Fédération Européenne des Médecins Salariés
European Federation of Salaried Doctors

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Title:	FEMS white book – psychosocial risks / burnout		
Author:	Jean Paul Zerbib		

The prevalence of burn out is very high: 8% among doctors; and half of doctors have already got symptoms of burn-out as insomnia, stress, depression, suicide ideas ….

Many reasons can increase the probability of this disease:
- work overload (too much work; work is not well-done enough, so high culpability feelings);
- not enough doctors at work; days are too long; no respect of rest periods);
- pandemics (as Covid 19, bronchiolitis among babies);
- war;
- lack of solidarity among doctors and health care team;
- young doctors in training; the risk is high; the risk of suicide is high;
- mental or body diseases of doctors;
- lack of adapted trainings;
- bad conditions of work (not enough heat in hospital; problems with computers; no good room to sleep at night …);
- numeric fracture;
- conflicts with hospital administration (the financial interest of administration is to organize lacks of doctors, even if doctors are available to work);
- conflicts of loyalty with family life (kids to take care; husband or wife);
- doctor an be helper (aidant) with a kid, a parent or a partner; it needs time and energy and it can be source of depression;
- no respect of European laws (rest time of 11h after work day)
- long distance to go back home and to arrive on time at work;
- stress in link with racism, with violence of patients and their family; if repeated if increases PSR.

So what to do ?

What to do to prevent burn-out? Solutions are, of course, answers to the reasons of burn-out:

- limitation of the number of worked hours every day, week and month; and to respect it;
- enough doctors working; if not services or part of services have to be closed; in French it is called: droit de retrait;
- hospitals have to organize kids gardens for the babies and young kids of doctors;
- appartments, very near of hospitals, could be available;
- psychologists could help to prevent conflicts among medical teams and health care workers;
- psychologists and psychiatrists have to be easily contacted by phone, visio or in reality, to help doctors as soon as possible at the beginning of burn-out;
- trainings for ALL doctors have to be available;
- violence, racism have to be prevented with security guards in hospitals;
- rooms to sleep and rest at work, have to be peaceful and well equipped;
- secretaries have to help doctors in their administrative job;
- for young doctors, prevention of suicide has to be organized, with speech groups and individual

Objet : Professional Associations of Doctors (PAD)

my dear colleagues ,
the goal of this work is to explain all the goals of PAD , in France and in Europe.
There will be examples to give sens to this text .

1- first level : local level
unions are very important to help and support doctors in their professional life :

to prevent and treat psycho-social risks
to represent doctors in négociations in hospitals
to explain all about retirement ; prévoyance ; health care system for doctors ;
to négociate salaries and social help (housing ; kids gardens ; holidays)
to organize work with other doctors and speak with administrative directions ;
to help doctors if sanctions against doctors are taken by the direction ;
to control trainings ;

unionist actions : strikes ; demonstrations ; discussions with other medical unions and non-medical unions ;

2- second level : national level (and in some European countries, regional level) :
discussions with the government about all professional levels :
initial trainings and trainings all along the life ;
diploms ;
foreighners doctors ;
salaries ;
prevention and treatment of psycho-social risks ;
health system organisation ;
relationships between private and public health-care structures ;
to look at the implementation of European directives (working time for instance) and ILO conventions (for instance C190 about violence and harassment at work) ;

unionist actions : congresses ; strikes ; demonstrations ;

3- third level : European level :
health system is under the responsability of every state ; but european level is important :

A) EMO's (european medical organisation) work on all medical topics ;
FEMS european federation of salaried doctors : i am the FEMS's treasurer ;
FEMS is working about all topics concerning salaried doctors in private and public hospitals and health care centers . We prepare a white book . One of the topic is psycho-social risks .
Document 1 and document 2 .
burn out , violence at work are everywhere in Europe .

B) my union UNMS (union nationale des médecins salariés) and CFE-CGC (confédération générale

des cadres - managers) is member of EUROCADRES : we are lobbyists to promote an European directive about psycho-social risks ; if the European Parliament votes this ED , every country will have to implement it .

C) NGO non governmental organisations in the European level are lobbyists :
this is another lever of action for our union .
as representative of FEMS , i have been elected since 3 years , board member of EPHA european public health alliance ; to understand what is EPHA ? document 3 and document 4 .

4- fourth level : international level : ILO international labour organisation :
with my union , unms and CFE-CGC, I am one of the representative's salaried people ; every year , there is an international meeting in Geneva . ILO is an agency of UN (United Nations) .
I worked for instance in Convention 190 , about violence and harassment at work .
Document 5 .
this convention 190 is to fight against burn out , psycho-social risks , and violence at work .

All this work is done with the help of my union Unms and FEMS

dr Jean-Paul Zerbib. FEMS treasurer

During 2 years , 2018 and 2019!, ILO , international labour organisation , one of the UN agencies , has worked in Geneva on this topping : violence and harassment at work .

2 FEMS members were in the French delegation of Workers : Anne-Catherine CUDENNEC and Jean-Paul zerbib.

Our goals were :

1- to protect all workers against violence at work ; in hospital it can be :

violence between colleagues ;

Violence coming from patients and their families ;

Violence coming from hospital (too much work ; not enough health care workers ; psycho-social risks)

2- to protect vulnerable groups : as migrants, disabled people , old and young people, women at work and at home .

3- to organize rules for prevention, and treatment of this kind of violence and harassment ;

4- to propose definitions of violence and harassment ;

5- ILO will look forward to the respect of those rules , including legal actions ;

The text of this convention 190 is in link downstairs and is possible to read in several languages ;

What is the procedure in ILO ?

ILO presents this convention to every government in the world (around 200) . Every country is free to sign or not this convention.

If it is signed by a government, this government has to implement the convention ; so observers as unms look at that : who has signed and who did not sign ? For instance , France has signed lately, after 4 years ….

ILO has voted this international convention about violence and harassment at work .

This convention has been adopted in UE , at this date , by Spain , Greece , Irlande , Italia , France .

It is a protection for all workers , including doctors.

It is duties and solutions for workers , employers , patients and their families.

All countries in the world, which signed this C190 need to adapt their laws to respect this international convention.

So now , we have to contrôle if this convention is well respected in all countries who signed it . It is the next Step to go to less and less violence and harassment at work .

It is a fighting for FEMS, fighting against psycho-social risks,

The result will be less burn out for doctors as well and a better protection.

The job we do since many years against psycho-risks with all EMO ´s , including FEMS, is the kind of lobbying which opens the possibility of European and international conventions. And now we wait for an European directive about psycho-social risks …. since 7 years . Let's us dream and go on our lobbying for a better life for doctors at work.

Dr Jean-Paul Zerbib. FEMS

Link:
https://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO::P12100_ILO_CODE:C190

EPHA MEMBERSHIP

THE WHY | THE WHAT | THE HOW

european public health alliance

THE WHY

The European Public Health Alliance is a change agent – Europe's leading NGO alliance advocating for better health. We bring together the public health community to provide thought leadership and enable change, to build public health capacity to deliver equitable solutions to European public health challenges, and to improve health and reduce health inequalities.

Established just short of 30 years ago, in its policy and advocacy work EPHA covers a broad range of public health topics, with a strong emphasis on health inequalities. As a member-led organisation, we work with all relevant policy and decision makers to strengthen the voice of public health in Europe, with EPHA's core values - **equity, solidarity, sustainability, universality, diversity, and good governance** - always in mind.

What sets us apart from other EU public health NGOs is our membership and our audiences. We can proudly say that we are a **people's platform for public health** – set up by people and for people. In our broad and versatile membership, we host organisations from the European umbrella ones, to the smallest of local grass roots. **Our members** include health professionals on the one hand, and patients orgs on the other. Most importantly, it includes an array of organizations that represent vulnerable population groups, including children, older, homeless, Roma communities, people living with AIDS, those that suffer from substance abuse or gender-based violence. Our nurses, doctors and scientists are not with us to talk with each other. For that, they have their own professional associations. They are in EPHA to get involved in people's voice, to talk with people and to work for people.

THE WHAT

In 2021, a new **EPHA 2021-2025 Strategic Plan** "**Artists and Scientists – New Partnerships for People's Health"** was introduced, bringing about four major changes to EPHA's approach. They include a stronger focus on evidence, more flexible and adaptable approach to advocacy, focus on collaboration and partnerships, and a shift from individual campaigns to clusters of overlapping policy areas. All aim to secure more flexibility in a changing policy environment, better adaptability to challenging public health times, and higher value to EPHA, its members and external partners.

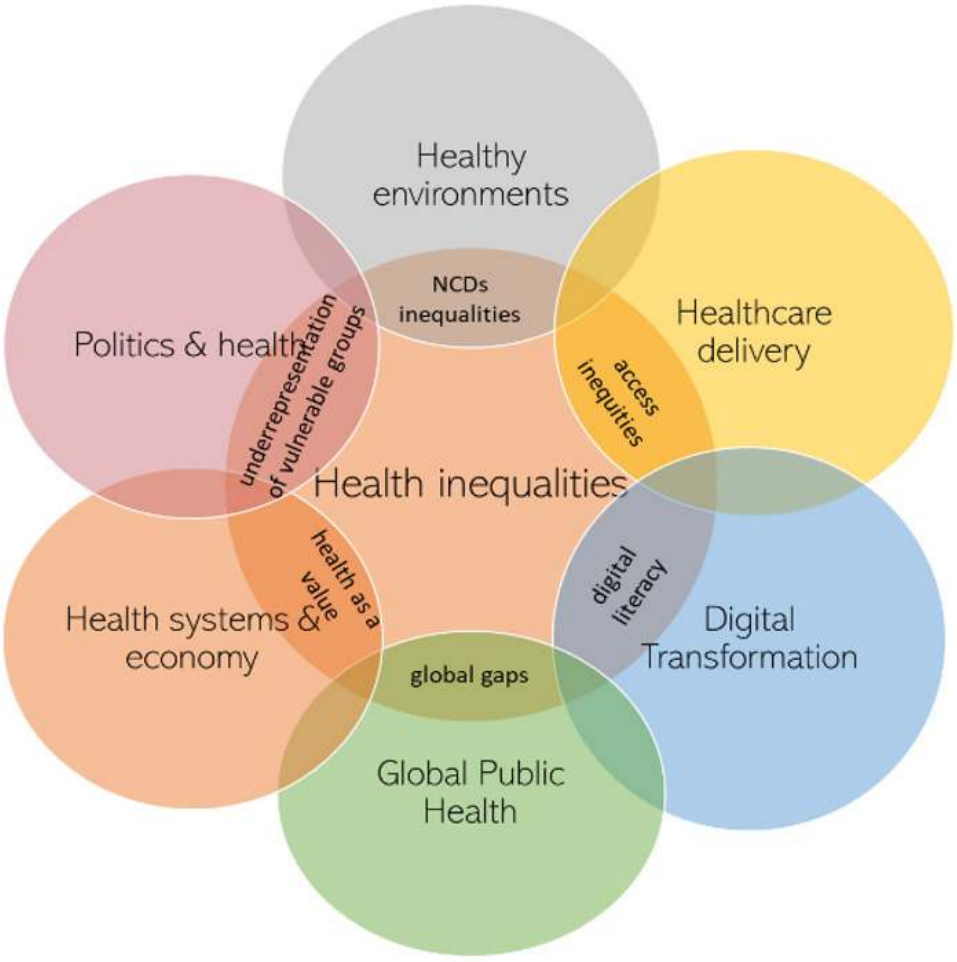
This new approach provides a **good fit for the increasingly integrated nature of European policy initiatives** and the progressively intersectoral cooperation within public institutions. It also reinforces EPHA's role as the main, if not only, civil society alliance that actively engages with European policies from the vantage point of a comprehensive public health vision. The new strategy is also geared towards maximising the potential of expanded partnerships with civil society, institutional and academic actors to support European, national and local policymakers and initiatives.

Thematically, the plan identifies seven core areas of activities – or 'clusters' – designed to promote an integrated approach to help tackle the complex and interrelated health, economic, environmental, social and political challenges that Europe and the world are facing today. EPHA's seven thematic clusters include.

1. **Healthy Environments,** which supports the development of policies that scale up disease prevention and health promotion for sustainable and healthy lives.
2. **Healthcare Delivery**, focusing on the development of safe and inclusive healthcare delivery systems, including by advancing universal access to medicines and healthcare.
3. **Health Inequalities,** aiming to reduce health inequalities and contribute to "leaving no-one behind" by promoting universal access to disease prevention and healthcare.
4. **Health Systems and Economy,** which aims at improving public health and healthcare systems' resilience.

5. **Global Public Health,** working to prepare for and effectively respond to serious cross-border health threats as well as to ensure policy coherence between public health and other policies.
6. **Digital Transformation** contributing to the development of people-centred digital policies that enhance population health and protect fundamental rights.
7. **Politics and health**, aiming to improve the way in which policymaking is conducted, including transparency and accountability, and to increase civil society involvement to ensure democracy and trust

Following the ambitious logic of EPHA's 2021-2025 Strategic Plan, EPHA's clusters do not operate in isolation. They are intertwined to allow cross-fertilisation of knowledge and expertise within EPHA's team and across membership.



THE HOW

EPHA's activities are driven by our **Members**, supported by a knowledgeable Management **Board**, and delivered by a **Team** of passionate professionals.

Members get engaged and their inputs get integrated into all EPHA's policy areas, especially via regular **members meetings** organised either per thematic groups or across topics, via **General Assembly** meetings, via tailored opportunities for feedback, including through **members' surveys**.

EPHA's members get invited to jointly engage in **projects**, EU or otherwise funded, we support each other and in the advocacy campaigns, we partake in networks and alliances and amplify each other voices.

EPHA's members regularly receive **tailored communications** through our monthly EPHA newsletter and Members newsletter, through emails on topics of common interest the various Working Groups and Clusters, but also by the Board, Officers and Director General. EPHA's Social Media channels are used to amplify members messages.

EPHA is renowned for, and proud of the support and **capacity building** it offers to its members and partners, for which the following quote recently came from our civil society partner as a welcome recognition:

"Being a young and youth-led organization, we have always had a great deal of support by EPHA and their staff. They have opened us many doors and taught us ways to act in the European public health arena."

Finally, while the **emphasis on evidence** is not new to EPHA's approach to policy and advocacy, with the new strategy and new leadership, it is getting an increased importance. Throughout the past three decades, EPHA has always worked with scientific advisers for guidance and direction. We are now working to further strengthen our **network of expert advisors** to secure an impactful evidence-to-policy translation, and secure a strong evidence underpinning of all areas of EPHA's policy work.

This close working relationship with the membership is essential to ensure their respective view and areas of expertise are well represented, and that a value from this relationship is clear and secured for both parties.

Illustrating the impact of such joint work, the **top examples of EPHA's success** in the last four years – according to a survey conducted in January 2022 among EPHA's members and partners – include (the list is not exhaustive):

- leading the relentless advocacy for the EC health mandate and the EU4health programme;
- mobilising EU health NGOs around the new financial framework and helping to shape the EU4Health budget;
- supporting its members in handling civil society responses to COVID-19;
- shaping the EU Code of Conduct for Responsible Business Marketing;
- getting antimicrobial resistance and medicines affordability high on the EU policy agenda;
- driving the impactful policy work on pharma strategy;
- loudly promoting civil society engagement in access to medicines;
- fostering greater accountability.

With our transition to the new thematic structure in our strategic plan, even more emphasis will be put on enabling and maximising members' engagement, and supporting members throughout the lifecycle of EPHA membership.

EPHA's membership benefits include:

- being part of an impactful alliance
- the access provided to key stakeholders
- the space for engagement on common topics
- speaking with one voice on important issues
- the impact achieved together
- the expertise within the Team
- the expertise within the membership
- the expert advice coming from scientific and strategic advisers
- the learning opportunities & capacity building
- the diversity of the membership
- the networking and socializing opportunities

Interested in becoming a Member?

Fill in this application form and send it back to:

Dr Aleksandar Sokolović
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Fédération Européenne des Médecins Salariés
European Federation of Salaried Doctors

Date:	29-10-2022	Document:	F23-015 EN
Title:	FEMS white book – psychosocial risks / workload		
Author:	Jean Paul Zerbib		

Workload is one of the main risks to increase PSR.

Workload can be due to:
- not enough doctors at work;
- not enough health care workers, at work;
- too much work hours in a short period; and repeated in a short period;
- too many patients;
- level of gravity of diseases treated, can be considered as workload (more work);
- too much administrative works;
- too much time and energy reserved to do non-medical work;
- confusion of missions;
- numeric fractures;
- troubles with the families of patients;
- too much mails to treat;
- conflicts among medical teams;
- lack of doctors in the country and in the speciality of doctors;
- economic troubles in the hospital;
- the risk of workload can be higher in private hospitals (not enough money to recruit doctors) and In private health centres, the pression to work can be very high;
- the lack of medical unions to protect doctors and to offer them information about their rights and duties;
- non-respect of European laws about the working time European directive;
- too high frequency of on duty work of doctors;
- long distance and time to go from home to hospital;
- no possibility to go in holidays;
- time to eat too short; quality of food in hospital restaurant can be not good enough;
- no possibility to go to doctors for himself, if any diseases;

Workload can have several reasons.

Culpability is often present; the feeling not to do enough, not to do well the job;
guilty for everything, as if doctors had to answer to all questions;
doctors are frightened to go to court if errors are done or considered as errors;
workload is still worse when stress and depression are present;
the quality of life at work of doctors in hospital is very important. Administration has to take care of doctors, which is not often the case.

Fighting against all reasons of workload is a main topic to fight against PSR of doctors.

The first part of our FEMS job was to realize the importance of PSR at work for doctors.
Now, we must resume actions and proposals:

1 - EMOs must lobby in their own country to sign the ILO convention about violence and harassment at work. It was decided at ILO in June 2019, but not yet signed by all European countries.

2 - discussions are on the floor in EC about a European Directive about PSR. I did the job as lobbyist with ETUI, Eurocadres, CFE-CGC, and for EPHA and FEMS. To improve this lobbying, I propose that all EMO.s become member of EPHA, to support and help. The visibility of EMOs about this topic is not strong enough.

3 - in each European country, at the state level, we need to improve the situation of doctors:
- more doctors in private and public hospitals;
- less overload work for doctors;
- better salaries;
- social advantages for doctors, men and women: to get an apartment near hospital, to get nurseries, to improve trainings;
- to improve collective bargaining.

4 - on the level of EMOs and national medical unions :
- we have to organize medical congresses about PSR;
- we have to get a hot-line to listen to doctors suffering of stress, depression, burn out;
- to offer insurances against the risk of violence at work;
- to fight to recognize burn out and PSR as an occupational disease;
- to invite specialists of those questions in our EMO.s congresses.

5- at the level of every private and public hospital:
- to offer a good room when we work at night;
- to organize meals 3 times a day, if necessary, for doctors;
- to promote consultations with psychologists and psychiatrists, very quickly if any mental disorders for doctors;
- to promote meetings among doctors to speak about a better organization of work for doctors.
- to let doctors have a better place in hospitals to organize work, financial decisions, to decide about medical materials; more place for doctors, less to administration;
- to organize good professional trainings for medical students; that point is very important.
- to organize a sustainable organization of life in hospitals;
- to promote better collaboration between private and public hospitals, to exchange competence, to share working time;
- to do more about trainings: medical trainings, digital trainings, social laws .
- to promote equality in rights and duties among men and women doctors.
- to promote learning languages, to help to care foreigners .

psychotherapy;
- medical chambers, medical unions, hospitals have to organize congress, symposium about this topic of prevention of PSR;

So, prevention and treatment of burn out largely depends on individual and collective behaviors of doctors and of all mangers in hospitals.

Results of the FEMS Survey

Question 1 :
About % of doctors who already were in burn out :
7/13: No data

3/13 : 7-8%
2/13 : 50%

So, data are not enough obvious to use .

Question 2 :
About a stronger probability among men:
10/13 : no
3/13 : yes

FEMS considers that it is an equal problem for men and women

Question 3 :
If BO is more frequent among men, to which % ?
12/13: no data
1/13 (France): 1 answer (France) , BO is a bit more frequent among men than women (55%)

Question 4 :
Older age is it a bigger risk ?

11/13: Yes
2/13: No
So, older age increases the risk of BO for FEMS members

Question 5 :
Lack of doctors, does-it increases the risk of BO ?

Yes, for 12/13
So, il is a very obvious item for FEMS

Question 6:
Work overload is it a risk stronger to get BO ?

Yes : 13/13 !!!!!!
Oui : 13/13 !!!!!
For FEMS members, this item is obvious

Question 7:
Feeling guilty not to be in possibility to work well, is it a risk to do BO ?
12/13: Yes
So, feeling of guilt increases the risk of BO for FEMS members .

Question 8:
Which facilities would help to prevent BO ?

1 – A sports center?
Yes 7/13

2 - Cafeteria?
Yes 7/13

3 - a rest room?
Yes 10/13

So a rest room looks to be considered as useful to prevent BO.

4-a library ?
No for 8/13

5 - a nursery ?
No for 8/13

6 - a comfortable room to sleep ?
Yes: 12/13
So, a rest room and a comfortable room to sleep are considered as very useful to prevent BO .

Question 9:
Is there hot line with psychologists to speak about BO in your country ?

8/13: no

It is organized by:
4/13: medical chamber
2/13 your hospital
1/14 Your union

Question 10:
Is there psychiatric support to prevent or to treat BO?

6/13 - yes

3/13 Organized by your hospital
1/13 Organized by union

Question 11:
How many doctors did: a suicide attempt; a suicide; a long work break ?
11/13: no data

So this item is impossible to use.

Question 12:
In your country, is there training available to prevent BO ?

Yes - 6/13
3/13: it is organized by medical chambers
2/13: organized by hospitals
2/13: organized by your union

Question 13:
Do have newspapers or books speaking about BO ?
7/13 Yes

6/13: organized by medical chambers
1/13: made by your hospital
2/13: proposed by your union

Question 14 :
Does your union have a policy to prevent, diagnose and treat BO ?

1/13: yes
No comment !!!!!

Method: I looked again at all answers made by our FEMS colleagues about burn out; so we get this final result: we have 3 kinds of answers:

1 - statistics about burn out in Europe:
Many datas coming from different countries cannot be useful. Some of them could be used;
What are the results?
- 8% of doctors already had burn out in their professional life;
- 50% among doctors already had 1 or more burn out symptoms
- the risk is equal for men and women
- age has no influence;

2- which factors increase the risk of burn out:
- the lack of doctors;
- work overload;
- too much work during nights and weekends;
- not enough solidarity among medical team and healthcare workers tea.
- no hot-line to call if help is neede;
- no psychiatric consultations organized to help quickly doctors.
- burn out is not enough considered as a disease by unions , hospitals and medical chambers;
- not enough information about burn out (books; magazines; press news);
- stress at work (psychosocial risks);

- Covid 19 sanitary crisis increases thoses risks;

3- what can decrease the risk of burn out:
- a pleasant rest room;
- a pleasant place to eat;
- a pleasant room to sleep at night;
- enough time to rest between 2 days of work;
- not too much work;
- a good prevention: staff, take care about doctors, e-consultations, psychiatric consultations;
- meetings among doctors to appreciate psycho-social risks;
- medical congresses to keep a high level of medical competency;