll Call / Right to vote

[F26-020](#)

Noel Carrilho recorded the presence of delegations from Austria, Belgium, Bulgaria, Croatia, Cyprus (CTMA, TCPU), France (UNMS, FPS, SNPHARe), Italy (AAROI, ANAAO), the Netherlands, Poland, Portugal (OdM, FNAM, SIM), Romania, Slovenia and Spain.

The quorum was established with 19 delegations present.

6. Approval of the agenda

The agenda was unanimously approved.

7. Approval of the minutes of the last FEMS General Assembly (Brussels, Belgium, 10-11 October 2025)

The minutes were unanimously approved.

Part II – Reports on Current FEMS Programmes and Activities and Strategy Follow-up

8. FEMS Activity report (Alessandra Spedicato)

9. FEMS Policy Paper on Medical Profession as an Arduous Job

10. FEMS Project Shaping the future of Doctors' Health – updates

Alessandra Spedicato (FEMS President) presented the main activities ongoing in 2026, including the initiative to recognise the medical profession as an arduous profession, the FEMS Position Paper on the EWTD, and the Declaration of Doctors' Fundamental Rights.

She also reported on FEMS engagement with UEMS and EU-OSHA, particularly regarding the Occupational Physical and Mental Strain Index, and highlighted the dissemination of FEMS documents at European and

national levels, increased media engagement, and the need for strengthened networking with health stakeholders.

Alessandra also provided a brief update on the FEMS project “Shaping the Future of Doctors’ Health”, based on data collected between May and December 2025 (“WORKING ON THE FINAL RESULTS – DATA collected from May to December 2025”). The project received 8,062 responses from doctors across Europe, with the highest participation from Italy, Sweden, Spain, Greece and Croatia. Preliminary findings confirm that doctors face specific health challenges and that work organisation affects doctors’ health. Final results are expected by the end of 2026.

Part III: Planning

11. Next FEMS meetings

a. Autumn 2026, 2-3 October, Cluj-Napoca, Romania – updates

The CFSMR delegation confirmed that everything is in place to host the next FEMS GA

b. GA spring 2027

The CESM delegation proposed to organise the next GA, in Alicante, Spain. The proposal was accepted.

c. GA autumn 2027

The FIDES delegation proposed to organize this GA, subject to future confirmation.

12. Guest and Observers to FEMS

a) Introduction to Swedish Healthcare

Swedish Association of Hospital Physicians representatives Karin Filipsson and Elin Karlsson presented an overview of the current status of the Swedish healthcare system, including statistical data and a critical analysis of the problems currently faced by the system.

b) Application of the Federation of Professional Unions of Doctors of Medicine and Dentistry of the Federation of Bosnia and Herzegovina as an Associate Member of FEMS

Damir Baždarević, from the Federation of Professional Unions of Doctors of Medicine and Dentistry of Bosnia and Herzegovina, gave an introduction to the Federation and its objectives.

The Application Form and Statutes of the Federation were made available to the GA delegates, who confirmed their compliance with the FEMS Statutes.

The application for Associate Membership was put to a vote and was unanimously accepted.

Part IV: Planning, Financial and Statutory Issues, Other Internal Affairs

c) Financial matters (Patricio Trujillo)

a. Closing of accounts 2025

F26-005

b. Treasurer's report 2025

The treasurer, Patricio Trujillo, presented the current financial status of FEMS, starting by stating that the financial year 2025 resulted in a deficit of 28.860,66 €.

Patricio explained that this deficit results mainly from one-time expenses, namely:

- Final legal costs associated with the change of statutes, and the complex cross-border procedure involving the closure of the organisation in France and its reopening in Belgium (28.290,70€)
- Bank-related costs that could not be accurately estimated due to the difficult communication from the French bank (4773.34€)

He also presented the 2025 income structure, noting that:

- Membership fees are the only source of income, calculated at 0.65 EUR per declared member.
- Amounting to a total of 68,932.80 EUR in membership fees.

Patricio highlighted the broader financial context, marked by increasing operational costs (travel, accommodation, meeting organisation...), the need for more resources to support organisational development and visibility, and the fact that membership fees have remained unchanged for more than ten years.

c. Internal Auditors' Report on accounts 2025

F26-023

Natalia Sot-Muszyńska informed the Assembly about the internal auditors' report, which recommended discharging the Board for the financial year 2025.

d. Approval of the Discharge of the Board regarding the 2025 Financial Report

The discharge was put to a vote, and was unanimously accepted.

e. Financial strategy 2025-2027: information and discussion

The strategic scenarios were presented by Noel Carrilho, Secretary General, who outlined four possible approaches:

1. Maintain the current membership fee structure and income sources, keeping the same level of activities, with a risk of negative financial results due to rising costs.
2. Index membership fees to inflation, maintaining the same level of activities, with the potential to achieve a balanced result.
3. Maintain the current fee structure, increase activities and visibility, and use financial reserves to compensate for the resulting deficit.
4. Increase membership fees, increase activities and visibility, and maintain balanced budgets with annual or biennial reassessment.

Under this scenario, the Board proposed a fee increase of 0.10 EUR per declared member of each association, raising the membership fee from 0.65 EUR to 0.75 EUR per declared member.

In the discussion that followed, the scenarios implying a reduction of FEMS activities or the acceptance of successive negative budgets were set aside, as no delegation supported or proposed such approaches. Tiago Villanueva (UEMO) asked for the floor to share that his organisation had recently approved an annual adjustment of membership fees in line with inflation.

Jean-Paul Zerbib (UNMS) stated that he understood the need to adjust the budget in order to maintain FEMS activities, although it's hard to propose an increase in the fees, highlighting the possibility of linking the increase to inflation.

Harald Mayer (Austrian Medical Chamber) intervened, expressing the opinion that a decision regarding the increase of FEMS membership fees should be taken immediately, considering the need for an increase to be evident. Ahmet Ozant (CTMA) intervened in the same sense, stating that action was necessary to safeguard the continuity of FEMS activities.

André Gomes (FNAM) noted that some organisations also maintain fixed membership fees which had not been increased, making it more difficult to justify such an increase before their respective boards.

Sabine Peterink (LAD) referred to the need to provide more information to her organisation before approving any potential increase, requesting further information from the Board regarding the action plan in this regard. Paulo Simões (ODM) also intervened in the same sense, stressing the need for arguments to present to his organisation in order to justify the increase.

Noel Carrilho (FNAM) clarified that the increase proposed by the Board referred to a forecast intended to maintain the current level of FEMS activity and did not concern an expansion of initiatives. He further recalled that a negative budget had already been approved for the year 2025.

Quirino Piacevoli (AAROI-EMAC) stated that his vote on this matter would be neutral, but that a detailed forecast of the budget for the following year would be essential.

Noel Carrilho (FNAM) clarified at this stage that, as usual, the Activity Plan and the corresponding draft budget for 2026 would be presented at the 2026 General Assembly.

Although some delegates expressed agreement with deciding on the matter immediately, it became clear that opinions were not unanimous. Many delegates expressed the need for more information and additional time to consult their respective boards before taking a final position on the Board's proposal.

A vote was held as to whether to postpone the decision to the next General Assembly or decide immediately. The majority decided that the topic should be brought before the next General Assembly again, for a final decision. The Board committed to providing the necessary information on the financial situation, as well as the proposed action plan and corresponding budget, ahead of the next meeting.

d) Any other business

No other business was addressed.

The meeting was closed

Saturday 9 May, 9:00-13:00

13. The floor to the European Medical Organisations

a. CEOM – Dr José Santos

- Core mandate: medical ethics, deontological values, professional independence/autonomy, safe working environments.
- Priorities: workforce retention, protection of doctor–patient relationship, leadership, prevention of violence/harassment/burnout.
- Initiatives: dissemination of a unified CEOM European form to collect data on violence; cooperation with EMOs and the European Academy of Clinical Leadership.
- Policy/advocacy: recognition of medical profession as arduous occupation at EU level; projects with CPME (Citizen Health in EU, Coalition for Vaccination, Workforce Mental Health), European Health Data Space; work on demography, telemedicine, digital therapeutics, AI training and certification standards.
- European Day on Violence Against Doctors (12 March): aims for visibility, coordinated policy, zero tolerance, improved reporting (European Protocol for unified data collection), training (communication/conflict management), physical/legal support for victims, strengthened legal measures.
- Emphasis on defending doctors' mental health and creating safe healthcare environments.

b. CPME – Dr Ole Johan Bakke

- CPME represents 36 countries; noted Belgium's temporary departure.

- Recent policy work: optimisation of healthcare workforce (developed from the GA in Athens to the one in March in Dublin), gambling/gaming policy, and concerns about digital threats and social media effects, especially for youth.
- Advocacy: amendments to Biotech Act, MDR (medical devices) and digital omnibus on AI; emphasis on strict AI regulation for medical devices and trust in clinical tools.
- Activities: members' conference on digital determinants of poor health (Dublin) — successful and influential; CPME magazine covering pharmaceutical reform.
- Upcoming events: GA in Berlin (November 2026), Sofia (March 2027), Oslo (autumn 2027).

c. UEMO – Dr Tiago Villanueva

- Overview: founded 1967; aims aligned with FEMS; promotes GP training standards, defends GPs' role, represents family doctors in EU institutions; expanding membership (25 members + 3 observers).
- Governance: presidency now may include members from different countries per new statutes; Brussels-based secretariat.
- Activities/data: GP job satisfaction study (Scandinavian countries top; Poland/Spain lower); variation in GP share across systems (6% in Greece to 44% in Finland); GP remuneration issues and stagnation.
- Main advocacy: recognition of general practice/family medicine as a medical specialty at EU level. Process requires member-state notifications via IMI; 4 countries have notified (Malta, Slovenia, Spain, Portugal); target is at least 11 notifications to prompt EC delegated act.
- Support received from Medical Council of Canada and Montenegro; ongoing outreach and planned events (General Assembly in Luxembourg, 5–6 June).

d. UEMS – Dr Andreas Papandroudis

- UEMS in strong financial and organizational position; new MJC for Disaster Medicine and reactivated MJC for Immune-Mediated Diseases.
- EACCME 3.0 fully implemented; record accreditation activity (2025: ~2,500 events and >250 e-learning materials). Accredited provider status pathway launching (expected recognition by July 2026).
- European Medical Specialist Review launched in March; editorial operations underway.
- First UEMS Congress: 27–30 May (Belgium) — 65 sessions, themes include AI/digital health, sustainability, mental health, workforce; accredited by EACCME.
- Upcoming meetings: Autumn Council Brussels (Oct), Spring Council Haarlem (2027), Autumn Council Lisbon (2027).

14. Working Group Reports

a. Declaration of Fundamental Rights of the Medical Profession — presented by Alex Ramos (FEMS)

- Aim: reach consensus document to present to European Parliament and national associations; inspired by Universal Declaration of Human Rights, ILO, Council of Europe, WHO, and national forums.
- Structure: five groups of rights: a) Professional autonomy (clinical autonomy, freedom of prescription, conscientious objection, non-discrimination). b) Labor rights and working conditions (safe/dignified environment, non-discrimination in employment and retirement,

limitation of working hours, fair remuneration, recognition of CME/research during work time). c) Rights against violence/discrimination/harassment (environment free of violence, mechanisms for reporting/redress, protection for vulnerable groups). d) Right to health (physical and mental wellbeing, attention to burnout, chronic stress). e) Collective rights and participation (freedom of association, representativeness, effective role in decision-making, right to strike).

- Proposed next steps: finalize text for translation and dissemination, event in European Parliament, engagement with DG Ethics/Human Rights and ILO, seek EMO endorsements.

b. Quality of Life of Doctors — Joanna Sava (AEMH/FEMS working group)

- Definition and findings: quality of life is dynamic, multidimensional (subjective: fulfilment, meaning; objective: workload, administrative burden, staffing, predictability). Varies across generations; younger doctors value flexibility.
- Identified 8 domains influencing quality of working life: teamwork, work organization, autonomy, leadership/culture, recognition/status, workload predictability, administrative burden, and personal wellbeing. AI noted as potential opportunity and risk.
- Proposals to improve: flexible schedules, predictable shifts, protected free time, reduced bureaucracy, adequate staffing, strengthened teamwork, leadership/communication training, clarified roles, and prevention strategies for burnout (primary/secondary/tertiary).
- Proposed working definition provided; document is finalized and ready for dissemination.

c. Additional Presentations - French sector report — Jean Paul Zerbib

- Focus on medico-social sector in France: large sector (~10 million people affected; ~1,000,200 workers; ~10% doctors). Low salaries for many staff, often near or below minimum wage; recruitment shortages including doctors; 45% of institutions for loss of autonomy lacked doctors in some settings.
- Social issues include insufficient resources for care of people with disabilities and the elderly, lack of statistical monitoring for abuse (paedophilia/gerontophilia) in care settings.
- Advocacy: raised issues with French Minister of Health; highlighted need for broader EMO attention to this sector.

9:00 -13:00 Joint AEMH-FEMS General Assembly; Chair João de Deus, AEMH President

15. Round table

Topic 1 — Workers' rights, strike action, sick leave and presentism

Key points raised:

- Alessandra introduced two themes emerging from national reports: continuous questioning of workers' rights (notably the right to strike and right to leave) and concerning policies in Romania that reduce pay during sick leave, causing presentism risk to patient safety.
- She opened the floor to the Spanish delegation for an overview of ongoing industrial action.

Spanish delegation report:

- Industrial action in Spain began around Christmas and continues. It is national in scope, though Spain's autonomous regions each apply the national framework differently.
- Primary grievance: doctors want the legal ability to negotiate doctors' working conditions "by doctors, for doctors." Current negotiations at national/regional levels include other professions and exclude doctors from specific negotiation mechanisms.
- Strike format: demonstrations, periodic industrial actions (one week per month until June). Daily/weekly industrial action causes wage loss for striking doctors and creates ethical/legal constraints regarding continuity of urgent and certain non-deferrable in-patient care.
- Economic impact: physicians on strike may lose more than €1,000 gross per month.
- Practical difficulties: different autonomies and health sectors negotiate minimum services at local levels, creating inconsistent minimum-service rules and complicating coordinated actions.
- Next steps: strike actions planned through June; strategy to be decided in July based on government response.

Questions/clarifications from members:

- João: Confirmed strikes involve hospital and primary care doctors—answer: action includes family doctors and a broad range of healthcare professions (pharmacists, psychologists, biologists) in many cases.
- Slovenia asked whether minimum services are defined by law; Spain confirmed emergency or time-critical services are mandated by law and local negotiations set minimums per sector/hospital.

Comparative experiences and legal considerations (Slovenia, Portugal, Netherlands):

- Slovenia's strike responded to two government-signed documents; government decrees and later legislative amendments attempted to impose continuous presence and broad lists of mandatory services and administrative duties during strike.
- FIDES (FEMS member organisation from Slovenia) launched a constitutional challenge arguing amendments disproportionately interfered with right to strike.
- Constitutional Court ruling (after two years): found several provisions unconstitutional (continuous presence requirement, overly broad mandatory services, inclusion of administrative tasks, parts of sanction provisions).
- National Assembly must redefine strike rules within one year to align with the Court's decision.
- Slovenia will prepare a questionnaire of member countries to collect how strikes/minimum services are handled elsewhere and requested FEMS delegations' assistance.

Portugal:

- Portugal has legislation that defines minimum services negotiated with government prior to strikes. This legal framework reduces disputes during strikes and streamlines industrial action.
- Negotiating minimum services outside periods of conflict (before strikes arise) is recommended and has worked well in Portugal.

Netherlands:

- Medical specialists in university hospitals undertook rare and successful strike action due to repeated unfavourable bargaining outcomes.
- Initial localized strikes in university hospitals escalated; administrations conceded after initial actions and demands were granted before the planned national strike.

Topic 2: Waiting lists and management measures (private practice in public hospitals; supplementary activity)

Key points:

- Italy: Public hospitals are contracting self-employed practitioners paid per on-call shift (e.g., about €1,200 gross for a 12-hour on-call), to reduce waiting lists and cover staffing shortages, particularly in high-demand specialities (anaesthesiology, emergency medicine). This is a short-term fix with risks: it incentivizes episodic work, reduces continuity, may cause skills dilution and can accelerate shift away from salaried public roles toward better-paid, flexible private arrangements.
- France: Private activity within hospitals exists; hospitals permit it and some clinicians use reduced public hours to pursue private practice. Concerns raised about oversight, economic transparency and abuse (one cited radiology fraud case with large-scale embezzlement).
- Slovenia: Ministry can allocate extra funds for specific procedures to address waiting lists; doctors may agree additional programs with employers to deliver these procedures in addition to standard duties.
- Portugal: Similar top-up programmes exist and generally function, though they can create inter-specialty discrepancies in access to supplementary income.

Conclusions:

- Mixed practice models and supplementary programmes can reduce waiting lists short-term but generate workforce, equity and governance risks if not accompanied by strategic planning and regulation.

Topic 3: Collective bargaining and health system reform

Issues and country updates:

- Austria: Not directly involved in government-led reform; Austria's complex multi-layered financing/administration ("Gordian knot" of federal, Länder, social security, communities) creates inefficiencies and administrative cost leakage. Government reform proposals expected in June; cautious outlook.
- Croatia: Collective bargaining continues after a one-year pause. Key negotiation priorities include standby duty remuneration, correct hourly wage calculation (addressing anomalies where hourly wage varies by number of working days per month), paid leave for union/teaching activities, and bringing pay in line with Croatian and EU law.
- Spain: Lack of power for doctors' organizations to negotiate doctors' conditions independently is a core grievance driving industrial action. Spanish doctors seek legal mechanisms enabling direct negotiation of doctors' working conditions.
- France: Public-sector doctor unions negotiate salary matters directly with government; private-sector contexts differ. Collective bargaining across salaried medical staff has pros/cons but can secure shared advantages.

- Poland: Nurses' unions are large and influential; Poland's minimum wage law and grouped minimums for medical professions have produced small differentials between doctor and nurse pay. Resulting public perception and media narratives portray doctors poorly; resident doctors and non-specialists are paid less than or near nurse wages. Poland faces severe fiscal pressures and rising health system debt; concerns about system collapse were voiced.

Discussion highlights:

- Several delegates recommended negotiating minimum service definitions and strike-related rules outside periods of conflict (best practice from Portugal).
- Delegates observed that combined bargaining with nurses/other professions can dilute doctors' ability to negotiate profession-specific terms, and where feasible negotiating doctors' terms "by doctors for doctors" is preferable.
- FEMS role: Alessandra proposed FEMS consider a statement on the right to strike for doctors and to assist member organizations (e.g., Slovenia) by compiling comparative strike/minimum-service information.

Topic 4: Shortage of Doctors / Workforce Retention

- Chair framed issue: movement from public to private sector, part-time trends, international recruitment does not fully offset shortages; training capacity concerns.
- Contributions and key points:
 - Austria: proposals to reduce bureaucracy via AI, task shifting (noting shortages across occupations), and enhanced self-organization for employed doctors.
 - Discussions highlighted concerns about task shifting due to parallel shortages of nurses and other professions.
 - Alessandra Spedicato: defining the medical act across EMOs would clarify limits and facilitate safe task sharing.
 - Greece: severe brain drain (~30% of doctors leave country), long working hours (60–100h/week), low pay driving emigration.
 - Croatia: Ministry-led working group to define time/staff norms to standardize time per activity and set staffing/scheduling standards.
 - Slovakia: eHealth/digitalization implementation issues; digital tools sometimes increase, not reduce, workload.
 - Portugal: wage devaluation over 20 years; reintroduction of past measures (e.g., exclusive dedication schemes) could improve retention.
 - Belgium: similar migration to private sector for better pay/quality of life; concern about hospital-based specialties that cannot transfer to private care and are thus understaffed; ongoing revision of the nomenclature of medical acts to revalue intellectual acts and rebalance technical acts.
 - Italy: decline in certain specialties due to low investment in public healthcare (low % GDP spend).
 - Multiple speakers: concern that loss of public sector doctors undermines training capacity for residents and teaching.
 - Remote/island areas: particular
 - challenges in staffing, transportation, professional isolation; proposal to develop targeted policies/compensation.

- 24-hour shifts: widespread practice in some departments; mixed drivers (staffing necessity vs. voluntary preference for extra pay). Emphasis on European Working Time Directive and need for self-regulation by doctors to avoid unsafe hours.
- Consensus observations:
 - Multifactorial causes: remuneration, working conditions, workload, administrative burden, governance, geographic factors.
 - Solutions require combined policy measures: appropriate remuneration, working time protections, staffing norms, targeted incentives for remote areas, reforms to nomenclature/reimbursement, improved digital tools, defined medical act to guide task distribution.
 - Concerns about impact on training capacity and quality of care if public hospitals lose staff to private sector.

Proposal to create a working group to define the “medical act”

- João de Deus/Alessandra Spedicato proposed to create a cross-EMO working group to define “medical act” (coordinators proposed: Filipa Lança Rodrigues (Portugal) and Fabrizio Mezzasalma (Italy). CEOM, UEMO, CPME, UEMS, FEMS, AEMH and other EMOs to be invited. João to send official invitations; Filipa and Fabrizio to coordinate.
- Working group membership: organizations to appoint representatives; aim to agree a common definition and use it to guide policy and task-sharing.

Members Reports (for information)

Austria	AEMH 26-010	Luxembourg	
Belgium	AEMH 26-013	Netherlands	<u>F26-019</u>
Bulgaria	<u>F26-016</u>	Poland	<u>F26-022</u>
Croatia	<u>F26-009</u>	Portugal	
Cyprus	<u>F26-011</u> <u>F26-015</u>	Romania	<u>F26-017</u>
Czech Republic		Slovakia	AEMH 26-012
France	<u>F26-021</u>	Slovenia	<u>F26-008</u>
Germany		Spain	<u>F26-010</u>
Greece	AEMH 26-016	Switzerland	
Italy	AEMH 26-011		