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Heads of Delegation
in the Administrative Council
By email

European Patent Office
80298 Munich
Germany

Central Staff Committee
Comité central du personnel
Zentraler Personalausschuss

centralSTCOM@epo.org

OPEN LETTER

Reference: sc22147cl

Date: 09/12/2022

Detrimental adjustment to the health services ([CA/85/22](#))

Dear Heads of Delegation,

The President has tabled a reform of the health services ([CA/85/22](#)) for the upcoming meeting of the Administrative Council which will further restrict the rights of sick staff.

The 2015 reform of sick leave and invalidity had already negatively affected staff and is currently under legal challenge:

- the **computation of sick leave**, where any part-time absence on a working day is counted as a full day of sick leave, is prejudicial to staff entering or in extended sick leave or (partial) incapacity because it resulted in them suffering salary deductions, unlike other staff (e.g. in the case of Covid-19 infections).
- the **abolition of the invalidity lump sum insurance** has violated the legitimate expectations of EPO staff who had been contributing to the insurance for many years. The Office did not follow the unanimous opinion of the Appeals Committee in favour of staff, leaving them no other option than to challenge the decision before the Tribunal right in the middle of the pandemic.
- the **abolition of a medical committee**, which previously had a balanced composition, paved the way for an unbalanced procedure fully empowering the medical practitioner (medical advisor) chosen by the President of the Office alone for the purpose of issuing medical opinions on incapacity.

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The Health Services should not be merged

The Health Services are currently organised in two separate teams:

- 1) an Occupational Health Service (OHS) responsible for staff on sick leave (less than 125 days in 18 consecutive months) and providing advice and support to staff members,
- 2) a Medical Advisory Unit (MAU) responsible for staff on sick leave for more than 125 days in 18 consecutive months and issuing opinions for the President for the purpose of taking potentially adverse administrative decisions (e.g. salary deductions, forced return to work...).

The proposed reform pretends to introduce “a seamless sick leave process” by merging the two teams. In our view, a sick staff member cannot build trust with the practitioner supposed to support them if this same practitioner is also actively involved in making potentially adverse decisions. Moreover, independence is at risk as the practitioner will find himself in an inherent conflict of interest. Such a reform would even be illegal in our major host country, Germany, as confirmed by the Mercer Marsh Benefits report.

Data protection issues

As a consequence of the reform, the two separate medical case management systems of OHS and MAU would be merged. It was an inherent strength of the system that medical data was accessed by different persons for different purposes: one to support staff, the other one (only if required) to be involved in making adverse decisions. The merge would increase the number of “health professionals” and administrative support staff who have access to the medical data of all staff, without asking the staff member for their consent.

In addition, the Staff Committee was never informed about how the Data Protection Officer has been involved.

Amendments in the Service Regulations outside the scope of the Working Group and not discussed

The document presents amendments to the Service Regulations allegedly to support implementation of “a seamless sick leave process”. None of the amendments were necessary for this purpose. Nor were they within the scope of the Working Group set up to discuss the reorganisation of the health services and were not discussed.

In particular:

- allowing the EPO medical practitioner to contact the employee's doctor without their consent is a violation of the employee's right to privacy and a blank check for violation of medical secrecy,
- the use of personal medical data for other purposes without the employee's consent breaches data protection,
- the employee's right to access medical data is now restricted,
- the establishment of new conditions for disregarding evidence voluntarily submitted by the employee deprives them of the possibility of handling their own medical situation in front of the employer,
- the employee's access to the arbitration procedure in case of disagreement with a medical opinion is now restricted.

More details can be found in our opinion in the General Consultative Committee of 22 November 2022, which is annexed to this letter.

Conclusion

The proposed reform is detrimental to staff, endangers the independence of the "health professionals", endangers medical secrecy and risks creating an atmosphere of mistrust. It would be illegal in our major host country, Germany. Furthermore, the reform introduces, after the 2015 reform, further restrictions on the rights of sick staff, raising the question of whether the health and well-being of staff is the priority for the EPO.

For the sake of sick staff, we urge the Council not to approve document CA/85/22.

Yours sincerely,



Alain Dumont
Chairman of the Central Staff Committee

Annex: Opinion of the CSC members of the GCC on GCC/DOC 27/2022: Adjustments to health services (CA/85/22)

Opinion of the CSC members of the GCC on GCC/DOC 27/2022:

Adjustments to health services (CA/85/22)

The CSC members of the GCC give the following opinion on the “Adjustments to health services” proposed in [GCC/DOC 27/2022](#) (CA/85/22).

On the consultation

Mandate of the Working Group

1. The Central Staff Committee (CSC) received several invitations from the President (the latter one dated 9 March 2022, see Annex 2 of [sc22135cl](#)) to constitute a Working Group on "Organisational Changes in the Health and Safety". The mandate was detailed in COHSEC/DOC 10/2022 (see Annex 1 of [sc22135cl](#)) and confirmed in the letter of the President as follows:

*“In parallel, there are other aspects which will continue to be driven by the team and its management, as well as being discussed with the COHSEC members. The transition will focus on **defining the future repartition of services between the Occupational Health function and the Medical Advisory function**. It will also **determine the scope of the hybrid service delivery model, the definition of the future roles and responsibilities and the review of the service catalogue**. These reflections can then inform the tender procedures planned in 2022, as many of the existing contracts are coming to an end by end of 2022.”*

2. The mandate even concludes that “[t]he scope does **NOT** include [...] any changes in the service regulations outside the defined scope”.
3. The Central Staff Committee (CSC) appointed on 18 March 2022 (see Annex 3 of [sc22135cl](#)) two staff representatives to the COHSEC Working Group.

Meetings of the COHSEC Working Group

4. A series of 8 meetings took place during which the COHSEC Working Group discussed organisational changes in the Health and Safety. No amendment to the Service Regulations was ever presented nor discussed. The present document was never presented to the Working Group.
5. During the discussions, the Working Group understood that the envisaged seamless sick leave procedure would be a trust-based seamless procedure by the Occupational Health Services (OHS) to support the health of sick staff members until the transition to incapacity after 250 days, a transition following a medical opinion of the distinct Medical Advisory Unit (MAU). No merge of OHS with the MAU was ever discussed.

COHSEC consultation

6. On 3 November, the present document was made available to the staff representation and tabled for opinion in the COHSEC meeting of 14 November (as COHSEC/DOC 22/2022) and for GCC consultation in the meeting of 22 November.
7. In view of the wide implications, our COHSEC nominees repeated their concerns of 2 November 2022 by email of 8 November 2022 (see **Annex 1**, pages 3 and 4) to the COHSEC Chairman and asked to change the document category from “*for opinion*” to “*for discussion*” and to discuss it in a meeting in person. None of the proposed amendments to the Service Regulations were ever presented nor discussed before.
8. In a reply sent on the same day (see **Annex 1**, page 2), the Chairman rejected the request by stating that already an “*intensive amount of discussions*” took place and that the “*Working Group worked well and delivered results jointly supported*”. In particular, the Chairman stressed that “*the document COHSEC/DOC 22/2022 proposes a seamless sick leave process which is supported by all members of the working group as well as the members of the COHSEC.*”
9. In an email of 10 November, the COHSEC members including the Working Group members rebutted the allegation.
10. The CSC addressed the President and VP4 by letter of 11 November ([sc22135cl](#)) and expressed a preliminary opinion concluding that the amendments proposed in the Service Regulations not only go beyond the scope of the mandate of the Working Group but introduce, after the 2015 reform, further restrictions on the rights of sick staff, calling into question whether the health and well-being of staff is the EPO’s priority. **The CSC urged to withdraw this text and not to submit it to the Administrative Council.**
11. On 14 November, the COHSEC meeting took place during which no progress was achieved. Our COHSEC members provided their opinion on 18 November (see **Annex 2**)

GCC consultation

12. On 22 November, two hours before the GCC meeting, the President answered the CSC letter and repeated again the wrong statement suggesting that “*the recommendation related to the seamless sick leave process was supported by all members of the working group and, subsequently, integrated in the proposal to amend the regulations in CA/85/22.*”
13. The GCC meeting took place on 22 November during which the administration attempted again to instrumentalize the COHSEC Working Group. The GCC members nominated by the CSC repeated that nobody in the staff representation supports the merge of OHS with the MAU and nothing in this sense was ever said by anyone. It was requested that this shall be put clearly in the minutes.

At the time of the GCC consultation, **the opinion of the COHSEC was not provided to the GCC.**

On the merits

Misrepresentation of the situation at the EPO

14. The document pretends that “the 2015 reform of sick leave and invalidity ([CA/14/15](#) and [CA/D 2/15](#)) stimulated a shift from a disability culture to a culture of integration in employment at the EPO” (§ 39) and contributed “to balance staff’s wellbeing and safety with business continuity as from the start of the pandemic in 2020” (§ 40). It is worth recalling that several Germany aspects of the reform are still being challenged and are currently negatively affecting staff:
- the computation of sick leave (Article 62a(7)(b) ServRegs) counting any part-time absence on a working day as a full day of sick leave is prejudicial to staff entering or in extended sick leave or (partial) incapacity because it resulted in them having salary deductions (e.g. in case of Covid-19 infections), contrary to the rest of staff.
 - the abolition of the invalidity lump sum insurance¹ breached the legitimate expectations of EPO staff who had been contributing to the insurance for many years. The Appeals Committee unanimously considered that the Office breached its duty of care by not providing transitional measures. VP4, by delegation of authority, rejected² in February 2021 the opinion which was in favour of staff, thereby giving no other option to them than to challenge the decision in front the Tribunal right in the middle of the pandemic.
 - the abolition of a medical committee (former Article 89 ServRegs) previously based on a balanced composition paved the way to an arbitrary and unbalanced procedure fully empowering the medical practitioner (advisor) chosen by the President of the Office alone for the purpose of providing medical opinions on incapacity.
15. Further misrepresentations of the situation are:
- the document alleges a “positive impact of the reform” on sick leave reduction although the average sick leave days had already started to decrease as of 2010 (see figure on page 2, §6) and sick leave is actually increasing again, especially in 2022. The decrease in 2021 was solely linked to very specific circumstances, the pandemic.
 - there is no reference to the fact that our COHSEC members disagreed with the Mercer Marsh Benefits study which focused only on three countries. The United Kingdom was included (although it is not a host state) for the purpose of justifying a merge of the Occupational Health Service and the Medical Advisory Unit which is actually unlawful in our major host state, Germany.
 - the statement that “*COHSEC members welcomed the inclusive and constructive approach, which had led to agreement in many areas*” is misleading because there are crucial points of disagreement on issues which are now the basis of the amendments proposed.

¹ See [CA/14/15 Add. 1](#), page 20-21/40.

² See [CSC publication](#) of 19.03.2021.

Occupational Health Services (OHS) and Medical Advisory Unit (MAU) must stay separate

16. Currently, there are two separate teams:

- 1) an **Occupational Health Service (OHS)** responsible for staff on sick leave (less than 125 days in 18 months) and who is providing advice and support to the staff member,
- 2) a **Medical Advisory Unit (MAU)** responsible for staff on sick leave for more than 125 days over a period of 18 consecutive months and who drafts opinions for the President for the purpose of taking potentially adverse administrative decisions (e.g. salary deductions, forced return to work...)

17. By using the same broad terms “health professionals” (§15), “health experts” and “medical experts” for both teams, the document blurs the distinction between the current very different roles: who is from the OHS?, who is from the MAU?, who is a physician? and who is a nurse?

18. The document proposes (§18) to eliminate the organisational separation between the two health services teams: Occupational Health Professionals (OHP) and Medical Advisory Professionals (MAP). Such a change allegedly enables a staff member to be “supported” by the same “health professional” throughout a cycle of health-related absence.

19. While COHSEC members agree to the idea that the same Occupational Health Practitioner supports the sick staff members during the process from sick leave to incapacity, **that same practitioner should at no point in time be involved in preparing adverse decisions** (e.g. salary deductions, forced return to work) against the staff member. Such decisions must be prepared by another practitioner, a Medical Advisory Practitioner. The EPO’s argues (§22) that the scope of services requested from Medical Advisory Practitioners, currently responsible for staff on long-term sick leave (beyond 125 days), would be considerably reduced. This argument is not convincing because it actually results in a shift (and increase) of the burden on Occupational Health Practitioners.

20. A sick staff member cannot build trust (§19) with the practitioner supposed to support him if this same practitioner is also actively involved in taking adverse decisions. The document pretends (§12) to maintain “*the independence of health experts in the execution of their tasks as enshrined in current Article 26c Service Regulations*” but this independence is at risk as the practitioner will find himself in an inherent conflict of interest.

21. In this respect, the two separate medical case management systems of OHS and MAU should not be merged. Contrary to the allegations in §35, it was an inherent strength of the system that medical data was accessed by different persons for different purposes: one to support staff, the other one (only if required) to be involved in taking adverse decisions. A merge of both systems would increase the number of “health professionals” and administrative support staff having access to the medical data of all staff and circulation without asking the staff member for their consent.

22. In the letter of 9 March 2022 (see Annex 2 of [sc22135cl](#), page 2, paragraph 2), the President explained that “*Data Protection requirements will be re-evaluated with the new structure*”. In

this respect, the staff representation was never informed how the Data Protection Officer has been involved.

23. In the meeting of 22 November, the Data Protection Officer (DPO) explained that the CSC should contact her in case they have questions. Actually, it is up to the administration to present all necessary documents to the GCC including any DPO document to the President on the re-evaluation of Data Protection requirements with the new structure.
24. In conclusion, the proposed merge of the two separate teams is detrimental to staff, endangers the independence of the “health professionals”, endangers medical secrecy and risks creating an atmosphere of mistrust.

Externalisation and reorganisation to save costs at the expense of staff health

25. Any medical task currently performed by OHS must be performed under the supervision of a medical doctor. Both medical doctors and nurses must be in-house staff. The advantages of in-house staff are:
 - increased commitment to the mission of the EPO,
 - internal knowledge of the Organisation, its practices and its culture,
 - better continuity,
 - higher quality of service and management,
 - better knowledge of compliance with specific internal Data Protection Rules (DPR).
26. In view of the New Ways of Working (NWoW), the paperless workflow and the increasing number of tools, software ergonomics is even more important than in the past. The EPO needs an in-house software ergonomics professional and we suggest that a dedicated COHSEC Working Group on ergonomics be put in place.
27. There is no analysis, no business case, showing that externalisation would save costs. In addition, having only a “*small [...] team of internal experts*” (§31) by putting the focus on “*managing their long- term costs and liabilities*” (§31), combined with the fact that externalisation would “*mitigate a potential lack of occupational health resources*” (§10) contradicts the alleged goal that the Office’s priority would be the health of staff.
28. The document reveals that “*a tender was run and will be concluded by the end of 2022*”. This fait-accompli casts doubts as to whether the consultation was in good faith.

Amendments in the Service Regulations not within the scope and not discussed

29. The document pretends (§41) that the proposed amendments to the ServRegs are to support implementation of a seamless sick leave process. In our view, none of the amendments were necessary for this purpose. They have furthermore not been within the scope of the Working Group and were not discussed.
30. Our comments on particular amendments:

Abolition of distinction between medical adviser and occupational health:

31. The deletion of Article 26a ServRegs abolishes the distinction between medical adviser and occupational health (see section above). The merge is detrimental to staff, endangers the independence of the “health professionals”, endangers medical secrecy and entails the risk of creating an atmosphere of mistrust.

Regular medical appointments at all times:

32. The introduction of “[r]egular medical appointments [which] will take place during the three phases” (sick leave, extended sick leave and incapacity (Article 62(2) ServRegs)) has not been within the scope of the Working Group and was not discussed.
33. This measure would allow the EPO to impose mandatory medical appointments at all times and even for short periods of sick leave. The regularity of such appointments is undefined and unlimited. Experience has shown that such appointments have been an instrument of institutional harassment against staff members. The generalisation to any phase of sick leave leads us to suspect that the EPO intends to put undue pressure on staff members to reduce sick leave registration.

No requirement for prior medical opinion to enter extended sick leave (125 days in 18 months). Medical opinion to enter incapacity at any point in time before reaching 250 days in 36 months:

34. The abolition of requirements and deadlines for the EPO (new Article 62a(7)(b) and Article 62b ServRegs) reduce predictability for sick staff because medical opinions for the potential purpose of taking an adverse decision can be triggered at any point in time and even long before reaching the limit of sick leave days.

Lack of transparency on the list of doctors:

35. The abolition of the requirement that the President draws the list of doctors every two years (Article 89(1) ServRegs) has not been within the scope of the Working Group and was not discussed.
36. The lack of deadline introduces a further lack of transparency, a potential risk of arbitrariness and a breach of the principle of regularity in the review of the list of doctors.

EPO medical practitioner may contact the employee’s doctor without their consent:

37. For the purpose of the assessment, the medical (advisory) practitioner may now contact the employee’s doctor without the consent of the employee (new Article 89(3) ServRegs). This measure has not been within the scope of the Working Group and was not discussed. It is intrusive and constitutes a breach of the employee’s right to privacy and a blank check to breach medical secrecy. The EPO should not allow itself to ask a question, if having it answered would be illegal (or not deontological for the physicians involved).

Use of personal medical data for other purposes. New conditions for ignoring evidence voluntarily submitted by the employee:

38. The current provisions (Article 89(3) ServRegs) already give a broad margin of discretion for the medical (advisory) practitioner to take into account inter alia pre-existing medical reports, or certificates, if they were submitted in due time by the employee.
39. New Article 89(4) ServRegs now completely deprives the employee of this right to have voluntarily submitted evidence be taken into account. However, the new text allows the medical (advisory) practitioner to **access pre-existing medical reports or certificates provided by the staff member in the context of other medical procedures without their consent**. In addition, the conditions such as *“as long as they are not outdated, they are necessary and relevant, and their use if compatible with the purpose for which they had been originally provided”* are so broad and unclear that they may remain without effect in practice.
40. This (again) blurs the distinction between the distinct roles of supporting staff and advising the President, allows unauthorised access to medical data of the employees and a breach of the duty of care. It deprives the employee from the possibility of handling their own medical situation in front of the employer. These new provisions have not been within the scope of the Working Group and have not been discussed

Restriction of the employee’s right to access medical data:

41. Currently, an employee may request the President of the Office to ask the medical (advisory) practitioner to provide access to medical information recorded or used in the course of preparing their opinion. The new text abolishes Article 89(6) ServRegs which guaranteed the employee’s right to access this medical information. Now access to medical data will be defined only in a lower-ranking document, which weakens staff’s rights³. This measure has not been within the scope of the Working Group and has not been discussed.

Restricted access to the arbitration procedure:

Currently, in case of disagreement with a medical opinion, an arbitration procedure may be triggered (Article 90 ServRegs) either by the EPO or by the staff member. The new provisions remove the possibility that *“the employee contests a medical opinion recommending not to extend the maximum period of sick leave as foreseen in Article 62a, paragraph 7”* (former Article 91(1) ServRegs). This measure has not been within the scope of the Working Group and was never discussed. It contradicts the alleged preference of arbitration over litigation and constitutes a severe restriction on the means of redress of sick staff.

³ See also Article 1b(4) ServRegs.

Conclusion

42. When asking the staff representation or the GCC for an opinion and a vote, all necessary information should be made available and the implications clearly understandable.
43. In this respect, we note that:
 - The opinion of the COHSEC was not presented in the GCC
 - An opinion of the Data Protection Officer on the merge of medical files from OHS and the MAU was not presented in the GCC.
44. The amendments in the ServRegs go beyond the scope of the mandate of the COHSEC Working Group. Furthermore, they introduce, after the 2015 reform, further restrictions on the rights of sick staff, calling into question whether the health and well-being of staff is the EPO's priority.
45. For the sake of sick staff, the document should be withdrawn and not submitted to the Administrative Council.

The CSC members of the GCC

Annexes:

- 1) Email exchanges between COHSEC members and Working Group member with the COHSEC Chairman (8 to 19 November 2022)
- 2) Opinion of COHSEC members on COHSEC/DOC 22/2022 (18 November 2022)
- 3) Letter from the President in reply to the CSC letter of 11 November [sc22135cl](#) (22 November 2022)

From:
Sent: 10 November 2022 15:30
To:
Subject: FW: 86th COHSEC Meeting

fyi

From: David de la Torre
Sent: 10 November 2022 15:30
To: Andreas Sattler <asattler@epo.org>; Social Dialogue <socialdialogue@epo.org>
Cc: JOINT SECRETARIATS <jointsecretariats@epo.org>; Raffaella de Greiff <rdgreiff@epo.org>; Detlev Schüder <dschueder@epo.org>; Michael Böcker <mboecker@epo.org>; Roberta Romano-Götsch <rromanogoetsch@epo.org>; Francesco Zaccà <fzacca@epo.org>; Richard Flammer <rflammer@epo.org>; Philippe Couckuyt <pcouckuyt@epo.org>; Jutta Haußer <jhausser@epo.org>; Ingrid Peller <ipeller@epo.org>; Barbara Bosch <bbosch@epo.org>; Yann Chabod <yhabod@epo.org>; Anne Boström <abostroem@epo.org>; Jakob Kofoed <jkofoed@epo.org>; Koen Lievens <klievens@epo.org>; Jürgen Mühl <jmuehl@epo.org>; Lutz Müller-Kirsch <lmuellerkirsch@epo.org>; Thomas Ellerbrock <tellerbrock@epo.org>; Carmen Schuhmann <cschuhmann@epo.org>; Susett Rolle <scrolle@epo.org>; Barbara Wolff <bwolff@epo.org>; Jan Boulanger <jboulanger@epo.org>; Alexander Kirch <akirch@epo.org>
Subject: RE: 86th COHSEC Meeting

Dear Mr Sattler,

We regret very much that Article 4 of the COHSEC Rules of Procedure has not been observed and that the COHSEC meeting cannot take place in person. The added time slot of 1.5 hours of virtual conference seems to us still to be completely insufficient, also in view of the other topics in the agenda.

In your email, dated 8th November 2022, you found that the document COHSEC/DOC 22/2022 proposes a seamless sick leave process which is supported by all members of the working group as well as the members of the COHSEC.

Unfortunately, we have to disagree.

Firstly, we already said in our email of 2nd November 2022, that we understood and understand the envisaged seamless sick leave procedure as a trust-based seamless procedure by OHS to support the health of sick staff members until the transition to incapacity after 250 days, a transition following a medical opinion by a medical advisor.

Secondly, the document COHSEC/DOC 22/2022 asserts amendments to the Service Regulations to support implementation of a seamless sick leave process (p.8, par.41). However, many of these amendments have never been touched upon at all in the working group (WG), came to a complete surprise to the COHSEC members nominated by the CSC, and thus need further discussion and clarifications, e.g.:

- Art.62(2): Regular medical appointments during all phases
- Art.62b(1): the President ... declare ... them unable for reasons of incapacity
- Art.89(1): the medical practitioner shall be chosen ... from a list ... ~~every two years~~
- Art.89(3): For their assessment ~~and provided the employee agrees~~, the medical practitioner...
- Art.89(4): the medical practitioner may, ... , take into account ... pre-existing medical reports...
- Art.89(6): ~~Upon request of the employee, to provide the employee ... medical information~~

Thus, we consider that the content and implications of COHSEC/DOC 22/2022 go well beyond the mandate of the WG.

Furthermore, COHSEC/DOC 22/2022 states that the outcome of the working group ... had led to agreement in many areas, but it is completely silent on the various points of disagreement.

For all of the above, we cannot consider COHSEC/DOC 22/2022 to be sufficiently mature for an opinion. We hereby kindly reiterate our request to modify the character of the document COHSEC/DOC 22/2022 from "for opinion" to "for discussion" and to schedule a meeting for at least half a day for the required discussions on this topic.

Yours sincerely,

David de la Torre
For the COHSEC members nominated by the CSC

From: Andreas Sattler <asattler@epo.org>

Sent: 08 November 2022 17:42

To: David de la Torre <ddelatorre@epo.org>; Social Dialogue <socialdialogue@epo.org>

Cc: JOINT SECRETARIATS <jointsecretariats@epo.org>; Raffaella de Greiff <rdgreiff@epo.org>; Detlev Schüder <dschueder@epo.org>; Michael Böcker <mboecker@epo.org>; Roberta Romano-Götsch <rromanogoetsch@epo.org>; Francesco Zaccà <fzacca@epo.org>; Richard Flammer <rflammer@epo.org>; Philippe Couckuyt <pcouckuyt@epo.org>; Jutta Haußer <jhausser@epo.org>; Ingrid Peller <ipeller@epo.org>; Barbara Bosch <bbosch@epo.org>; Yann Chabod <yhabod@epo.org>; Anne Boström <abostroem@epo.org>; Jakob Kofoed <jkofoed@epo.org>; Koen Lievens <klievens@epo.org>; Jürgen Mühl <jmuehl@epo.org>; Lutz Müller-Kirsch <lmullerkirsch@epo.org>; Thomas Ellerbrock <tellerbrock@epo.org>; Carmen Schuhmann <cschuhmann@epo.org>; Susett Rolle <srolle@epo.org>; Barbara Wolff <bwolff@epo.org>; Jan Boulanger <jboulanger@epo.org>; Alexander Kirch <akirch@epo.org>

Subject: RE: 86th COHSEC Meeting

Dear Mr de la Torre, dear COHSEC Members,

We have taken note of your request but wish to recall the following:

In the COHSEC meeting of 23 February 2022, a mandate for a WG on health services was presented to the COHSEC. This was followed by 8 meetings of the WG between April and September 2022 in which the staff representatives were given the possibility to provide their input. Regular updates were also sent to the COHSEC and a presentation of the WG outcomes was given in the COHSEC meeting on 24 October. This WG has worked well and delivered results that were jointly supported. In the circumstances, the extensive discussion process should now conclude with the submission of the relevant document for "opinion". In particular, the document COHSEC/DOC 22/2022 proposes a seamless sick leave process which is supported by all members of the working group as well as the members of the COHSEC. The proposed document will therefore be maintained on the agenda for "opinion" in the upcoming meeting.

We also invite you to submit any written comments in advance of the meeting if you feel these could facilitate the exchanges which are to take place. Furthermore, it is noted that you will have the possibility to provide a reasoned opinion on the document following the meeting.

As regards your request to meet in person, please note that in accordance with the letter sent to the Chair of the CSC on 20 October 2022, the principles of less travel in general and more environmentally friendly travel when necessary are to be applied equally Office-wide and to all services. Furthermore, hybrid meetings – allowing both in-person and virtual attendance – are part of the Office's transition to a hybrid working environment under the new ways of working as well as of the Office's environmental policy. These have continued to prove as efficient as live meeting and allow for constructive discussions to take place on all matters.

Finally, we are confident that we can handle all topics on the agenda in the scheduled time, especially when considering the intensive amount of discussions that happened on the topic. Nevertheless, we will schedule an additional block at the same day, from 17.30 to 19.00 should it not be possible to conclude our exchanges in time. We are however hopeful that this will not be needed.

We look forward to our meeting.

Best regards | Mit freundlichen Grüßen | Sincères salutations
Andreas

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From: David de la Torre <ddelatorre@epo.org>
Sent: 08 November 2022 09:38
To: Andreas Sattler <asattler@epo.org>; Social Dialogue <socialdialogue@epo.org>
Cc: JOINT SECRETARIATS <jointsecretariats@epo.org>; Raffaella de Greiff <rdgreiff@epo.org>; Detlev Schüder <dschueder@epo.org>; Michael Böcker <mboecker@epo.org>; Roberta Romano-Götsch <rromanogoetsch@epo.org>; Francesco Zaccà <fzacca@epo.org>; Richard Flammer <rflammer@epo.org>; David de la Torre <ddelatorre@epo.org>; Philippe Couckuyt <pcouckuyt@epo.org>; Jutta Haußer <jhausser@epo.org>; Ingrid Peller <ipeller@epo.org>; Barbara Bosch <bbosch@epo.org>; Yann Chabod <[ychabod@epo.org](mailto:yhabod@epo.org)>; Anne Boström <abostroem@epo.org>; Jakob Kofoed <jkofoed@epo.org>; Koen Lievens <klievens@epo.org>; Jürgen Mühl <jmuehl@epo.org>; Lutz Müller-Kirsch <lmuellerkirsch@epo.org>; Thomas Ellerbrock <tellerbrock@epo.org>; Carmen Schuhmann <cschuhmann@epo.org>; Susett Rolle <trolle@epo.org>; Barbara Wolff <bwolff@epo.org>; Jan Boulanger <jboulanger@epo.org>; Alexander Kirch <akirch@epo.org>
Subject: 86th COHSEC Meeting

Dear Mr Chair, dear Andreas,

We consider that the time scheduled (one and a half hours) and format (video-conference) for the next meeting of the COHSEC is insufficient in view of the number and density of the documents in the agenda. The complexity of COHSEC/DOC 22/2022 and its wide implications also requires an in-depth understanding of the impact and consequences for staff.

Therefore, and in view of the – in our opinion - immature status of the document, we request to change the nature of the document from opinion to discussion and to extend the time scheduled for the discussions on COHSEC/DOC 22/2022 to at least half a day. The importance of the topic in our view requires a meeting in person (as set out in Article 4 of the Rules of Procedure for the COHSEC).

Please provide us with the approval by Wednesday eob at the latest, so that we can arrange the duty travel requests in time for the meeting.

With best regards,

David de la Torre
For the COHSEC members nominated by the CSC

The members of the COHSEC nominated by the CSC give the following VOTE and OPINION on COHSEC/DOC 22/2022 on “Adjustments to Health Services (CA/85/22)”:

I. PROPOSED CHANGES

(1) Terminology

The document COHSEC/DOC 22/2022 uses terminology through the text, which is non-harmonized or inconsistent within the document itself or with the Service Regulations. This causes severe ambiguities, both in the proposed changes of the Service Regulations and in the introductory part of the document, to the effect that some of the proposed changes cannot be understood.

We identified the following terms which need clarification:

- “health professional”: This term is ambiguous and seems to refer to a wide range of health related jobs. The term does not occur in the Service Regulations, apart from Articles 11 and 17 of the Data Protection Rules, which restrict “health professional” to those “subject to the obligation of professional secrecy”, i.e., doctors.
- In the proposed Article 89 ServRegs, the term “medical practitioner” seems to refer to any doctors who deliver opinions for the President of the Office. It remains unclear, whether the Occupational Health Physicians are part of such doctors or excluded, also in view of their independence requirement under Article 26c.

We consider that the medical practitioners in charge of the medical opinions must have the formal qualifications of a doctor according to the national law in the respective host Member State(s). For the list of doctors under Article 89(1) ServRegs, they should be specialized doctors according to the national law in the respective host Member State(s)¹. In both cases they must be authorised to practise such regulated professions in the respective host Member State(s)².

- “experts” (also cited as medical experts or health experts): The service regulations only define the “occupational health and safety experts” in Articles 26c, 38a. The implementing Rule of Article 38a also mentions “other experts”.

(2) Description of the status quo / context of the changes

Document COHSEC/DOC 22/2022 makes a rather optimistic analysis of the effect and outcome of previous reforms, notably the reform of 2015. While general criticism of the 2015 reform does not belong to this opinion, we remark that the model for sickness management was readapted at that time, and that some of the current difficulties with reintegration were aggravated with the transition beyond 125 days sick leave adopted with this reform. We also consider the effect of the apparent decrease in the sickness statistics for a relative short period is much more complex than as presented in the summary³. The document itself⁴ shows that the sickness statistics are indeed slightly increasing since 2017.

The proposed document must be seen within the context of the changes to the organisational structure proposed in COHSEC/DOC 5/2022 on “H&S Reorganisation”, to which we gave a negative opinion (see COHSEC/AV 1/2022). The main deficiencies found in that document were:

- further erosion of the position of the occupational health physicians and the occupational health and safety officers, who are currently reporting to non-medical staff in the DG4;
- the merging between the Occupational Health Physician and Medical Advisor roles and resources creating conflicts of interest and
- Data Protection issues.

In our view, the proposed changes to the Service Regulations included in COHSEC/DOC 22/2022 do not successfully address the problems identified in our opinion to COHSEC/DOC 5/2022. While we understand that the intention of the present document is more reduced in scope – mainly the introduction of a seamless sick leave process – the text of the proposed changes introduces new

¹ The doctor selected from the list of doctors should have a speciality related to the nature of the sickness of the patient

² For Member States member of the EU those qualifications are harmonised through Directive 2005/36/EC of the European Parliament and of the Council of 7 September 2005 on the recognition of professional qualifications

³ Furthermore, some adaptations had to be made in the meantime concerning inter alia the removal of the obligation to be available at home during certain daytimes every day of the sick leave absence.

⁴ See p.2, the graphic under §6

elements which will aggravate the problems created with the adoption of the H&S reorganisation. The plans to externalize an important part of the health-related resources in those areas do not contribute to address the detected problems neither.

Also, the present document needs to be seen in context with the fact that the responsibilities of the occupational health physicians, in charge of prevention, reintegration and support to employees, and the responsibilities of the medical advisors, in charge of the opinions for decisions to be adopted by the President (e.g. incapacity) should be separated. It is long understood at the EPO that merging those tasks leads to conflicts of interests, a further erosion of the independence of the Occupational Health physicians and a decrease of trust of EPO staff in the EPO health policy.

From the perspective of the data protection, the EPO has recently adopted with decision CA/D 5/21 a new Data Protection framework, including the EPO Data Protection Rules (DPR), which de facto transposes to the EPO the legal obligations defined by the EU GDPR. The treating of medical data within the seamless sick leave process and for the purposes of medical opinions have already been affected by this new framework, and the present proposal creates new implications within the EPO Data Protection framework.

(3) The seamless sick leave process

With amendments of Article 62a(7)(b) ServRegs, document COHSEC/DOC 22/2022 proposes a seamless sick leave process, which indeed removes the need of a medical opinion for the extension of the first period of sick leave of 125 days. On this aspect of the proposal, a consensus could be found among all members of the Working Group.

We understand that removing the medical opinion would substantially reduce the overall workload of the medical advisory services, which seems to be one of the main motivations for the changes proposed.

The document, however, proposes, in an addition to Article 62(2) ServRegs, regular medical appointments to take place during the three sick leave phases, depending on the employee's health situation. There are no limitations as to the frequency or timing of such appointments. The text also does not clarify the purpose of them. Are they there for absence verification, for treatment or for continuous health checks? Where would these appointments take place? At the Office premises or at the home of the employee? The text also does not make clear if such medical appointments will be made by the Occupational Health physicians or by other practitioners.

In view of such lack of clarity and the absence of limitations to protect the sick staff, e.g., from excessive administrative burden caused by too frequent appointments, we disagree with the changes proposed to Article 62(2) ServRegs.

(4) Incapacity

With the amendments of Article 62b(1) ServRegs, COHSEC/DOC 22/2022 proposes a new procedure for declaration of incapacity and discharge of duties. We have the following comments on this procedure:

- (a) The amended text of Article 62b(1) ServRegs⁵ implies that the declaration of incapacity takes place after reaching the applicable maximum period of sick leave, but with a medical opinion which is issued at a certain moment in time before or after reaching the applicable maximum period of sick leave.

It remains unclear from the text, however, which will be the status of the staff member during the time after reaching the applicable maximum period of sick leave and up to the declaration. Will such declaration be retroactive to the date of reaching the applicable maximum period? This point should be clarified.

As such, the procedure is untransparent for the employee because the medical opinion can be established at any moment, and the employee can not foresee the steps of the procedure to come.

- (b) According to amended Article 89(5) ServRegs, the medical practitioner chosen by the President for writing such medical opinion only informs the President.

⁵ Also clarified during the meeting by the Office's Medical Advisor

As the medical opinion would be issued at a certain moment in time before or after reaching the applicable maximum period of sick leave, the staff member must be informed as soon as a medical opinion is in preparation about the name and contact of the doctor. The employee must also be informed when such medical opinion has been issued and must receive a copy of such medical opinion at the same time.

(c) It should be clarified that the declaration of incapacity under amended Article 62b(1) is indeed a decision of the President. The effects of such decision as well as the means of redress shall be communicated to the employee in writing.

(5) Conflicts of interests – Need to keep both roles separated

The introductory part of the document, in paragraph 24, seems to imply that the opinion for the declaration of incapacity under Article 62b(1) ServRegs would be made, based on the medical observations and the information available – e.g., the information given of the patient –, by the Occupational Health Physician who is supporting the staff member during the reintegration, as soon as the OH physician has sufficient indications that the sick leave period may take the total absence beyond 250 days in a period of 36 months.

While this idea is attractive at first sight, it creates in our opinion, a severe conflict of interest on the Occupational Health Physician, who will be in charge of two incompatible roles:

- advice, support, and prevention of occupational diseases and work-related disorders, the support for the employee's reintegration and the promotion of the health and safety of the employee; in this role, the OH physician must act in the best interest of the patient
- the issuance of opinions for the declaration of incapacity, which has a serious impact:
 - on the employee (administrative situation, reduction of salary) and
 - on the EPO itself (impact on the social security scheme, impact on the work capacity in the department in which the employee is working)

We consider that the impact of the incapacity declaration on the EPO itself is sufficient to create a severe conflict of interests on the Occupational Health physicians. The reduced independence of the Occupational Health physicians in the current and future organisational structure exacerbates even more such conflict of interests. These conflicts of interest are and will be especially acute in view of:

- their wrong hierarchical positioning, not reporting directly to the Site Manager, but to an intermediate layer embedded within HR⁶;
- the job precariousness of future OH physicians;
- the risk of non-renewal of service contracts, in the case of external OH physicians;
- their reduced autonomy to administer resources for the performance of their duties⁷; and
- the application of performance management to OH physicians based on HR-defined criteria.

We note that such conflicts of interest need not necessarily be related to direct financial interests, but may also be associated with indirect, non-financial interests, or they can also be conflicts of loyalty or conflicts in professional duties and responsibilities⁸. We further believe that the OH physicians under the proposed construction would have to declare such conflicts of interest to the employees under reintegration and they likely would have to decline taking part in subsequent medical decisions on incapacity.

For those reasons, we consider that the issuance of medical opinions under such circumstances would further jeopardize the independence of the Occupational Health physicians which is required by law⁹.

(6) Medical opinions

COHSEC/DOC 22/2022 proposes to amend Article 89(1) ServRegs so that the list of doctors for certain cases – i.e., Articles 90(2), 91(2) ServRegs - can be drawn at any time by the President of the Office, and not only every two years.

⁶ See, e.g., §8 of the Gesetz über Betriebsärzte, Sicherheitsingenieure und andere Fachkräfte für Arbeitssicherheit (ASIG)

⁷ See, e.g., §2(2) of the Gesetz über Betriebsärzte, Sicherheitsingenieure und andere Fachkräfte für Arbeitssicherheit (ASIG)

⁸ <https://stephenmccaffreybarrister.com/conflicts-of-interest-guidance-for-doctors/>

⁹ See current Articles 26b and 26c ServRegs

We reiterate our general disagreement with construction of the arbitration procedure (Article 91 ServRegs) and the additional medical opinions (Article 90 ServRegs), as we consider that the points of view and the interests of the employee are not properly guaranteed through such procedures, and we believe that the medical committee¹⁰ was a much better functioning organ as compared to the present situation. The proposed removal of the two-years limitation for the drawing of the list of doctors is considered a further worsening of the system from the perspective of the staff members, as it makes possible for the Administration to quickly substitute those doctors based on undefined criteria, thus weakening their necessary independence.

As indicated above, the medical practitioners in charge of the medical opinions must have the formal qualifications of a doctor according to the national law in the respective host Member State(s). For the list of doctors under Article 89(1) ServRegs, they should be specialized doctors according to the national law in the respective Member State(s). In both cases, they must be authorised to practise such regulated professions in the respective host Member State(s)¹¹.

(7) Medical file

Document COHSEC/DOC 22/2022 – see §33 to §35 of the introductory part – proposes to create a single medical file for EPO employees, instead of the two different medical files that exist nowadays (one for OHS and another one for the MAU).

During the 86th COHSEC meeting, we requested clarifications about the future handling of the medical file(s), which we consider to be essential to understand the scope of the proposal COHSEC/DOC 22/2022. Unfortunately, the Administration was not able to provide us with specific answers on this topic.

We oppose explicitly the merging of medical files which are used for the following two distinct purposes:

- advice, support, and prevention of occupational diseases and work-related disorders, the support for the employee's reintegration and the promotion of the health and safety of the employee; and
- the issuance of opinions for the declaration of incapacity, or other medical opinions under Article 89 ServRegs

We consider that, in any case, before the proposal is adopted, the following should be clarified:

- who would be responsible for the medical file(s) and who would grant access to them (who is the delegated controller under Article 28 DPR)?
- whether the delegated controller under Article 28 DPR is a health professional subject to the obligation of professional secrecy under Member State law or rules established by national competent bodies?
- what would be the content of such file(s)?
- who would have access to it/them (who are the processors under Article 30 DPR)?
- whether such medical file(s) would be internally or externally managed (are there joint controllers under Article 29 DPR)?
- for which purpose the information is collected (Article 4 DPR)?
- which are the compatible purposes of the data collection (Article 6 DPR)?

In our view, the delegated controller of the medical file must:

- be “subject to the obligation of professional secrecy under Member State law or rules established by national competent bodies”¹²;
- have the formal qualifications of a doctor according to the national law in the respective host Member State(s)¹³; and

¹⁰ See Article 89 ServRegs previous to CA/D 2/15.

¹¹ For Member States member of the EU those qualifications are harmonised through Directive 2005/36/EC of the European Parliament and of the Council of 7 September 2005 on the recognition of professional qualifications

¹² See Art. 9 GDPR, compare with Article 11 EPO DPR

¹³ For Member States member of the EU those qualifications are harmonised through Directive 2005/36/EC of the European Parliament and of the Council of 7 September 2005 on the recognition of professional qualifications

- be authorised to practise such regulated profession in the respective host Member State(s).

(8) Processing of medical information

The proposed amendments to Articles 89(3), 89(4) and 89(6) ServRegs have a serious impact on data protection and the processing of medical information, which is regulated under the EPO Data Protection framework.

We strongly disagree with the removal of the employees consent for the consultation of the employee's doctor, as proposed in the new formulation of Article 89(3) ServRegs: The obligation to obtain a previous consent from the employee is an important guarantee of the medical secrecy that cannot be removed for the sake of the purely administrative convenience of the services. It is remarkable that the Administration has not provided any reasons for the removal of such consent so far.

In the same proposed Article 89(3) ServRegs, the addition of “without prejudice to any applicable deontological national rule” is clearly insufficient, as the consultation of medical information of the employee is not merely a deontological national rule, but also defined by law. In our view, the Article should indicate ““without prejudice to any applicable deontological national rule or without prejudice to the obligation of professional secrecy under national law or rules established by national competent bodies”¹⁴.

The newly added Article 89(4) ServRegs specifies that “the medical practitioner may, in exceptional circumstances, take into account inter alia pre-existing medical reports or certificates provided by the staff member to the Office in the context of other medical procedures, as long as they are not outdated, they are necessary and relevant, and their use is compatible with the purpose for which they had been originally provided”. Such Article give to the medical practitioner very wide powers to gather medical information from different internal sources, without clear restrictions.

It was also not possible to obtain information, during the 86th COHSEC meeting, about which “other medical procedures” are meant in this newly formulated Article 89(4) ServRegs. We could also not be informed about who and how the following will be evaluated:

- (i) the compatibility of the purposes,
- (ii) the relevance of the medical reports or certificates, and
- (iii) the up-to-date character of the medical reports or certificates.

It would be welcome if the Administration could clarify that question and in particular, that the following procedures are excluded from such “other medical procedures” and that the medical practitioner cannot access pre-existing medical reports or certificates provided by the staff member to the Office in the context of:

- the procedures under Articles 26c ServRegs for the protection of the health and safety of employees;
- the procedures under Articles 62(1) to 62(7) for sick leave management; and
- the procedures under Article 83a ServRegs and under the Implementing Rules for Articles 83a, 84 and 84 ServRegs, e.g., the framework of reimbursement procedures by CIGNA or cures.

In any case we clearly express that we disagree with the present formulation as proposed in COHSEC/DOC 22/2022. Also in view of the requirements of data secrecy from Member State law, we highly recommend the Office that the evaluation of the compatibility of purposes, the relevance of the medical reports or certificates and their up-to-date character is made by professionals subject to the obligation of professional secrecy under Member State law or rules established by national competent bodies¹⁵.

We don't understand the reasons for the proposed deletion of Article 89(6) ServRegs and the Administration did not give any. Reasons are also not apparent from the introductory part of the document¹⁶. In any case, we disapprove such deletion of a clear right of employees to know the content

¹⁴ See Art. 9 GDPR, compare with Article 11 EPO DPR

¹⁵ See Art. 9 GDPR, compare with Article 11 EPO DPR

¹⁶ We would have welcome in the 86th meeting of the COHSEC that the discussions had not been prematurely interrupted and that we could have discussed this point.

of the medical information recorded or used in the course of preparing the medical opinion¹⁷. Even if the Administration would be of the opinion that Article 18 of the Data Protection Rules has made 89(6) ServRegs redundant, we consider that such right to consult the medical file should be explicitly reiterated in Article 89 ServRegs.

(9) Mixed internal-and-external-sourcing service delivery

One of the purposes of COHSEC/DOC 22/2022 – see §28 to §32 – is to strengthen the mixed internal-and-external-sourcing service delivery model. We can't really identify such a strengthening from the proposed changes of the Service Regulations, but we agree with the reasons given by the members of the COHSEC Working Group nominated by the CSC for providing health services by internal staff:

- Internal staff is more committed to the mission of the EPO;
- Internal staff knows best the Office, e.g., site specific problems, internal processes and all aspects of the organisation (shared view of staff representation and health experts);
- Internal staff guarantees the quality and continuity of health services and surveys the quality external providers (shared view of staff representation and health experts);
- Internal staff safeguards data protection in a simple manner (shared view of staff representation and health experts); and
- external labour market for external health experts is difficult (shared view of staff representation, health experts and MercerMarsh).

We have certainly noticed that, in parallel to the running of a specific Working Group, the administration has been running different tenders for different health-related services in the occupational health area. We wonder why the COHSEC has not been provided with information about such tender procedures, which would have brought some better understanding of the present proposal, of its scope and other constraints.

(10) Consultation

We don't share the understanding that long discussions have to be avoided at all costs during the COHSEC meetings. While preparatory discussions within the context of Working Groups should happen, discussions on specific matters must also take place within the COHSEC, to make sure that the proposals lead to sound changes which are conducive to the Health and Safety of staff. We welcome very much, from this perspective, the few specific questions which were exchanged during the meeting, although we got the impression that the discussions on many of the topics were not finalised when the discussion was hastily closed after short 45 minutes of exchanges.

In addition, we notice that most details in the text to be adopted were not discussed within the COHSEC Working Group on the health reform and therefore the discussion which took place in the 86th meeting of the COHSEC was insufficient.

II. **CONCLUSIONS AND WAY FORWARD**

Because of the little time foreseen for the discussions in the COHSEC, and the premature conclusion of the discussions, we conclude that the Administration is not interested in a genuine consultation of the COHSEC. Many of the topics in the document were not discussed sufficiently. That leads to unclarity in the final legal text.

We request therefore to resubmit the document to the COHSEC for final consultation, once the deficiencies identified within this opinion are addressed.

In conclusion, for all the reasons and arguments set out above, the CSC members of the COHSEC give a negative vote and opinion on COHSEC/DOC 22/2022.

The Members of the COHSEC nominated by the CSC

¹⁷ Excluding staff member's access to the medical file appears to be not in line with the ILOAT Jurisprudence, see for example Judgment no. 4260, considerations 2.

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By e-mail

Your open letter on CA/85/22 of 11 November 2022

Dear Mr Dumont,

Reference is made to your open letter concerning the adjustments to the health services (CA/85/22) sent on 11 November 2022.

First, please be assured that the Office has taken note of all your comments, especially the proposed adjustments. These elements have been subject to the ongoing information and consultation process of the COHSEC on 14 November 2022 and the upcoming GCC consultation today.

Second, as you know, the health of our staff is our priority. Our employees are the driving force behind the EPO and its achievements, and they are at the heart of our People strategy. This approach has not changed with the Office's proposal in CA/85/22. In fact it aims to optimise our support for sick staff. We would therefore like to clarify the essence of the proposed regulatory changes.

Seamless sick leave process

The Office wants to streamline the sick leave process across the three stages of sick leave, extended sick leave and incapacity. This is based on the experience of our health professionals over the past years, and enhanced by feedback from staff. The adjustments abolish the medical opinion at the cut-off date of the extended sick leave status at 125 days of sick leave. In fact, the change of status will occur automatically when 125 days of sick leave have been reached.

A medical opinion will still be required to determine whether an employee fulfils the condition of incapacity. This opinion can be issued as soon as the medical practitioner has sufficient indications that the sick leave period may

take the total absence beyond 250 days in a period of 36 months, and not necessarily exactly at the moment when the employee reaches the 250 days of sick leave.

These modifications will simplify the sick leave process and enable our team of Occupational health experts to assist and better support staff during the whole period of sickness. The Occupational health experts can flexibly arrange medical consultations with sick staff through the whole sick leave period.

It needs to be stressed that the independence of our health professionals remains guaranteed and enshrined in our regulations. The possibility to seek an additional medical opinion in case of disagreement or call for an arbitration procedure also continue to exist for our employees.

Data privacy

The protection of personal data, and data protection oversight mechanisms are integral to our legal framework. The proposed amendments in the relevant provision under Article 89 ServRegs clarify and strengthen data protection, providing more legal certainty.

Regarding access to medical records, the Data Protection Rules have established this right of the data subject, which has also been confirmed by ILOAT case law. The concerned staff member can always exercise this right before the Office or before the medical practitioner.

COHSEC working group

The mandate for the working group was presented to the COHSEC of 23 February 2022. In total 8 meetings took place between April and September 2022 on the agreed subjects in a collaborative atmosphere. The COHSEC was regularly updated on the proposed changes, and discussed them thoroughly. The final recommendations of the working group were presented to the COHSEC in the meeting of 24 October. In particular the recommendation related to the seamless sick leave process was supported by all members of the working group and, subsequently, integrated in the proposal to amend the regulations in CA/85/22. In sum, comprehensive and intense discussions in the COHSEC have taken place before submitting the proposed changes to the consultation procedure.

We trust this letter further clarifies the Office's proposal and look forward to further constructive exchanges on the matter.

Yours sincerely,

António Campinos