About the BMA
The British Medical Association (BMA) is an apolitical professional association and independent trade union, representing doctors and medical students from all branches of medicine across the UK and supporting them to deliver the highest standards of patient care. We have a membership of over 154,000, which continues to grow each year.
Background to the dispute

The BMA entered negotiations with NHS Employers (NHSE) for a new junior doctors’ contract in October 2013. This was the first invitation to negotiate the contract for a decade. Junior doctors had themselves identified many areas where they felt the contract could be improved and promote the modern NHS. In October 2014, after a year of negotiating, contract talks stalled over concerns about safety for patients, and that doctors’ welfare was not being effectively considered by NHSE. The negotiations were then referred to the Review Body on Doctors’ and Dentists’ Remuneration (DDRB) which was asked to make recommendations on changes for contractual arrangements for doctors in England, Northern Ireland and Wales, which would enable the delivery of seven-day services, something previously outside of the DDRB’s remit. For juniors in Scotland, they were asked to just make observations.

The DDRB report was published on 16 July 2015¹, coinciding with a speech the Secretary of State made which set out an ultimatum to the medical profession to re-enter contract negotiations² on the consultant and junior doctors’ contract or face imposition of new contracts.

The BMA has been clear about our support for better seven-day hospital services, with a focus on urgent and emergency care, but we do have concerns over how extended services will be paid for, staffed and what guarantees can be made to ensure current services do not suffer. Junior doctors already work to provide care 24 hours a day, 7 days a week. There is no ability for junior doctors to opt out of weekend services.

On 10 September the BMA consultants committee took the decision to re-enter negotiations.

On 13 August, the BMA junior doctors committee took the decision not to re-enter negotiations. Despite significant concerns raised about the DDRB’s recommendations, it was made clear that failure to accept those recommendations as the basis for talks would result in the government imposing a contract on junior doctors from August 2016. The threat of imposition created an atmosphere in which a fair, negotiated settlement would be impossible to reach. BMA members felt that the proposals in the contract were unsafe for patients and unfair for doctors.

The BMA has been clear that we would like there to be a fair, negotiated settlement, however before negotiations can recommence for junior doctors, we need the following concrete assurances from the government:

- Withdraw the threat of imposition
- Proper hours safeguards protecting patients and their doctors
- Proper recognition of unsocial hours as premium time
- No disadvantage for those working unsocial hours compared to the current system
- No disadvantage for those working less than full time and taking parental leave compared to the current system
- Pay for all work done


On 8 October, the Secretary of State for health wrote to Dr Johann Malawana, chair of the BMA junior doctors committee, recognising the vital role that junior doctors play as medical leaders of tomorrow and acknowledging the points above, however, he refused to give the concrete assurances which the BMA have requested. Much of the subsequent detail that has been discussed in the news, was never fully outlined as part of the previous negotiation process.

**What is a junior doctor?**

Junior doctors in the United Kingdom are those in postgraduate training towards becoming a Consultant, a General Practitioner, or some other non-training post. It takes, on average, between 5 and 10 years (longer if the doctor goes less than full time, undertakes vital academic research, takes parental leave or changes their specialty, for example) to become a specialist in a particular area of medicine.

Junior doctors graduate from medical school with provisional registration with the General Medical Council (GMC). They complete their training under the supervision of consultants against curricula determined by the GMC. They routinely work 7 days a week, with many often working punishing rotas over nights and weekends. Their basic starting salary is just over £22,636, and many aspects of their ongoing training are often paid for from the junior doctor's own pocket.

**Key issues and concerns about the proposed contract**

**Removal of vital hours safeguards**

The current contract provides a safety net to prevent junior doctors from working dangerously long hours, called the banding system. This provides financial levers to ensure that excessive hours cannot be worked. The hours juniors work are monitored, and if they work over their rostered hours they can be entitled to supplementary payments. This was a mechanism introduced in 1999 when NHS trusts were routinely breaking the law with unsafe practices by pushing junior doctors to work excessively long hours. This created patient safety concerns as a result of tired and overworked doctors. NHSE proposals are to remove this safety net without a robust replacement which is likely to mean a reversal back to practices last seen in the 1990s that were extremely unsafe for patients and the doctors that were caring for them.

It has been suggested that employers will just be expected to follow the law on Working Time Regulations (WTR) which, unlike the current mechanism, does not impose a financial penalty on employers that breach it. With no penalties for employers making doctors work long hours without sufficient breaks, the BMA believes we will simply go back to the previous problems we had with overworked doctors making dangerous decisions – a huge and obvious risk to patient safety. In his letter of 8 October the Secretary of State said he would give “an absolute guarantee” that this contract would not impose longer hours, but we are yet to see a proposal for a system that can be as effective as the current banding payments.

**Extension of plain time**

Under the current juniors’ contract, hours worked between 7am and 7pm Monday to Friday is paid at a basic rate. Junior doctors routinely work outside of this, providing patients with high quality care around the clock, and rightly receive a pay premium for these hours as part of their banding supplement. This reflects the impact that working evenings, nights, Saturdays and Sundays has on personal and family life. It also ensures that there is no financial disincentive for juniors who choose to work in specialties like emergency medicine, maternity services and intensive care which require a high proportion of out of hours working. The government wants to expand plain time to 7am to 10pm Monday to Saturday, meaning that an hour worked at 9pm on a Saturday would be worth the same as 9am on a Tuesday. We are concerned that the proposed system will not value doctors’ time appropriately.

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3 Department of Health (October 2015), *Health Secretary Jeremy Hunt writes to JDC Chair Johann Malawana*
With a workforce that is majority female and has over 30% of doctors married to other healthcare staff, we are seriously concerned about how families with young children will juggle childcare and other obvious family pressures. With a potentially significant cut in salaries for doctors, and the resulting likely rise in childcare costs, we can see a situation where fewer doctors can return to the medical workforce following having children. This could have a negative impact on recruitment and retention as well as participation rates. We believe this could result in a substantial loss of medical staffing whole time equivalent time. Whilst we acknowledge that the Secretary of State has recognised the issue of increasing plain time for Junior Doctors in his letter of 8 October we cannot accept that work on Saturdays and late evenings can be considered as the same as daytime on a weekday, simply because the knock on effects are so significant and will result in an undeliverable service in many areas of medicine.

We are also concerned that if it costs less to employ a junior doctor during evenings and weekends, over the longer term, employers may start seeing junior doctors as a cheap way of staffing ‘seven-day services’, meaning they may end up working fewer hours during the day and more hours at the evening and weekends. Since training opportunities in many specialties tend to be during daytime hours, this could have a knock on effect on the delivery of curricula and training for doctors. This could result in negative consequences for delivering the long term trained workforce.

**End to current pay progression arrangements**

At the moment junior doctors’ pay rises automatically each year in recognition of the experience they have gained over that time. The DDRB recommendations around pay set out the principle that progression will be based on stage of training and level of responsibility. This would see trainees, who currently go through up to 11 levels of training, put into just six pay grades. This would mean that doctors might be on the same pay grade, and earning the same salary, for three years (or more if you are in less than full-time training), despite the experience gained during this period. The BMA is concerned that the proposal will discourage some people from entering medical training, particularly those who wish to have families, because of the financial worries of taking time out of training for maternity leave or to work part time. It will also discourage those already in training from undertaking research or retraining in a more suitable specialty to the long term detriment of the NHS.

**Strength of feeling amongst the medical profession**

The medical profession has reacted strongly to the threat of an imposed contract and feel that their professionalism and dedication has been called into question. This is at a time when NHS staff, as highlighted by the recent grass roots social media campaign[^4^], are already providing a first-class service, every day of the week, and are, in the words of the NHS England chief executive, propping up the service with their goodwill.

Junior doctors have themselves, without any central suggestion or coordination, organised rallies and protests as a result of the government’s announcement to impose a contract further demonstrates their sense of indignation. The rhetoric since the Secretary of State’s speech in July 2015 has resulted a huge loss of confidence amongst junior doctors for their long term futures in the NHS. The goodwill and trust once lost, may never fully be recovered. This could have an obvious impact on the ability to deliver any meaningful reforms as doctors disengage from government initiatives.

**Industrial action**

Following the UK government’s decision to impose a potentially unsafe and unfair contract on junior doctors in England, and the strength of feeling highlighted above, the BMA junior doctors committee has voted to ballot its junior members in England for industrial action.

This is not a decision taken lightly, and we are fully aware of the implications, but such is the strength of feeling – not only within the BMA junior doctor committee, but also from junior doctors across the country – that we believe that this is the right thing to do to defend the current and next generations of junior doctors. Ballot papers are scheduled to go out to doctors on 5th November.

Answers to key questions about the dispute

How will this impact an individual junior doctor?
Junior doctors are understandably worried about the impact the new contract proposals could have on their lives. Many have significant financial responsibilities and commitments, like families, rent and/or mortgages, so a sudden pay cut could be disastrous. We are unable to calculate exactly how individual doctors may be affected as NHSE refused to provide robust data modelling which would enable us to establish accurate and detailed estimates of how it would affect pay.

It is important to note that the potential for cuts in pay is just one part of the reason for junior doctors’ anger at these proposals. Many report already feeling undervalued and overworked, so facing pressure to deliver more for less is extremely demoralising. The constant perceived attacks in the press by the Department of Health has had a considerable impact on the morale of junior doctors. Junior doctors are dedicated professionals who care first and foremost about the safety of their patients — and they are worried that this will be put at risk if they have to work dangerously long hours. Juniors are also rightly worried about the impact of these proposals on their personal and family life. Evenings and weekends are precious opportunities to spend time with friends and family.

If the overall pay bill is staying the same how can junior doctor pay go down?
The combination of the removal of banding payments and an increase in plain time hours means that trainees who do a lot of out of hours work may see their pay fall considerably, despite a rise in basic pay as proposed. The specialties that will be hardest hit, will be the specialties that we are absolutely desperate to attract trainees for, such as emergency medicine, maternity and paediatric services.

One further proposal from the DDRB is to consider the use of pay premia to incentivise hard-to-fill specialties. However, these premia would be outside of any contract and could be removed over time. They would also be funded from within the current junior doctors’ pay envelope which means that they could only be funded by cutting the pay of other trainees elsewhere.

Why could women be disadvantaged by the proposed contract?
The proposals mean that pay will no longer match the experience junior doctors’ gain through their training. At the moment trainees’ pay rises each year in recognition of the experience they have gained. Removing this will impact on trainees who take time out of training, for reasons such as parental leave — something that will disproportionately affect women — because it will take them longer to progress to the next level. Pay progress would also be slower for those who train less than full time — 80% of whom are women. As previously highlighted an increase in plain time has also a potentially significant financial consequence on childcare costs for doctors with young children.
How will the proposed contract impact on shortage medical specialties?

Regarding proposals on pay for doctors who chose to go into general practice, the government wants to remove a supplement which guarantees GP trainees receive the same pay – on average – as hospital trainees, and replace it with a discretionary payment which, by definition, and can be removed at any point. This has also been mooted to be allocated as different amounts geographically, which could cause a lot of disruption and confusion. This adds an element of uncertainly and insecurity over pay when considering whether or not to choose to become a GP. This would be a disaster for general practice at a time when we’re already struggling to recruit enough GPs.

Changes to pay will reduce the amount that doctors receive for evening and weekend work, meaning junior doctors in specialties which involve a greater amount of evening and weekend work, such as emergency medicine, maternity services, intensive care medicine and paediatric services, could be left worse off, therefore making these specialties less attractive.

Crucially, the government could not provide us with any detail or modelling of how their proposed changes would impact on different groups of doctors and by how much. Doctors cannot be asked to sign up in the dark to changes without understanding how they will be affected.

Won’t a decision to take industrial action put patients at risk?

Patients are doctors’ first priority and they would never compromise the safety and welfare of patients. That’s why we are objecting so strongly to these proposals, we think they will compromise the quality of patient care and safe working in the long term. No doctor takes the possibility of industrial action lightly, but junior doctors feel backed into a corner. Unless the government drop the threat of imposition and provide the necessary assurances we need on key issues junior doctors will be left with very few options.