CPME MEDECINS EUROPEENS EUROPEAN DOCTORS

MAGAZINE SUMMER 2025

Supply and demand

What role for prevention in solving the health workforce crisis?

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Investing in health must be part of Europe's competitive edge

The proposal for the European Union's next long-term budget, the Multi-Annual Financial Framework (MFF) for 2028-2034, was published on 16 July and prioritises European competitiveness.

This follows Mario Draghi's 2024 influential report, which mentioned health only in terms of the pharmaceutical industry and the opportunities arising from sharing health data across borders.

Indeed, research and innovation is vital. There are dramatic changes in other countries in governmental attitudes towards universities, research, vaccination and evidence-based measures in general. There is an urgent need for Europe to step up and take a leading role in research in general, and medical research specifically.

However, we must also remember that a healthy population is the backbone for economic productivity. Incorporating health into the EU's competitiveness agenda is not merely a social imperative but a strategic economic move. A healthier population can drive innovation, workforce participation, and reduces long-term healthcare costs. This includes investment in the health workforce, a key focus in this edition of our magazine.

Ultimately, investing in health is not a cost, but a long-term investment in the EU's future, a message emphasised this month by a group of national medical association in the Charter of Rome. A healthier Europe is a stronger, more united Europe. By making health a central pillar of its next budget, the EU can lead by example in promoting equity, resilience, and shared prosperity.

Dr Ole Johan Bakke

CPME President

When the health workforce breaks, the system follows

Dr Andreas Botzlar moderates our recent event on the health workforce at the European Parliament

Across Europe, the shortage of healthcare professionals is a growing crisis. In 2022, EU countries faced an estimated shortfall of 1.2 million, which is forecast to rise to 4 million by 2030.

This shortage is deepening with our ageing population and medical workforce alike. Without urgent action, the effects will only worsen, threatening the health of patients across Europe.

The impact on patients is already clear. Across Europe, countries are grappling with understaffed clinics, longer waiting lists, and communities left medically underserved. In some regions, patients must travel hours to see a doctor.

These gaps translate into unmet medical needs, poor patient outcomes, and stark health inequalities.

Dr Andreas Botzlar
CPME Vice President


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As a practicing doctor in Germany, I see firsthand how shortages strain the system. Unsafe staffing levels force early patient discharges and postponed operations. Yet these issues often go unnoticed by management, who sometimes claim we have too many doctors.

There is a disconnect between the realities of frontline care and the decisions of administrators and policy-makers.

Instead of addressing structural causes, quick fixes such as recruiting doctors from abroad are implemented but without sufficient integration support. At my hospital in Murnau, we treat numerous patients who are referred from other hospitals with lower levels of care. Experience shows that our international colleagues there often work hard, but language barriers persist, hindering teamwork and patient communication.

Addressing this workforce crisis is European doctors' top priority.

In March, I was honoured to moderate our European Parliament event on solutions to the workforce crisis, bringing together MEPs, European Commission officials, and doctors from over 30 countries.

The discussion launched our 'Doctor's Voice' campaign to ensure policymakers hear directly from those on the front line. I kindly thank MEP András Kulja for hosting this event in the Parliament as well as MEP Tilly Metz for co-hosting the event, (see pages 7-12)

While political currents are increasingly shifting from cooperation towards self-sustaining isolationism, this approach is fundamentally incompatible with the challenges facing our healthcare systems. European health policy has traditionally respected national sovereignty over the organisation and financing of healthcare systems.

The reality is that training and sustaining a robust medical workforce cannot be solved in isolation.

Working conditions, education and training quality, and doctors' mobility are not separate technical challenges but interconnected issues that extend well beyond the health sector itself.

They implicate education systems, labour and social policy as well the functioning of the Single Market.

This is precisely why we need a comprehensive EU Health Workforce strategy, built on coordinated and multisectoral solutions that give this crisis the political priority and practical answers it urgently deserves.

The Belgian Council Presidency deserves recognition for twice putting the health workforce crisis on the European agenda: first in 2010 and again in 2024 through its Council Conclusions on the future of the European Health Union.

These calls have been important signals of shared concern, but the fourteen years between them highlight the danger of leaving this issue dormant, while too many other governments bury their heads in the sand instead of delivering lasting change.

Building on this work, we now call on EU institutions and national authorities to match this commitment with real political will and sustained action.

A window of opportunity has opened to keep the health workforce at the top of political agendas, thanks to the Health Workforce Own-Initiative Report to be prepared in the European Parliament in the coming months.

It represents an important vehicle for defining the EU's political direction and fostering long-term commitment.

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We urge EU institutions and national authorities to seize this moment to move beyond declarations and deliver the concrete, coordinated strategies and investments needed to support Europe's healthcare professionals and ensure high-quality care for all patients.

Europe's doctors, nurses and healthcare professionals deserve more than well-meaning words. Let us not look back in another decade and see another missed opportunity. This is the moment to act decisively, to prioritise recruitment and retention, and to secure the future of high-quality care for every patient across Europe.

Report: Solutions for the European Health Workforce Crisis

20 March 2025, European Parliament

Hosted by
MEP Dr András Kulja

Co-hosted by
MEP Tilly Metz

In collaboration with the
Standing Committee of European Doctors (CPME)

epp group in the european parliament

THE GREENS/EFA in the European Parliament

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Four take-home messages on the European health workforce crisis


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Doctors from over 30 countries gathered in the European Parliament to discuss sustainable solutions to the European health workforce crisis at an event hosted by MEP Dr András Kulja and MEP Tilly Metz, and moderated by Dr Andreas Botzlar.

Two panels discussed shortages of doctors and the working conditions of healthcare professionals. In this report, we share four take-home messages.

1. The health workforce crisis is a shared European problem

Dr Nikolay Branzalov (Bulgarian Medical Association) highlighted that Bulgaria is facing an ageing medical workforce combined with increasing emigration of healthcare professionals, which has created disparities in healthcare access and services.

Dr Milan Kubek (Czech Medical Chamber) added that there is a significant and widening gap between the availability of the healthcare in rural area and urban areas.

Panelists emphasised that this crisis is not limited to one region—almost every European country is experiencing staff shortages. Even wealthier countries are struggling to recruit and retain enough health professionals. The shortages are interconnected, and a fragmented response will not solve them.

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2. We must improve working conditions

Dr Kitty Mohan (British Medical Association) emphasised that doctors are struggling with overwhelming workloads, poor IT systems, decreased job satisfaction, and decades of underfunding, leading to deep dissatisfaction.

In addition, Dr Philippe Cathala (French Medical Council) reported that nearly one in two doctors faces some form of aggression each year. Prof. Dr Bojana Beović (Medical Chamber of Slovenia) shared that Slovenian doctors have been on strike since January 2024 due to excessive working hours.

Participants warned that we need to take action or the crisis will deepen. Solutions include ensuring compliance with the EU Working Time Directive. It was also highlighted that high-quality postgraduate training programs are essential for retaining medical professionals.

3. High-quality data is crucial for workforce planning

Dr Martin Balzan (Medical Association of Malta) urged for more standardised data across Europe, not only on numbers of doctors but on full-time equivalents. This would identify variables, such as whether doctors are working part-time or double time.

Dr Ina Kelly (Irish Medical Organisation) stressed that we need comparative figures to learn from each other, and to understand our health systems to interpret it correctly.

This high-quality data is crucial to diagnose issues in our healthcare system and address workforce planning

Panelists warned that as long as Europe continues to lack high-quality, comparable data, we cannot plan, coordinate, or fix the health workforce crisis effectively.

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4. We need an EU Health Workforce Strategy

CPME President Dr Ole Johan Bakke concluded the event by noting that the stories of doctors across Europe illustrates a health workforce on the brink. He emphasisied that investing in the health workforce is an investment in the resilience and prosperity of our societies.

Retaining our doctors and other healthcare professionals is not only vital for public health but also for ensuring that Europe remains prepared and resilient in the face of crises.

Healthcare professionals are the backbone of the entire healthcare system. Without them, there is no care delivery, no patient care, and no universal health coverage. European coordination is needed to ensure that EU countries are self-sufficient in training a highly educated healthcare workforce to meet their needs.

The workforce crisis is a shared European challenge that no country can address alone. Addressing this crisis requires a coordinated effort across policy areas.

CPME is calling for an EU Health Workforce Strategy to ensure that this issue is given the attention it deserves at the European level.

We are committed to working together with the European institutions to ensure that we rescue our health workforce back from the brink.

View of MEP András Kulja

Event co-host
European People's Party, Hungary

"We should act now. The joint report on the healthcare workforce from the European Parliament should urge the Commission to take immediate measures and establish a long-term strategy to tackle the workforce shortages across Europe."

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We have a common aim to provide accessible and affordable healthcare for all EU citizens with sustainable workforce management. Yes, it is a member state competence, but I think now we all realise that we also have to work together to find the proper solutions.

The COVID-19 pandemic showed us that we can make better decisions and find better solutions together.

That is why we have the European Health Data Space and a Critical Medicine Act, because the EU realised that that we face similar problems in every member state.

It is crucial to find solutions for workforce shortages to secure the health security of patients. Without doctors, we cannot give the necessary therapy to patients.

Brain drain has a particular effect on the central and eastern European region. The migration of healthcare professionals from rural areas to capitals, and from Eastern to Western Europe has devastating effects.

Rural hospitals are emptying, and departments are closing, posing enormous difficulties for patients living with chronic diseases and needing regular checkups.

In Hungary, we have a shortage of around 30,000 nurses and almost 1,000 GP practices are not occupied, making it difficult for nearly 1.5 million people to access to primary care in their own neighborhood.

Healthcare systems have not managed to recover fully from the pandemic, leaving postponed interventions, lengthened waiting lists and exhausted nurses and doctors.

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View of MEP Tilly Metz

Event co-host
Greens / EFA, Luxembourg

"The health workforce cannot continue like this. There are challenges that are best addressed at the European level, there are even challenges that can only be resolved at European level. We need more cooperation and not more competition."

Today, we face the undeniable truth that our healthcare systems are under immense pressure and the backbone of this system, our healthcare professionals, are bearing the brunt of this crisis.

The reality is that we have staff shortages, deteriorating working conditions, growing violence and insufficient support. This is pushing doctors, nurses and caregivers to their utmost mental and physical limit.

The consequences of the health workforce crisis is a declining quality of care, longer waiting times, reduced access for patients, worsening health inequalities and increased costs for the health system.

As European politicians, we cannot just stand by and watch this continue. It is time for bold and decisive action.

During the pandemic, if we would have only stuck to our official competence, we would not have had vaccination for the 27 countries.

We need better working conditions, fair pay and continuous training. We also need to reinforce the social dialogue with the healthcare professionals we need to promote collective bargaining and really ensure that their voices are heard.

We need also legislation that supports the working conditions. It is essential to develop directives targeting the psychosocial risk and muscular skeletal disorders also key drivers also of the burnout and staff shortages.

We must explore the creation of a directive on safe staffing, ensuring adequate personal levels for both patient care and staff well-being and mental health.

Why paper medicine package leaflets matter to patients

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Diogo Teixeira Pereira
EU Policy Adviser

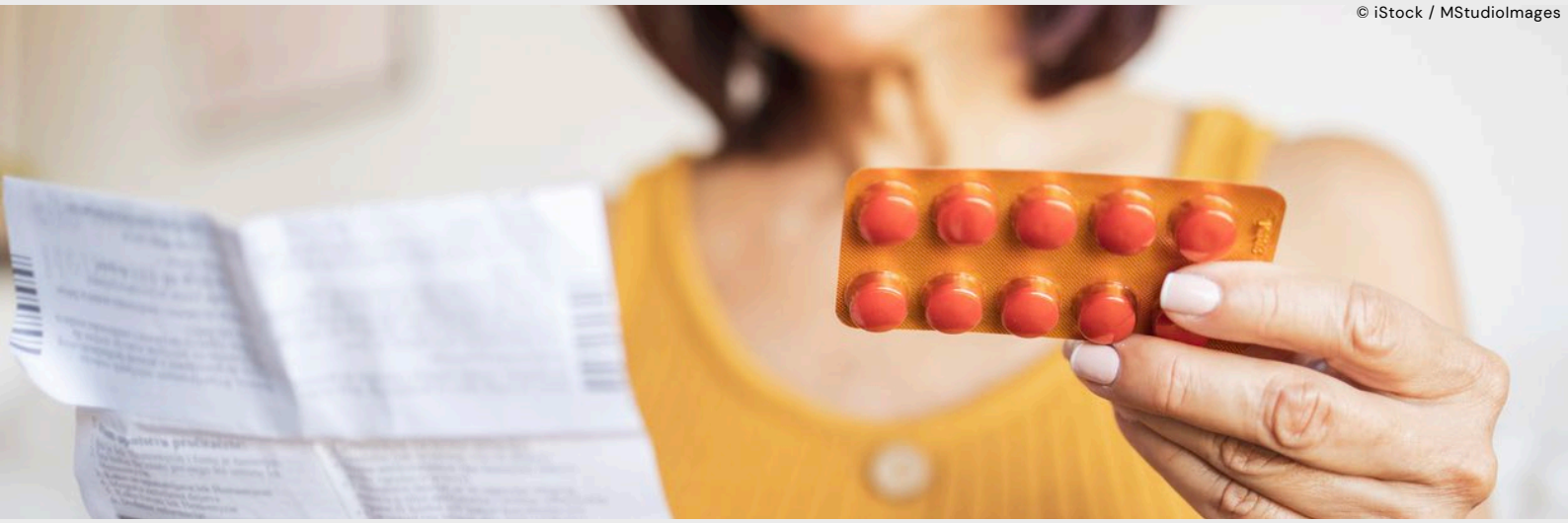
Package leaflets are a vital component of the information provided to patients on the safe and effective use of the medicines they take.

However, they could soon disappear from Europe's medicine packages through the EU's pharmaceutical reform.

The EU institutions are now moving into trilogue negotiations on the revision of the EU general pharmaceutical legislation.

The European Commission's proposal would allow EU Member States to remove all medicine package leaflets, leaving a QR code linking to Electronic Product Information (ePI) as the only way for patients to access important details about their medicines.

European doctors and other stakeholders are deeply concerned that ePI will not provide inclusive access for all patients, and favour both digital and non-digital options so patients can choose based on personal preference or needs. Therefore, we adopted a joint statement calling on legislators to maintain paper package leaflets, and use electronic leaflets as a complementary tool.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There are a number of potential benefits of ePI. When developed in close collaboration with patients and healthcare professionals, ePI offers opportunities to improve readability and meet specific patients' needs, such as those with impaired sight.

Electronic formats can also be updated immediately when new safety information becomes available, ensuring patients receive the most current guidance.

However, ePI requires access to smartphones, internet, and data plans, which are not accessible to all patients, due to age, geographical location, disability, health, income, religion or social situation, or by choice.

Internet connectivity issues in hospitals, rural areas and during emergencies could also prevent access. Paper instructions need to be kept being used in case of electricity blackout, or when there is not a robust digital infrastructure in place or in emergencies. Studies conducted in other fields show that a many consumers are unable to scan product information through a QR Code.

There are also patient privacy concerns. The ePI should ensure that patient data is not used for commercial purposes or promotional activities and that third-party links should not store personal information

In summary, paper leaflets help improve health literacy and empower patients to make informed decisions about the medicines they take.

European doctors strongly believe that the medicines package leaflets must continue to be made available by pharmaceutical companies in the packaging in paper format, and the electronic format should be a complement to that.

Read our joint statement here,

Prevention: Enabling healthier living

A lack of action on preventable diseases causes avoidable mortality, morbidity, and financial costs.

The most sustainable healthcare is the reduced need for healthcare. Investing in prevention can significantly reduce the burden on the health workforce by decreasing the number of people who require medical care.

In this issue, three guest articles provide a view on action on how to stop illness before it starts. The first two articles focus on alcohol harm, through the recently launched European Health Alliance on Alcohol, and an update on the progress of Ireland's Public Health Bill from the Irish Medical Organisation.

Thirdly, the Helmholtz Association provides a forward-looking perspective on prevention medicine research.

Uniting for Health: Why Europe's Medical Community Must Take a Stand on Alcohol Harm

Catherine Paradis, Carina Ferreira-Borges and Gauden Galea
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At a time when Europe faces multiple public health challenges, alcohol remains an overlooked crisis hiding in plain sight. It kills 800,000 people across the European region every year.

Among young Europeans, one in four deaths is caused by alcohol. The damage is visible in hospitals, in families, in communities, and it is entirely preventable.

In May 2025, a new chapter began. WHO/Europe launched the European Health Alliance on Alcohol at the European Association for the Study of the Liver (EASL) Congress 2025.

The Alliance is a coalition of medical, clinical, and health professional organisations determined to tackle the harm caused by alcohol. We had the privilege of witnessing this moment and left with a renewed sense of urgency and hope which are both essential as we prepare to shape a new vision for the prevention and control of noncommunicable diseases at the UN High-level meeting in September.

Why now? Because more and more people, in and out of the medical community, are starting to recognise that alcohol harm is not an individual problem. It is a system failure.

We live in environments where alcohol is cheap, readily available, and aggressively promoted. Alcohol is treated like a harmless commodity. Meanwhile, doctors, nurses, and researchers are left to treat the consequences: liver disease, heart disease, cancer, mental health disorders, accidents, and premature death.

It is time to shift from cure to prevention. We cannot keep asking individuals to "drink responsibly" while the environments around them drive up consumption. Those environments need to be changed. And we already know how.

The WHO's 'Quick Buys', including higher taxation, marketing bans, and restrictions on availability, are among the most cost-effective interventions in public health . They save lives.

They work fast. Just look at Lithuania: after adopting strong alcohol policies, the country saw immediate drops in consumption and alcohol-related mortality, as well as a rise in life expectancy.

These are not abstract recommendations. They are real solutions backed by data, ready to be implemented.

So why are they not?

Because there is fierce resistance. The alcohol industry is no passive observer. It actively works to delay, dilute, and derail effective public health measures.

Through dedicated policy teams, the industry builds political alliances and engages directly with governments to frame regulatory discussions in ways that protect commercial interests.

Let's be clear: this is the new tobacco playbook, more polished, more subtle, but just as dangerous.

European Health Alliance on Alcohol Symposium in Copenhagen on 11 December 2024

That is why WHO/Europe developed the Alcohol Policy Playbook, a practical tool to help policymakers, advocates, and public health professionals recognise and counter industry interference.

For key alcohol-related issues, the Playbook presents common industry narratives and counters them with public health evidence.

For health professionals, there is a moral duty to respond. That is why the European Health Alliance on Alcohol matters.

It is a unified front, one that brings together Europe's most trusted voices to defend the right to health. The health community is stronger when its members act together.

When cardiologists, oncologists, hepatologists, pediatricians, addiction specialists, public health experts, and family doctors speak with one voice, they are impossible to ignore.

This is not just about alcohol. It is about reclaiming health policy from vested interests and restoring evidence as the basis for decision-making.

And it is about protecting the next generation from a product that too often claims lives before they even really had the chance to begin.

The launch of the European Health Alliance on Alcohol is more than the creation of a new organisation, it is the beginning of a movement that refuses to accept preventable death as the status quo. A movement that will demand public health above profit.

To all medical professionals across Europe: this is an opportunity. Join the Alliance! Bring your credibility, your expertise, and your compassion to help deliver better health and well-being to all.

Ongoing Delays and Challenges with Ireland's Public Health Legislation

Ireland's national parliament building

Despite intensive lobbying from the alcohol industry, Ireland's Public Health (Alcohol) Bill 2015 was passed on 3 October 2018.

The PHAA 2018 is ground-breaking legislation introducing a range of evidence-based measures in accord with the WHO 'best buys' to reduce alcohol consumption and the WHO SAFER initiative.

However, it needs to be implemented in full.

Riona Casey and Vanessa Hetherington
Irish Medical Organisation

The measures include:

- Minimum unit pricing of alcohol products;
- Warning labelling on alcohol products and notices in licensed premises;
- Prohibitions and restrictions on advertising and sponsorship;
- Separation and visibility of alcohol products and advertisements for alcohol products in specified licensed premises;
- The regulation of the sale and supply of alcohol products in certain circumstances.

A legal specification of the labels was developed by the Irish Dept of Health

The medical profession played a critical role in informing the debate, presenting the evidence of alcohol-related harm and advocating for the measures.

However, seven years after the Act was passed, the legislation is still not fully implemented, and it continues to face potential delays and ongoing challenges.

From May 2026, health labels will be required on alcohol products, listing health implications associated with alcohol consumption including risks during pregnancy, and the link to fatal cancers and liver disease.

While alcohol companies have until May 2026 to comply with the comprehensive labelling guidelines, the Irish alcohol industry has argued that the timeline for implementation should be reconsidered .

Both alcohol companies and their allies have contended that the recent tariffs proposed by the United States could negatively impact companies and the deadline for compliance should be delayed to ensure companies are not financially devastated. As a result, the May 2026 deadline for compliance is currently under examination by the Irish government and will likely be delayed to 2028 or 2029.

The Act also introduced a number of restrictions on advertising of alcohol products including a ban on advertising within 200 metres of the perimeter of a school, playground, or childcare facility. It also introduced a broadcasting watershed between 3am and 9pm on TV and 3am and 10pm on radio and a ban on advertising at sports events primarily aimed at children.

However, the restrictions are undermined by ongoing advertisements of alcohol on social media and the exploitation ‘alibi’ marketing loopholes.

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Alibi marketing is a technique used by alcohol companies where they will use features of their brand that are similar to the brand, without actually advertising an alcoholic product such as the advertising of zero-alcohol products.

As a result, alcohol advertisements continue to be seen on billboards, TV, online, and most notably at sports events.

A further challenge is the governments proposed Night-time Economy Bill, while yet to be published the bill is likely to reduce restrictions on alcohol sale and extend the hours in which alcohol can be purchased, threatening to reverse many of the public health benefits contained in the 2018 Act.

Since passing the legislation in 2018 alcohol consumption per capita over the age of 15, has fallen 13% to 9.49 litres.

However, alcohol continues to be a major public health issue in Ireland:

- 4 people die each day in Ireland because of alcohol
- 1000 cancers caused by alcohol are diagnosed every year
- Alcohol accounts for 30% of emergency department presentations
- An estimated 4.8% of babies born in Ireland suffer from Fetal Alcohol Spectrum Disorder.

Despite the ongoing delays and challenges the medical profession continue to lead the conversation on this issue advocating for timelines to be met in relation to alcohol labelling, for advertising loopholes to be addressed and for tighter restrictions on alcohol advertising and sale.

Furthermore, the medical profession seeks to ensure that public health is prioritised in alcohol policy and that public health policy is not derailed by the alcohol industry which is wholly concerned about turning a profit.

Improving human health through prevention medicine

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"An ounce of prevention is worth a pound of cure." Scientist, diplomat, and publisher Benjamin Franklin coined this phrase in the 18th century. However, many years later, this insight remains underutilised in modern healthcare.

Over 1.1 million Europeans die each year from diseases that could largely be prevented with existing knowledge and interventions.

Patients suffer – often needlessly – while health systems buckle under the weight of avoidable chronic illnesses. Economically, the impact is staggering: Chronic diseases alone cost the EU over €700 billion annually in health care and lost productivity.

Why Prevention Matters – and Works

The usual suspects, cardiovascular and metabolic diseases, remain the "big killers" that are responsible for the majority of deaths in Europe. Yet many of their risk factors are well understood and modifiable: regular physical activity, a balanced diet, avoiding tobacco, and managing stress can dramatically reduce risk.

Doctors are the linchpins of this effort. In private practice, general practitioners are often the first to notice the quiet emergence of long-term risks – rising blood pressure, increasing waistlines, creeping HbA1c levels, or a missing vaccination. Their ability to intervene early, counsel effectively, and refer wisely is vital in curbing disease before it strikes.

In hospitals, physicians not only treat acute manifestations but also provide crucial "teachable moments" for patients – after a heart attack, for instance – to commit to secondary prevention.

Then there are more surprising candidates. Take colorectal cancer, a condition with rising incidence across Europe. Regular screening and early detection can reduce mortality by up to 70% – yet participation rates remain uneven, particularly among people from socioeconomically disadvantaged groups.

Indeed, health inequalities across the board start early in childhood, making childhood health a prime target for preventative approaches, for example curbing the obesity epidemic.

Science Illuminates the Risk Factors – If We Let It

For diseases like Alzheimer's and other neurodegenerative conditions, the story of prevention is still unfolding. Only through large cohort studies – involving hundreds of thousands of participants over decades – have researchers identified the web of lifestyle, genetic, and environmental factors at play. Turns out: chronic inflammation, disrupted sleep, and even air pollution can significantly increase the risk of cognitive decline.

In cutting-edge fields like genomics and metabolomics, researchers are making the invisible visible. For example, studies of gene-environment interactions show how certain people may be more vulnerable to high-sugar diets based on genetic variants that affect insulin sensitivity.

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For several conditions, it is even possible to predict onset or complications through genetic risk scores, which can be inexpensively measured at any point in the life course, even at birth. It's not quite personalised fortune-telling – but we're getting closer to knowing who might need prevention most, and which kind specifically.

The European Union plays a crucial role in enabling such discoveries.

Through programmes like Horizon Europe, the EU has consistently funded high-impact research that identifies modifiable risk factors, explores disease mechanisms, and develops population-level strategies.

What's equally important is the EU's commitment to helping member states integrate these findings into national healthcare systems – ensuring that prevention is a research goal and a healthcare reality.

Currently, public research funding is heavily skewed toward developing new treatments. And while that is undoubtedly essential – no one is arguing against new cancer drugs – prevention remains dramatically underfunded.

Yet, the economic logic is clear: Research suggests that every €1 invested in prevention can yield a return of €14 through avoided healthcare costs and increased productivity. Imagine what our healthcare systems could do if doctors were not overburdened with preventable conditions. They could spend more time treating diseases that cannot be avoided – those rooted in genetics, external factors, or complex trauma – and deliver better outcomes overall.

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Prevention must be a public priority.

Governments and public institutions have the mandate to act in the collective long-term interest – through health education, accessible screening programs, clean air initiatives, and healthy urban planning, and the research to guide the way for these interventions.

Prevention research requires robust funding mechanisms, which should be seen as an investment, empowering interdisciplinary collaboration and involving diverse stakeholders including the private sector. And governments must be held accountable for doing so.

The Final Word

Although Benjamin Franklin's famous quote wasn't originally about health, he was nonetheless a strong advocate for immunisation against infectious diseases. We would be wise to adopt his intelligent approach when it comes to disease prevention in general – not just in clinical practice, but in research strategies, policy-making and the development of digital tools to deliver precision prevention at the population level. Indeed, Helmholtz Health has put together a dedicated Prevention Task Force to develop a roadmap for prevention research and its application globally. Investing in prevention is not just an act of health planning. It is an expression of respect for human potential, a smart economic decision, and a moral imperative in modern medicine.

Let's ensure that future generations don't just treat preventable diseases – but never suffer them in the first place.

Doctors in the digital age: rights, protections and the role of trade unions

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Fédération Européenne des Médecins Salariés
European Federation of Salaried Doctors

Integrating artificial intelligence (AI), augmented reality (AR), and even the Metaverse, into medical practice is no longer science fiction, but a revolution in progress that is redefining the practice of medicine — from university lecture halls to operating rooms and right into the patient's home.

On one hand, these technologies offer diagnostic accuracy, surgical simulations, and remote consultations once deemed unthinkable; on the other, they raise contractual and labor-union issues that can no longer be postponed.

Let us imagine an algorithm capable of identifying oncological patterns in a radiological image with over 90% reliability; or a surgeon who, thanks to an AR headset, sees the patient's vascular network projected in real-time onto the chest before making the incision.

The promise is for faster, safer, and less invasive procedures. But who bears responsibility if an AI makes a diagnostic mistake?

And how can the physician's decision-making power be reconciled with "mechanical" advice that could become binding?

In upcoming collective bargaining agreements, hospitals and technology providers must clearly define roles, liability limits, and usage protocols to ensure that the doctor does not become a mere executor of an algorithmic report.

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At the same time, since the increasing use of Augmented Reality in remote consultation, medical education, training, surgery, employment contracts might evolve to include stipulations on how, and how much, doctors engage with these technologies.

There will be a requirement for mandatory skill updates, not only professional skills but technological abilities, and training hours exclusively dedicated to virtual learning.

With this in mind, it's fundamental to underline that the current shortage of doctors means increasingly reduced time and quality dedicated to continuing medical education.

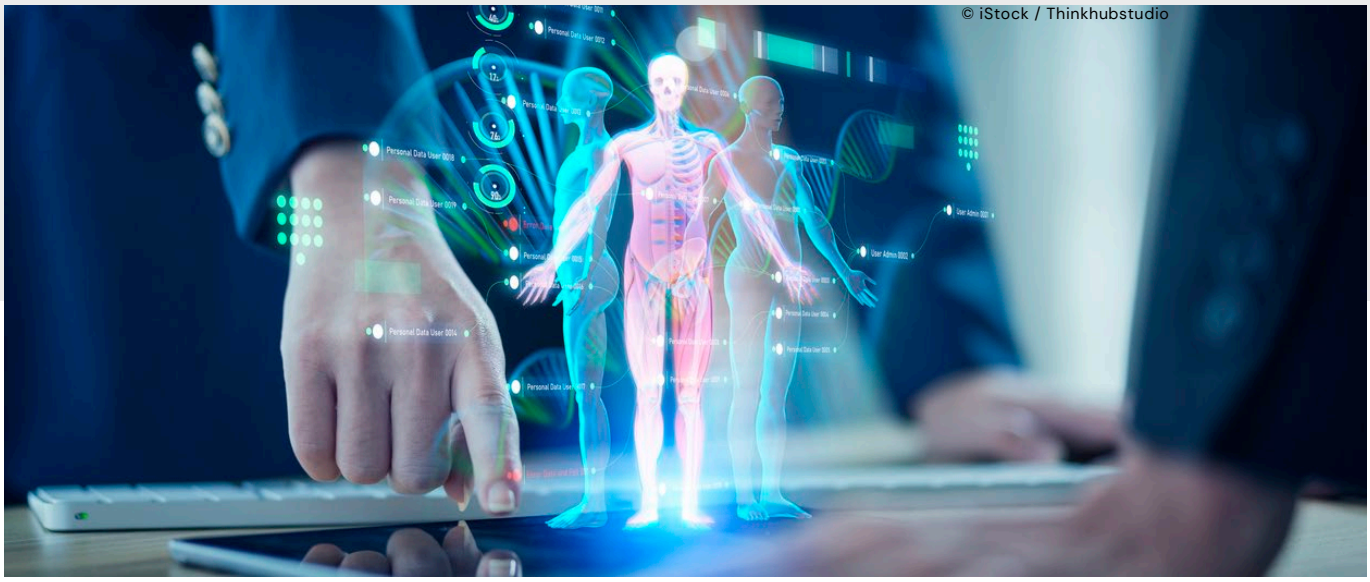
It will be essential to establish structured training pathways, recognised as mandatory within working hours, in which physicians become proficient not only with software interfaces but also with immersive simulation techniques.

In an era when a lack of familiarity with digital tools creates an internal "digital divide," partly due to generational differences in immersive experiences, collective-bargaining agreements must guarantee equal access to these technologies — by awarding training credits, granting dedicated leave and allocating financial resources for AR courses and virtual workshops.

But the revolution doesn't stop at the "physical" clinic: the Metaverse is a complete new workspace opening new frontiers for telemedicine.

Virtual-reality consultations, group simulations with multiple specialists, and three-dimensional consultation spaces where the patient interacts with the doctor's avatar—all become possible.

In this context, unions will need to negotiate pay equivalency between in-person and Metaverse visits, set limits on working hours, and establish rules for the right to disconnect, safeguarding work–life balance even in virtual environments.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It will be essential to define a "Metaverse jurisprudence" that lays down the rules and contractual framework for medical services.

especially given the increasing likelihood that doctors and patients reside in different countries, each governed by its own, often divergent, professional-liability laws.

The establishment of a transnational medical workers' trade union - such as FEMS - may become necessary to detect issues and suggest collective agreements and working conditions as equitable as possible, across Europe.

Unionists will advocate for more stringent privacy clauses: AR headsets and immersive platforms collect biometric data, eye-tracking information, dialogues and personal strategies in performing surgery, all of which demand robust cybersecurity protocols and give physicians the rights of access, correction and deletion of their data.

This underscores the key role of trade unions: no longer merely defenders of wages and working hours, but leading actors in the governance of emerging technologies.

To this end, unions will need in-house research units dedicated to studying digital evolutions; to include ICT specialists and bioengineers at the bargaining table; and to participate actively in ethics committees and international AI consortia.

Moreover, they should establish outskilling and reskilling programs for those whose tasks are automated—offering alternative career paths and options for early retirement—and negotiate "dignified retirement" agreements to secure economic and professional protections for colleagues approaching the end of their careers.

Alongside the issues already mentioned, a further critical frontier emerges: the use of AI in the medical staff selection process. On one hand, algorithms can speed up resume screening and identify profiles with specific skills; on the other, they risk replicating and amplifying biases present in historical data.

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Imagine a system that, based on past hires, unwittingly penalises candidates of a different gender or ethnic background: without proper review and transparency mechanisms, this could exclude valuable professionals and erode workforce diversity.

Unions, therefore, will need to negotiate binding clauses that require healthcare institutions to subject their algorithms to regular bias audits, to verify selection criteria and prevent discrimination, and to guarantee candidates the right to appeal if they feel they have been unfairly penalised. Human evaluation will remain essential for assessing the soft skills at the core of our profession.

Another threat concerns the algorithmic surveillance of physicians' behavior. Digital platforms can collect detailed data—movement patterns, reaction times and even conversation transcripts—and convert them into performance metrics that may trigger automatic sanctions or career penalties. Without specific contractual safeguards, the AI "eye" could become an instrument of intensive, punitive oversight, infringing on both professional and personal privacy.

Unions must therefore insist on contract clauses that:

- Restrict the use of these data strictly for patient-safety purposes;
- Define clear limits on which types of information may be collected;
- Prohibit any form of "punitive profiling";
- Guarantee physicians the right to access, review and delete their data;
- Provide for sanctions against any misuse or abuse of surveillance systems.

Finally, there are also possibilities for new occupational illnesses to occur. The use of visual instruments could determine ocular and vision issues. Doctors could suffer from epilepsy, anxiety, depression and psychosocial disorders such as burn out.

This Copernican revolution will require trade unions to work with teams of doctors, unionists, legal experts and AI specialists to ensure quality and safety of care — for both patients and practitioners.

CONTACT

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