

BMA policy book 2021-2022

British Medical Association
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(The date in brackets is the year in which the policy was made by the Annual Representative Meeting)

	ABORTION
1.	<p>On July 6th a Health Minister in the Commons announced a public consultation on the continuation of home use of mifepristone with remote consultation support for abortion, which had been agreed as a temporary measure in response to the COVID pandemic.</p> <p>This house urges the BMA to support continuation of these remote services post pandemic which are in line with best global practice and benefit women, particularly those at risk of domestic violence</p> <p>(2020)</p>
2.	<p>That this meeting insists that women accessing lawful abortion services and the staff providing those services: -</p> <p>i) should not be subject to intimidation;</p> <p>ii) should be provided with protestor free buffer zones outside abortion clinics.</p> <p>(2019)</p>
3.	<p>That this meeting condemns the fact that women in Northern Ireland are currently being discriminated against in their inability to access safe and legal abortions in Northern Ireland.</p> <p>This meeting: -</p> <p>i) notes with alarm that in 2016/2017 only 13 abortions were performed in Northern Irish hospitals compared to 861 abortions for Northern Irish women and girls in hospitals on mainland UK in 2017;</p> <p>ii) calls on the UK government to repeal sections 58 and 59 of the 1861 Offences Against the Person Act;</p> <p>iii) calls for the repeal of section 25 of the Criminal Justice Act (Northern Ireland) 1945.</p> <p>(2019)</p>
4.	<p>That this Meeting:-</p> <p>i) supports the universal availability of non-directive counselling for women considering abortion;</p> <p>ii) deplores picketing and intimidation around abortion services.</p> <p>(2012)</p>
5.	<p>That this meeting:-</p> <p>i) supports the principles set out in part three of the February 2017 BMA discussion paper on decriminalisation of abortion;*</p> <p>ii) believes that abortion should be decriminalised in respect of health professionals administering abortions within the context of their clinical practice;</p> <p>iii) believes that abortion should be decriminalised in respect of women procuring and administering the means of their own abortion</p> <p>vi) believes that abortion should be regulated in the same way as other medical treatments.</p> <p><i>*(Footnotes)</i></p> <p><i>'1. Abortion must only be permitted in cases where the woman gives informed consent, or in cases where the woman lacks capacity and an abortion is determined to be in her best interests.</i></p> <p><i>2. Health professionals must have a statutory right to conscientiously object to participating in abortion.</i></p> <p><i>3. There should be a central collection of abortion data (subject to agreed appropriate confidentiality protections) to ensure future services are fit for purpose.</i></p> <p><i>4. There must be clarity about what is, and what is not, lawfully permitted, so that health professionals are clear about the scope of their clinical discretion.</i></p> <p><i>5. There should be robust clinical governance in settings where abortion care is provided.</i></p> <p><i>6. There should be the continuation of some degree of regulation and the setting of professional standards in the provision of abortion services'.</i></p> <p>(2017)</p>

6.	<p>That this Meeting:</p> <ul style="list-style-type: none"> i) acknowledges that abortion can be a psychologically traumatic process for women; and ii) urges the BMA to campaign for increased counselling and support for women before and after this procedure. <p>(2008)</p>
7.	<p>That this Meeting calls for legislation to be amended so that first trimester abortion would be available on the same basis of informed consent as other treatment and therefore without the need for two doctors' signatures. That this Meeting believes that changes in relation to first trimester abortion should not adversely impact upon the availability of later abortions.</p> <p>(2007)</p>
8.	<p>That this Meeting deplors moves by South Dakota, USA to re-criminalise abortion for women who have been subjected to rape and incest and for mothers whose health may be adversely affected by continuance of the pregnancy and further to actively pursue prosecution of doctors performing these procedures. This constitutes a significant retrograde step in public health policy, damaging both mental and physical health and resulting in unmonitored, potentially dangerous 'back-street' abortion clinics as the only option for women seeking abortion. This Meeting calls for the BMA to work closely with American health care organisations to highlight the possible catastrophic and adverse effects of such a policy.</p> <p>(2006)</p>
9.	<p>That this Meeting calls upon the MSC and BMA to work with the GMC, NHS and appropriate Royal Colleges to ensure that babies born alive as a result of termination of pregnancy procedures receive the same full neonatal care as that available to other babies.</p> <p>(2004)</p>
10.	<p>That this Meeting deeply regrets that women in Northern Ireland are denied access to the same abortion services available to women in the rest of the UK and requests that the government increase their efforts to ensure this anomaly is rectified as soon as possible.</p> <p>(2003)</p>
11.	<p>That this Meeting maintains the right of a patient requesting termination of pregnancy to receive balanced medical counselling addressing all aspects of her problem from her chosen medical practitioner, irrespective of the conscientiously held beliefs of that practitioner. Thereafter she is entitled to receive a second opinion if she wishes and the doctor is bound to comply. Unreasonable delay which compromises the interest of the patient is contrary to good practice.</p> <p>(1992)</p>
12.	<p>That the inalienable right of doctors to conscientious objection to termination of pregnancy be upheld.</p> <p>(1992)</p>
13.	<p>That this Meeting agrees that in other than the most extreme cases, 24 weeks should be the upper limit for termination of pregnancy, and the figures show that this has already been achieved. It believes that to change the law now may pose legal and professional hazards for doctors.</p> <p>(1988)</p>
14.	<p>That this Meeting urges the BMA actively to pursue its policy of support for the extension of the 1967 Abortion Act to Northern Ireland.</p> <p>(1984, reaffirmed 1985)</p>

15.	That this Meeting deplores the persistent attacks on the 1967 Abortion Act and reaffirms its belief that it is a practical and humane piece of legislation. (1978)
16.	That the BMA is absolutely opposed to confidential information relating to therapeutic abortion being made available to others than the CMO except with the consent of the patient, or for bona fide research purposes, or upon order of a court of law. (1968)
ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)	
17.	That this Meeting deplores the continually growing rates of sexually transmitted diseases within the United Kingdom. We therefore: (i) welcome the start of the DH national TV advertising campaign promoting Safer Sex amongst young people; (ii) regret the cut of funds for the advertising campaign from £50 million to £7.5 million; (iii) acknowledge that whilst prevention is better than cure, a national expansion of GUM services is needed to cope with the increasing demand. (2007)
18.	That this Meeting expresses grave concern at the high concentration of poverty and HIV/AIDS in many developing countries, particularly in sub-Saharan Africa and calls upon the BMA to: (i) work closely with the Medical Foundation for AIDS and sexual health in promoting UK awareness of this global crisis, particularly the link between HIV/AIDS and poverty; (ii) work with medical associations in the countries concerned on developing lobbying strategies to influence their governments' policies on addressing these problems. (2003)
19.	That this Meeting believes that, in the absence of a vaccine or cure, education is the best weapon we have against the rapid spread of HIV and removing prejudices. This Meeting therefore calls upon the government to ensure young people receive proper use sex education in line with good medical practice. (2003)
20.	That this Meeting urges the BMA to seek to abolish the perceived stigma attached to HIV/AIDS thereby encouraging openness, increased detection and reduced transmissions. (2003)
21.	That this Meeting calls on the Government to ensure that the funding for HIV/AIDS treatment, prevention and education be protected in real terms. (1997)
22.	That this Meeting recommends that all HIV positive medical staff should be allowed identical rights, confidentiality and counselling as are afforded to HIV positive patients. (1993)
23.	That it be emphasized that doctors are at much greater risk from HIV positive patients than are patients from HIV positive doctors. (1993)
24.	That the Representative Body insists that all pregnant women should be offered routine screening for HIV antibodies. (1991)

25.	That access to health care provision should be protected for HIV positive patients. (1990)
26.	That this Meeting considers that all doctors who are testing for HIV antibodies should counsel the patient to allow his general practitioner to be notified of the result, except that there may be individual clinical circumstances where a doctor believes that in the best interests of a particular patient it is necessary to depart from this general rule. (1988)
	ADVERTISING
27.	That this Meeting calls for the BMA to lobby the government to prohibit organisations involved in healthcare delivery from promoting alcohol or tobacco. (2007)
28.	That this Meeting should call for bans on the advertising of unhealthy food and drink to children. (2006)
29.	That this Meeting congratulates those sports, sports-persons, sports teams and governments that have successfully broken their addictions to tobacco sponsorship. (2005)
30.	That this Meeting regrets the inaction of the government in adopting new graphic pictorial warnings on all tobacco products sold in the UK and calls on the BMA to lobby government for the introduction of these powerful warnings on UK tobacco products immediately, mirroring the lead of the Irish and Belgian governments. (2005)
31.	That this Meeting fears that some forms of advertising may be contributing to an increase in the incidence and prevalence of anorexia nervosa. It calls for greater responsibility in the use of such images in the media. (1998)
32.	That this Meeting is concerned that unacceptable levels of alcohol is present in some of the drinks which are aimed at the teenage market and believes that the deliberate targeting of this group by purveyors of alcohol should be made illegal. (1997)
33.	That the Association, while recognising the need to inform patients about medical services, strongly opposes advertising by doctors. (1989)
34.	That this Meeting deplores the widespread increase in surgery "by advertisement", e.g. fertility and laser therapy clinics, and believes that there should be proper safeguards and rigid control of same, including other commercial interests. (1983)
35.	That this Meeting sees no objection to a doctor allowing his name to be published in support of any public cause or campaign provided that he is acting in good faith and is not seeking any personal professional advantage. (1968)

	ALCOHOL
36.	That this meeting asks the BMA should lobby the government to ban supermarkets selling alcohol as a loss leader. (2018)
37.	That this meeting calls on all 4 UK governments to focus leadership and resources to address the consequence of alcohol use in pregnancy causing foetal alcohol syndrome by:- i) elevating public awareness of the risks of alcohol in pregnancy; ii) enhancing the labelling of alcohol products with respect to the risks of alcohol in pregnancy; iii) providing reliable information to all women with respect to the risks of alcohol in pregnancy; iv) providing improved services and referral pathways for diagnosis, management and support regarding foetal alcohol syndrome for all families and children. (2015)
38.	That this meeting deplores that the government reneged on their promise on the minimum pricing of alcohol. We congratulate the BMA on its continued campaign on this issue and notes with dismay the lobbying activities of the alcohol industry. (2015)
39.	That this Meeting:- i) applauds the action of the Chair of BMA Council in establishing a petition with the Alcohol Alliance to impose a minimum unit pricing of alcohol; ii) continues to advocate for a minimum unit pricing of alcohol as is planned in Scotland. (2013)
40.	That this Meeting, with regard to the UK government policy on alcohol, this Meeting: (i) calls for the abandonment of the failed "responsibility agreements" relying on the drinks industry to promote responsible drinking; (ii) instructs the BMA to raise awareness of the increased risks related to alcohol consumption during pregnancy and increased incidence of foetal alcohol syndrome; (2012)
41.	That this Meeting calls on the UK governments to acknowledge the seriousness of the risks posed to the health of the nation by alcohol and the unsustainable burden this places on public services, including the NHS, by acting as a matter of urgency to introduce wide-ranging measures including:- i) restricting licensing hours; ii) introducing a realistic minimum price per unit. (2011)
42.	That this Meeting expresses grave concern about the ongoing high levels of alcohol related health and social damage in this country, and: (i) exhorts the BMA and government to consider further measures to educate the population and encourage sensible and appropriate drinking; (ii) supports a rise in the cost of alcohol as a method of reducing alcohol consumption in the home, in public places, and by children;

	<ul style="list-style-type: none"> (iii) supports a rise in the cost of alcohol as a method of supporting traditional pubs which can, at their best, be a vital part of our social fabric; (iv) demands a complete ban on alcohol advertising; (v) calls for a properly enforced ban on drunkenness on public transport. <p>(2010)</p>
43.	<p>That this Meeting deplores the increasing burden of alcohol-related diseases and complications on our nation's health. We:</p> <ul style="list-style-type: none"> (i) support the introduction of a minimum price for a unit of alcohol; (ii) believe that a minimum pricing strategy would not unduly disadvantage responsible alcohol consumers; (iii) call for all alcoholic beverages to have clearer labelling indicating alcoholic content and unit value; (iv) call on the BMA to lobby government for a total ban on alcohol advertising in the media; (v) demand that revenue obtained from increased prices should be used for the prevention of alcohol misuse and the rehabilitation of alcohol abusers. <p>(2009)</p>
44.	<p>That this Meeting recognises the growing problems of excessive alcohol consumption and of binge drinking in society and:</p> <ul style="list-style-type: none"> (i) congratulates the Board of Science for its expert production of the 2008 report on "Alcohol Misuse: tackling the UK epidemic"; (ii) believes that government has failed to devise a coherent and effective strategy to tackle alcohol abuse; (iii) calls for graphic images, similar to those on cigarette packets, on all alcoholic beverages, and on posters displayed in bars and pubs; (iv) calls for soft drinks to be significantly cheaper than alcoholic drinks; (v) calls for government to make units per drink a mandatory requirement on alcohol drink labels and on bar taps; (vi) calls on government to invest in services for the treatment of alcohol dependency. <p>(2008)</p>
45.	<p>That this Meeting believes that the rise in alcohol-related morbidity and mortality is extremely worrying and calls for:</p> <ul style="list-style-type: none"> (i) a national roll-out of local schemes to outlaw the consumption of alcohol in public streets; (ii) an increase in funding of services designed to treat alcoholism and alcohol-related illnesses; (iii) doctors to lead by example in changing both attitudes and behaviour with respect to misuse of alcohol; (iv) an increase in taxation on drinks containing alcohol, with taxation proportionate to the amount of alcohol in the product; (iv) advertising on alcohol to cease to be considered a business expense reclaimable against tax; (v) the BMA to produce a report on the effects of alcohol in society to include the health effects of binge drinking and the effects of alcohol on the young. <p>(2007)</p>
46.	<p>That this Meeting believes that alcohol and alcoholism are major problems in society and calls on the BMA to:</p> <ul style="list-style-type: none"> (i) call for more alcohol awareness campaigns and teaching in secondary schools and universities; (ii) promote destigmatisation of alcohol dependence in the medical profession; (iii) work to change public attitudes on alcohol consumption and alcoholism. <p>(2006)</p>

47.	That this Meeting calls on the government to provide statistics on the effect of increased opening hours on binge drinking. We support the select committee call to disband happy hours and this should be effected within existing legislation without delay. (2005)
48.	That this Meeting is concerned about the proliferation of sweetened, flavoured spirits sold in pre-dispensed shot glasses. (2002)
49.	That this Meeting calls for tough action to protect children from the dangers of alcohol. (1999)
	ALTERNATIVE THERAPIES
50.	That this Meeting believes that, in the absence of valid scientific evidence of benefit: (i) there should be no further commissioning of, nor funding for, homeopathic remedies or homeopathic hospitals in the NHS; (ii) no UK training post should include a placement in homeopathy; (iii) pharmacists and chemists should remove homeopathic remedies from shelves indicating they are 'medicines' of any description, and place them on shelves clearly labelled 'placebos'. (2010)
51.	That this Meeting urges the government to require by legislation that gullible or vulnerable patients who may wish to consider the purchase of 'complementary' or 'alternative' healthcare products or treatments have their interests protected by the requirement that terms such as 'toxins'; 'detox'; 'natural aid'; 'energy' etc be banned from marketing material unless and until they are defined and proven on a rational evidence basis. (2009)
52.	That this Meeting with regard to complementary and alternative therapies: (i) calls for the BMA to compile and produce guidance for clinicians on all currently available complementary and alternative therapies, with graded evidence for specific clinical areas or problems; (ii) calls for the Board of Science to work with organisations and charities to encourage and produce validated research into complementary and alternative therapies that have little evidence available, particularly with regards to efficacy and safety; (iii) believes that all complementary therapies should be regulated to the same standards expected of the medical profession and have an independent regulatory body; (iv) calls for an outright ban on the use of NHS resources to fund unregulated therapies, whose associations choose not to join the Complementary and Natural Healthcare Council; (v) calls upon the National Institute for Health and Clinical Excellence (NICE) to review and report on the cost effectiveness of homoeopathic remedies and to recommend whether they should continue to be funded by the NHS. (2008)
53.	That this Meeting believes that complementary therapy should be regulated by statutory authority. (2004)
	ARMED FORCES

54.	That this meeting condemns the gagging of the BMA Armed Forces representatives serving as reservists and calls upon the MoD to urgently review the policy of preventing a reservist expressing any opinion on government matters. (2019)
55.	That this meeting notes that a majority of senior doctors and dentists in the Armed Forces have stated an intention to leave the Services due to the disproportionate impact that taxation rules on Annual Allowance have on Armed Forces doctors and calls upon the BMA to lobby both MoD and Treasury to take urgent action to prevent this outflow. (2019)
56.	That this meeting is dismayed to note that, despite the motion passed by this Body in 2017, military primary care still regularly sees compromised patient safety, breaches of confidentiality and postponed appointments as a result of failures of the military IT system. This meeting calls upon the Surgeon General's Department to take responsibility for these failings and the consequences thereof. (2018)
57.	That this meeting requires the BMA to request that Defence Medical Services research is fully supported to ensure that military clinicians are able to provide the best medical care to patients on and off operations, both now and into the future. (2017)
58.	That this meeting requires the BMA to ensure that junior doctors within the Defence Medical Services are not disadvantaged against civilian junior doctors employed in the same department. This specifically includes, but is not limited to, ensuring that military junior doctors:- i) have access to the guardian and exception reporting; ii) are not allocated more out of hours work than civilian counterparts; iii) are not used disproportionately to cover gaps in rotas shared with civilian junior doctors; iv) are appropriately remunerated for extra hours worked in a manner akin to civilian junior doctors. (2017)
59.	That this meeting calls upon the Ministry of Defence to explore and implement all possible financial incentives to resolve the staffing crisis within the Defence Medical Services Reserves. (2015)
60.	That this meeting welcomes the return of military units from Afghanistan with cessation of military activities in that theatre of conflict but calls for appropriate and sustained long term funding to provide medical, psychiatric, psychological, physical and prosthetic support for the veterans. (2015)
61.	That this Meeting believes that serving Armed Forces personnel who have reached their pension lifetime allowance should receive their salary unabated. (2013)
62.	That this Meeting recognises the recent announcement by the Royal Navy regarding redundancies of medical staff and mandates the BMA Council and the Armed Forces Committee to:- (i) liaise with the Royal Navy and Ministry of Defence to establish an optimal outcome in the current economic climate minimising unnecessary loss of skilled staff;

	<p>(ii) achieve this in part by encouraging the option of interforces transfer from those on the redundancy list.</p> <p>(2012)</p>
63.	<p>That this Meeting urges the NHS to consider the looming problem of the continued support for veterans, and in particular amputees with expensive prostheses.</p> <p>(2012)</p>
64.	<p>That this Meeting is extremely concerned by the chronic understaffing in the Defence Medical Services in specialties crucial to supporting the Armed Forces overseas and in the UK and calls on the MoD to ensure that staffing in the DMS is appropriate to the task required of them.</p> <p>(2011)</p>
65.	<p>That this Meeting commends the three single services in placing all the General Duties Medical Officers who had benchmarked into GP or Specialist training posts this year but deplores the inconsistent career management of junior doctors in the Defence Medical Services. We urge the Ministry of Defence to introduce a clear career pathway that takes into account their military role and medical training needs to ensure that those applying for specialty training posts in the DMS are not disadvantaged compared to their NHS counterparts.</p> <p>(2011)</p>
66.	<p>That this Meeting believes that military junior doctors working in a NHS trust are owed a duty of care by that trust including support, ongoing education and flexibility to aid easier integration back into NHS posts following a period of active duty.</p> <p>(2011)</p>
67.	<p>That this Meeting welcomes the introduction of the Reserves Mental Health Programme and calls on the BMA to work with the MoD to improve the promotion and advertising of this service to civilian doctors and to the individuals it is designed to help.</p> <p>(2010)</p>
68.	<p>That this Meeting recognises that operational deployment results in unique stressors to the families of reserve and volunteer forces and calls on the BMA to work with the MoD to improve the information and practical support given to the families of reservists and volunteer forces.</p> <p>(2010)</p>
69.	<p>In harmony with the Armed Forces Day, this Meeting wishes to record a vote of thanks to the UK military and its continuing endeavours.</p> <p>(2010)</p>
70.	<p>That this Meeting notes that, on 20th October 2009, the Scottish Health Secretary permitted all NHS staff in Scotland who serve with the Reserve Forces to have two weeks' paid leave in order to undertake military duties. The BMA urges that this policy be extended to all NHS staff throughout England, Northern Ireland and Wales.</p> <p>(2010)</p>
71.	<p>That this Meeting calls upon the MoD to support all military F1 and F2 doctors by allowing entitlement to service accommodation comparable to that of their non-medical junior officer colleagues.</p> <p>(2010)</p>
72.	<p>That this Meeting deplores the continued reduction of the Defence Medical Services resulting in loss of dedicated specialist provision.</p> <p>(2010)</p>

73.	That this Meeting is concerned with regards to the growing health implications for military personnel and veterans, and therefore urges all UK governments to implement a mechanism for flagging the medical records of military personnel and veterans within the NHS. (2009)
74.	That this Meeting proposes that the MoD work with the Confederation of NHS Trusts and NHS Employers to increase the cooperation of NHS trusts in facilitating the release of armed forces reservist doctors for training and deployment without prejudice of their employment status. (2009)
75.	That this Meeting agrees that the government must be pressed to ensure appointment of MoD consultants (regular and reserve) is facilitated in trusts at a local level and not just agreed at a strategic level. (2008)
76.	That this Meeting congratulates the Defence Medical Services on the level and standard of care provided to the British, coalition, local and insurgent military casualties at operational hospitals by specialist in-flight evacuation teams and by the Defence Rehabilitation Centre (Headley Court) to British casualties. (2008)
77.	That this Meeting is concerned that the current work being undertaken by the MoD on medical operational capability may lead to a reduction in uniformed doctors which, whilst meeting the basic operational requirement, will not deliver a career structure sufficiently attractive to retain the high quality personnel required to sustain the DMS. (2006)
78.	That this Meeting urges the MoD to take urgent steps to improve the level of personal and vehicle protection available to service personnel in operational areas. (2006)
79.	That the new MoD pension scheme should be extended to cover all Reservist service. (2005)
80.	That this Meeting calls on the BMA to lobby the Ministry of Defence to ensure that all military medical personnel are adequately equipped and supplied. (2004)
81.	That this Meeting calls on the Departments of Health to ensure that all Reserve Medical Officers receive two weeks' paid leave to fulfil their annual training requirement. (2004)
82.	That this Meeting believes that the Ministry of Defence should work with the BMA to identify effective strategies in order to tackle the DMS manpower crisis. (2001)
83.	Pay That this meeting notes that Civilian Medical Practitioners are being called upon to undertake the additional responsibilities of military Senior Medical Officers without additional remuneration, and calls upon the Ministry of Defence to ensure that:- i) this issue is addressed as a matter of urgency, recognising that CMPs play a vital role within the DMS workforce; ii) those who undertake such extended duties are appropriately remunerated; iii) this remuneration is backdated to the date such additional duties were commenced.

	(2018)
84.	That this Meeting calls upon the MoD to redress the imbalance between the whole-career earnings of NHS GP principals and their Armed Forces counterparts in order to improve recruitment and retention within the Defence Medical Services. (2009)
85.	That the 2007 AFPRB Report provides compelling evidence that much more needs to be done to recruit, retain and motivate suitable staff and this conference feels that the 2% pay increase awarded to armed forces doctors is an inadequate response and calls upon the BMA to work closely with the Defence Medical Services Department to improve medical manning within defence medical services. (2007)
86.	That this Meeting: <ul style="list-style-type: none"> (i) considers the Armed Forces Pay Review Body (AFPRB) is too dismissive of the good evidence submitted to it without adequate explanation in its report for rejecting or ignoring the evidence; (ii) regrets that the Armed Forces Pay Review Body (AFPRB) has failed to recognise and remunerate the work of military doctors in line with the changes in the NHS. (2005)
87.	That the BMA support the armed services consultants in being remunerated for any additional PA in excess of 10 by the tasking agency. (2005)
88.	That all evidence put before the Armed Forces Pay Review Body should be free of any outside interference, and that the AFPRB should be reminded that, in order to recruit, retain and motivate DMS personnel, the AFPRB should be encouraged to independently assess the evidence. (2003)
89.	That this Meeting believes that TA medical officers on deployment should be paid at a seniority rate commensurate with their clinical seniority and not an "on appointment" rate. (2001)
90.	That this Meeting believes that the current military pay analogue fails to take account of the civilian GP net income and their self-employed tax status. (2000)
	BMA, STRUCTURE AND FUNCTION
91.	That this meeting notes the importance of the Romney Report and instructs the BMA to:- <ul style="list-style-type: none"> i) undertake an audit of all BMA committees, subcommittees, council and the organisation regarding the implementation of the Romney Report; ii) circulate to all members within 6 months of the proposed audit a report on the implementation of the Romney recommendations. (2021)
92.	That this meeting believes that in instances where the BMA advocates for members with protected characteristics, the

	<p>lived experience of members possessing those characteristics is of fundamental importance to the discussions. It therefore calls for the BMA to create a fair and transparent process for the appointment of liberation officers from within the committee of each branch of practice. (2019)</p>
93.	<p>That this meeting: -</p> <ul style="list-style-type: none"> i) believes the current BMA in-house complaints procedure is not fit for purpose; ii) believes that BMA members with valid complaints are actively discouraged from raising a concern due to the current complaint system; iii) believes that sexism and harassment are not seriously addressed by the BMA; iv) welcomes the announcement of an independent external investigation into recent complaints of sexism and harassment within the BMA, as long as the investigator has the confidence of the complainants; v) expects the findings of the external investigation into complaints of sexism and harassment within the BMA to be published in a timely manner and any recommendations to improve the complaints procedure to be implemented. <p>(2019)</p>
94.	<p>To best achieve our aims for the National Health Service, medical students, doctors, physician associates and other Medical Associate Professionals (MAPs), this meeting resolves that the BMA should work with organisations representing physicians associates, other MAPs and students of these professions in staff and/or student joint committees. (2019)</p>
95.	<p>That this meeting recognises and values the local engagement trials which have enabled more meetings between members. (2018)</p>
96.	<p>That this meeting requires the BMA to invest in training its activists:-</p> <ul style="list-style-type: none"> i) to provide e-learning and interactive sessions on current BMA policy, structure and function; ii) to centrally coordinate the existing network of activists to do media work for the organisation in a precise, targeted way informed by current policy positions. <p>(2018)</p>
97.	<p>This meeting asks the BMA in future elections to produce more social media posts and emails about the elections, in addition to videos, graphics and posters explaining:-</p> <ul style="list-style-type: none"> i) what the voting categories are; ii) how to vote; iii) how the Single Transferable Vote system works; iv) the last postal date to ensure receipt at ERS by the deadline; v) when ballot papers should have been received; vi) who to contact if ballot papers have not been received. <p>(2018)</p>
98.	<p>That this meeting notes that retired members are the only branch of practice not represented by a standing committee and:-</p> <ul style="list-style-type: none"> i) believes they need and should have a standing committee; ii) calls on the organisation committee to bring forward proposals to set up a standing committee for retired members. <p>(2017)</p>
99.	<p>That this meeting is seriously concerned by the major impacts that fossil fuels have on health via air pollution and climate change, and is aware of the role of divestment in strengthening the advocacy position of the BMA, and calls on the BMA to:-</p>

	<p>i) take advice from suitably qualified financial advisers to develop a policy to divest from fossil fuels, to include those investments currently in pooled funds, and substantially reduce exposure to the financial and reputational risks associated with climate change causation;</p> <p>ii) heed the recommendation of the World Medical Association in its 2016 statement on divestment to "begin a process of transferring their investments, when feasible without damage, from energy companies whose primary business relies upon extraction of, or energy generation from, fossil fuels to those generating energy from renewable energy sources".</p> <p>(2017)</p>
100.	<p>That this meeting believes that retired members need more recognition in the structures of the BMA if their potential is to be realised and their membership retained.</p> <p>(2017)</p>
101.	<p>That this meeting congratulates the association on its 'Living Our Values' campaign, and urges the BMA to:-</p> <p>i) produce a code of conduct for all members and representatives.</p> <p>(2017)</p>
102.	<p>That this meeting calls for the BMA to review its committee structures and propose recommendations to ensure:-</p> <p>i) effective representation of members regardless of employer or contractual situation;</p> <p>ii) stronger and more devolved 4-nation and regional structures;</p> <p>iii) improved visibility and engagement of under-represented groups, including women doctors.</p> <p>iv) appropriate changes are brought to the 2017 ARM and 2017 AGM.</p> <p>(2016)</p>
103.	<p>That this meeting insists that honesty, transparency and professional competency are the hallmarks of British medicine and confirms that the BMA:-</p> <p>i) is a trade union;</p> <p>ii) is the leadership organisation of the profession promulgating science, research, ethics, quality of care and advocacy for patients;</p> <p>iii) represents its members interests and concerns first and foremost;</p> <p>iv) should disseminate easily understood information informing members of the numerous ways they can involve themselves in consultations and activities.</p> <p>(2015)</p>
104.	<p>That this meeting recognises that there is evidence that organisations function better if they have a gender balance on their decision making bodies and:-</p> <p>i) notes that women are under-represented in medical politics;</p> <p>ii) asks the BMA to examine the best ways to guarantee an optimal gender balance;</p> <p>iii) asks that the BMA should highlight more female doctor role models;</p> <p>iv) asks that the BMA should explore new ways to enable doctors who work part time to participate in leadership within the BMA</p> <p>(2015)</p>
105.	<p>That this Meeting calls for all BMA expenses and honoraria to be listed and available for scrutiny by BMA members.</p> <p>(2014)</p>
106.	<p>That this Meeting believes that employment advisory services are a core trade union function of the BMA and any providers of these services must not have conflicts of interest in running services for BMA members.</p>

	(2012)
107.	That this Meeting calls for the deliberations of BMA to be transparent. It proposes that votes on medico-political and trade union issues at BMA Council be recorded, so that members can see what council members stand for. (2012)
108.	That this Meeting notes the challenges of communicating with BMA members by electronic means and:- (i) notes the BMA is a membership organisation which exists to serve its members; (ii) is concerned that the present arrangements hinder the effective working of honorary secretaries of divisions and regional councils; (iii) believes that the reactivation of dormant divisions could be assisted by the ability to directly email their members with local information; (iv) calls on the BMA to develop arrangements which enable more effective divisional and regional communications with members; (v) believes that honorary secretaries should be entitled to an annual postal mailing to members. (2012)
109.	That this Meeting believes that there is a material role for retired members supporting the BMA Divisions and Regional Councils as representatives upon Health and wellbeing boards, other locality bodies, and attending PCT /Trust board meetings. (2011)
110.	That this Meeting congratulates the JMF on reaching its 50th birthday. We seek support from the chief officers that the BMA will support the next 50 years for this event which encourages new active young members of the BMA to become involved in medico-political activities. (2007)
111.	That this Meeting believes food and refreshments at all BMA meetings (national and local) should not (even in part) be paid for by pharmaceutical companies. (2007)
112.	This Meeting commends the remarkable contribution that professor Parveen Kumar has made to the British Medical Association as its president, and gratefully acknowledges her willingness to continue to serve the profession. (2007)
113.	That there should be accountability as a result of BMA elections and results of elections should be published on the website including number of votes received. (2006)
114.	That this Meeting is proud of the magnificent way in which all staff and members in and round BMA House responded to the bombings on 7th July 2005. (2006)
115.	That this Meeting: (i) supports and recognises the rights of the members that it elects (from whatever part of the United Kingdom) to take part in, attend, and sit on the committees and boards of the BMA without undue pressure from the Treasurer's office; (ii) insists that any further review of committee expenditure be first informed by a review of their activity and function, in order to avoid a de facto reduction in representative activity of the Association. (2005)

<p>116.</p>	<p>That this Meeting, being concerned about recent charges made against the BMA of institutional racism:</p> <ul style="list-style-type: none"> (i) calls on all medical representative organisations, including the BMA, to review their policies and procedures to ensure that there is no, and there is seen to be no, institutional racism; (ii) calls on the BMA to take a strong stand against all forms of racism wherever they occur, in the Association, the profession or the NHS. <p>(2004)</p>
<p>117.</p>	<p>That the BMA should ensure that compliance with the Disability Discrimination Act applies for the venues for all conferences arranged by the BMA, whether at BMA House or external venues. In particular they should provide high quality loop induction and wheelchair access.</p> <p>(2002)</p>
<p>118.</p>	<p>That this Meeting calls on the BMA to adopt a policy of avoiding investment in the arms trade.</p> <p>(1998)</p>
<p>119.</p>	<p><u>ARM process</u></p> <p>That this Meeting believes the BMA Council must feed back to the membership more clearly on the actions taken on resolutions of the ARM.</p> <p>(2014)</p>
<p>120.</p>	<p>Report that the Committee has arranged in groups certain motions and amendments which cover substantially the same ground and has selected in each group one motion or amendment (marked with a star) on which it is proposed that discussion should take place. Items prefixed 'P' and 'C' will be dealt with in accordance with standing orders 36 and 40. Motions or amendments prefixed 'A' or AR' will be dealt with in accordance with standing orders 38 and 39. But the meeting regrets that due to designating so many motions as "grey" the aspirations of some divisions has been curtailed.</p> <p>(2013)</p>
<p>121.</p>	<p>That this Meeting requires the BMA to improve its accountability to the ARM by keeping an updated log of action against all successful conference motions, easily found by members and public on its website.</p> <p>(2013)</p>
<p>122.</p>	<p>That this Meeting believes that the following aspects of the ARM should be reviewed:-</p> <ul style="list-style-type: none"> i) the mechanism for distributing seats at the ARM; <p>(Lapsed 2018)</p> <ul style="list-style-type: none"> ii) guidance for constituencies on selecting representatives. <p>(2013)</p>
<p>123.</p>	<p>That this Meeting calls on the BMA to provide complete transparency on subsequent outcomes of all motions passed at the Annual Representatives Meeting (ARM) each year. Clear updates should also be provided on work being done by the BMA to ensure that implementation is in progress. Clear information should also be provided work in progress on motions that are taken as reference.</p> <p>(2013)</p>
<p>124.</p>	<p>That this Meeting calls on the BMA to act on all policy voted through ARM and SRM and to report back to ARM on motions that have been passed.</p> <p>(2011)</p>

125.	That every ARM should be reasonably accessible to all members. (2007)
126.	That this Meeting requires that, in future, all resolutions of the RB shall have a fixed life of five years. At the end of that time the resolutions shall be brought back to the Representative Body, divided, under the instruction of Council, into those to be renewed for a further five years and those which should be allowed to lapse. The two groups shall be presented, as formerly, to the Representative Body as a blanket resolution. (2007)
127.	That this Meeting recommends that reallocation of RB seats through the Regional Fora should not be restricted by branch of practice. (2006)
128.	That this Meeting: (i) recognises that the procedure for the allocation of seats at the ARM, only allows for redistribution of unfilled ARM seats within their respective region; (ii) believes that there is no reasonable rationale for redistributing the seats within a region as opposed to the whole of the UK; (iii) believes that redistributing unfilled ARM seats within the whole of the UK would increase ARM attendance figures; (iv) demands that the BMA allow redistribution of unfilled ARM seats within the whole UK. (2006)
129.	That: (i) individuals chairing or organising debates at the ARM should refrain from using their position to advance their personal views; (ii) the Treasurer or their representative should confine their comments to the financial aspects of motions when addressing the meeting in their official capacity. (2006)
130.	With regard to the debate on health care policy reform on Wednesday 28 June 2006, this Meeting: (i) believes open debates have a positive value; (ii) believes the handling of the debate and its outcome were potentially damaging to the reputation of the BMA; (iii) does not believe RB made a coherent statement on such a complex issue; (iv) insists, in future, following an open debate representatives should be able to submit new substantive motions for the subsequent formal debate; (v) insists, in future, motions published in the open debate section of the agenda are managed as substantive motions in the formal debate; (vi) instructs the Organisation Committee to bring forward proposals to amend standing orders to regulate all aspects of future open debates. (2006)
131.	This Meeting deplores the fact that the so called final version of the policy statement on NHS reforms in England does not match what the RB voted for on 28 th June 2006. We call for the reinstatement of the exact wording as agreed and also that the statements of OD4 did not 'command support' and the wording must be changed to 'were mentioned'. Alternative mission statement: "The profession is dismayed by the incoherence of current government's policies and the damage it has caused to the NHS and the delivery of patient care. The BMA actively opposes

	<p>the government's plans and restates its belief in the core values of the NHS which are: Free at the point of delivery, Ethically rationed by clinical priority without discriminatory values, Equitably resourced, Funded out of general taxation. These fundamental values cannot be maintained if the NHS is broken up and tendered into private corporations.”</p> <p>(2006)</p>
132.	<p>That this Meeting welcomes the amendment to the Bye-laws relating to the Representative Body and believes that:</p> <ul style="list-style-type: none"> (i) this reflects the evolving and developing make-up of the profession; (ii) there should be periodic review to ensure future demographic changes are accommodated. <p>(2005)</p>
133.	<p>That this Meeting recognises the importance of debating as many of the motions submitted as possible, in the time available, and regrets that some important issues are timed out and not debated. It, therefore, requests that the amount of time spent debating uncontroversial motions be kept to a minimum.</p> <p>(2002)</p>
134.	<p>That this Meeting considers that items of Representative Body policy which Council proposes should be withdrawn must be published each year:</p> <ul style="list-style-type: none"> (i) in time to allow discussion at divisional agenda meetings; and (ii) in such a way as to be available to all members. <p>(1999)</p>
135.	<p><u>Communications</u></p> <p>That this meeting recognises the value of sharing positive stories and messages in healthcare and therefore calls on the BMA:-</p> <ul style="list-style-type: none"> i) to engage in a national listening exercise to collect and disseminate best practice in improving workforce morale; ii) to work closely with the BMJ, Student BMJ and BMA News to develop a 'Good news' media campaign celebrating outstanding examples of compassion in the workplace and/or university. <p>(2018)</p>
136.	<p>That this meeting believes that regional matters are part of the legitimate remit of central communications support services and believes:-</p> <ul style="list-style-type: none"> i) Regional Councils must be kept informed of any changes in central communications; ii) there must be a dedicated person or team responsible for proactive regional communications; iii) professional media engagement at a regional level would enable the BMA to promote campaigns more effectively across the country; iv) regular regional media liaison and strategic communications should be undertaken. <p>(2018)</p>
137.	<p>That this Meeting:-</p> <ul style="list-style-type: none"> i) demands that the BMA uses the paper method of communicating with those of its members who have notified that as their preference; ii) recommends that verification of contact details should take place by standard mail on an annual basis, as is customary for other organisations. <p>(2011)</p>
138.	<p>That this Meeting insists that:-</p>

	<ul style="list-style-type: none"> i) members in the area of an inactive division be better informed of available mechanism[s] to enable them to send motions to the ARM and/or any SRM; ii) members receive better information about applying for an unfilled place at an Annual or Special Representative meeting, particularly where that member is from a district without an active Division; iii) the Association accepts its ARM nominations from Divisional Secretaries in the form of an electronic communication (e-mail) rather than insisting on written communication; iv) in large parts of the UK, it is more effective and less costly to the BMA for members to communicate electronically, using emerging technologies such as Voice Over Internet Protocols [such as Skype], and calls on the Organisation Committee to bring forward appropriate amendment to Bye-Law 18 in time for the 2012 ARM to allow members to vote on local issues without being physically present at a meeting. <p>(2011)</p>
139.	<p>That this Meeting demands that each year's RB motions should be placed on the BMA website as soon as practicable and action taken to support them appended throughout the year as it arises.</p> <p>(2009)</p>
140.	<p>That this Meeting believes that the existing electronic interfaces used by the BMA are not fit for purpose and need radical overhaul. In particular the main BMA website is outdated and difficult to navigate.</p> <p>(2008)</p>
141.	<p>That this Meeting believes to reconnect the wider membership with its representatives on local, regional and national committees, any BMA member should be able to rapidly contact those representatives, and it calls upon the BMA to provide by the end of 2008 the following information and facilities on the BMA website:</p> <ul style="list-style-type: none"> (i) the names of all elected and appointed representatives and office bearers of local regional and national committees; (ii) either their agreed contact details or a central email address which forwards emails to those representatives. <p>(2008)</p>
142.	<p>That this Meeting offers its congratulations and thanks to those BMA staff who have delivered the facility for honorary secretaries to communicate electronically with their members.</p> <p>(2008)</p>
143.	<p>This Meeting believes that the BMA's website and communications require radical improvement. We call on BMA Council to:</p> <ul style="list-style-type: none"> (i) ensure that the website is reviewed and that radical improvements are implemented; (ii) ensure that the website is used for regular surveys of membership opinion about topical issues; (iii) introduce a regular, usually weekly, report of the main activities of the BMA in the previous week(s). <p>(2007)</p>
144.	<p>That the BMA set up and fund an email list server for BMA divisions.</p> <p>(2006)</p>

145.	<p><u>Constitution and governance of the Association</u></p> <p>That this meeting:-</p> <ul style="list-style-type: none"> i) recognises that BMA devolved national councils and devolved nation branch of practice committees have delegated authority to make their own decisions, based upon what is best for members in their nation; ii) demands that the organisation committee delivers a proposal to ensure the Articles and Byelaws of the BMA reflects the diverging contexts of the RB across nations with a view to agreeing at ARM in 2022. <p>(2021)</p>
146.	<p>That this Meeting calls on the BMA to:-</p> <ul style="list-style-type: none"> i) recognise the divergence in the four UK National Health Services; ii) produce plans for the Association's future structure and governance that fully take into account the implications of devolution. <p>(2013)</p>
147.	<p>That this Meeting believes that the constitution and/or bylaws of the BMA should be amended to allow regional councils to call for a Special Representatives Meeting.</p> <p>(2011)</p>
148.	<p>That this Meeting vote on the preferred model for the future governance of the Association (including the status quo) and for future local cross craft structures.</p> <p>(2004)</p> <p>[Note: The 2004 ARM voted to retain the status quo with regard to the Association's governance and to retain divisions as the local cross-craft structures.]</p>
149.	<p>That this Meeting instructs the Organisation Committee to co-ordinate a wholesale review of the Articles and Bye-Laws of the British Medical Association and bring recommendations to the 2005 ARM:</p> <ul style="list-style-type: none"> (i) using expert legal assistance; (ii) using a task group of the Organisation Committee to include members of the 2003-2004 Governance Committee of the RB; (iii) consulting members and representative committees; (iv) with due regard to the balance of representation by branch of practice and geography; (v) using a common terminology; (vi) with due regard to the inclusion of science, education and ethics; (vii) to implement the preferred model of governance chosen by the RB at the 2004 ARM. <p>(2004)</p>
150.	<p>That this Meeting believes as a result of the working operation of current UK health departments there remains a need for full representation of all nations on UK craft committees.</p> <p>(2002)</p>
151.	<p>That this Meeting asks that details of proposed changes in the governance of the BMA should normally be published in the Annual Report of Council prior to implementation.</p> <p>(2002)</p>
152.	<p>That this Meeting calls upon the BMA:</p> <ul style="list-style-type: none"> (i) to recognise medical students as a "craft"; and (ii) to make the Medical Students Committee a craft committee of equal standing with the other craft committees. <p>(2001)</p>

153.	That this Meeting calls for an effective representation within the BMA for non-consultant career grade doctors to negotiate their terms and conditions of their service. (2001)
154.	That this Meeting urges the GMSC: (i) to look at the possibility of LMCs obtaining trade union status so they can negotiate on behalf of GPs locally; (ii) to look at the possibility of LMCs being given equal status with LNCs to negotiate on behalf of GPs locally; (iii) to work more closely with BMA regional offices to ensure that appropriate expertise and local knowledge is available to LMCs. (1997)
155.	That this Meeting believes that the divisional system of the Association is central to the democratic process for its members, and should be strengthened as a result of any constitutional review. (1993)
156.	That notwithstanding any alterations made in the Constitution, the Representative Body shall retain its sovereignty with regard to all matters concerning hospital, general practice, and the public health services, and will consider the reports from these bodies at each Annual Representative Meeting. (1967)
157.	Council That this meeting wishes to see increased BMA policy feedback and engagement locally and asks the BMA to consider a move to an element of regional representation on council. (2017)
158.	That this Meeting calls on BMA Council to have a formal agenda item on the motions passed at ARM in the morning of the July full meeting of Council. (2013)
159.	That this Meeting insists BMA Council members should be able to speak openly and freely even if critical of the BMA policy decisions. (2013)
160.	That this Meeting calls on Council to establish a formal register of interests which is mandatory for all elected BMA Officers. (2013)
161.	That this Meeting notes the decision by BMA Council not to implement the ARM resolution of 2012 on the recording of votes on medico-political and trade union issues and:- i) deplores the failure by BMA Council to implement this ARM resolution; ii) requires Council to implement a system of transparency and accountability of Council members; iii) asks that reports of debates at Council should, (subject to delay on items which are under active negotiations), be circulated to devolved and regional councils, branch of practice committees, and divisions; iv) insists that Council adopt a system of recording all such votes, which is made available to the membership. (2013)
162.	That, in order to effectively hold the chief officers and secretariat to account, the UK Council must:

	<ul style="list-style-type: none"> (i) hold meetings more regularly throughout the year; (ii) hold at least 5 meetings a year, excluding any meetings specifically to elect Chairman of Council; (iii) at no time have more than 3 months between meetings; (iv) bring proposals to the 2008 ARM that are designed to widen the electorate for Chairman of Council beyond the members of Council. <p>(2007)</p>
163.	<p>That this Meeting is concerned to enhance democratic input and accountability in electing the Chairman of Council. This meeting supports the Organisation Committee in providing a consultation process to consider this matter and:</p> <ul style="list-style-type: none"> (i) calls for proposals to widen the electorate beyond the 34 voting members of Council to be developed through this consultation; (ii) calls for formal proposals to be brought to the 2008 ARM; (iii) instructs Council to build and strengthen mechanisms of holding its Chairman to account; (iv) calls on Council to build mechanisms that provide greater support to the role of the Chairman of Council using Deputies, the other elected Chief Officers and the Branch of Practice and professional committee chairmen. <p>(2007)</p>
164.	<p>That this Meeting believes the proposals from the Organisation Committee to modernise UK Council will make it more “fit for purpose” and facilitate the moves towards a Council that fulfils the needs of the whole BMA membership.</p> <p>(2005)</p>
165.	<p>That any member of the British Medical Association be allowed access to Council Meetings but that Council shall have the right to hold all or part of a meeting in private.</p> <p>(1965)</p>
166.	<p><u>Devolution</u></p> <p>That this Meeting:</p> <ul style="list-style-type: none"> (i) welcomes the start that the BMA has made to address issues raised by the devolution of the UK into 4 countries; (ii) expects this process to continue with urgency; (iii) expects the process to be fully resourced. <p>(2005)</p>
167.	<p>That this Meeting recommends that the BMA should retain a UK wide system of membership benefits and services after devolution.</p> <p>(1998)</p>
168.	<p><u>Divisions</u></p> <p>That this meeting recognises the value of divisions in engaging grassroots members on behalf of the association. However, with increasing pressures within the NHS it is becoming more difficult for members to give up time to attend meetings regularly and so calls upon the association to explore new ways of holding division meetings/events virtually to improve engagement with members.</p> <p>(2018)</p>
169.	<p>That this meeting asks that the BMA:-</p> <ul style="list-style-type: none"> i) explicitly counts virtual attendees towards a quorum at Divisional meetings; ii) actively supports Divisions to make the best use of technology to enable virtual participation. <p>(2018)</p>

<p>170.</p>	<p>That this Meeting notes the hard work done by honorary secretaries in supporting and continuing the work of the BMA at divisional level. We believe that enabling the officer posts at divisional level to be 'job-shared' with co-appointments would reflect the ethos of the rest of the BMA and ask for this to be made possible. (2014)</p>
<p>171.</p>	<p><u>Local structures</u></p> <p>That this meeting believes it to be reprehensible that English regional structures in the BMA have no devolved funding. We require the BMA to rectify this. (2018)</p>
<p>172.</p>	<p>That this meeting congratulates the association on the progress made through the Member Voice and Democratic Structures review, and calls for:-</p> <ul style="list-style-type: none"> i) the treasurer to report to the 2018 ARM on the outcome of the recently-begun pilot of direct reimbursement of divisional expenditure through Concur; ii) the treasurer to report on the lessons learned from phases 1 and 2 of the local engagement pilots. <p>(2017)</p>
<p>173.</p>	<p>That this meeting welcomes the BMA pilot on local membership engagement and demands the outcome of the pilot:-</p> <ul style="list-style-type: none"> i) specifically enhances BMA visibility and meaningfulness to the members in the regions; ii) encourages genuine membership engagement with new ways of communicating at a local level; iii) assists in providing a far greater and meaningful role for Regional Councils in planning and delivering positive outcomes in important issues such as 'new models of care'. <p>(2016)</p>
<p>174.</p>	<p>That this Meeting notes with concern that junior doctors are not always adequately represented on, and at times are discouraged from membership of some Local Negotiating Committees (LNCs) and calls on the BMA to:-</p> <ul style="list-style-type: none"> i) improve awareness regarding the importance of junior representation on LNCs; ii) work with regional JDCs to review the membership of each LNC and where there is no junior representative, to specifically recruit and train a junior doctor member to fill that post; iii) encourage sharing of best practice by forming a network for junior doctor LNC representatives, with JDC input. <p>(2011)</p>
<p>175.</p>	<p>That this Meeting believes the Association benefits from robust, empowered regional councils which are responsive and accountable to the needs of their local membership. (2010)</p>
<p>176.</p>	<p>That this Meeting demands that:</p> <ul style="list-style-type: none"> (i) additional funding and support for regional councils be now provided as a matter of urgency; (ii) the pilot of new Regional Co-ordinators be now assessed and, if deemed successful, be rolled out to other regional councils expeditiously. <p>(2009)</p>
<p>177.</p>	<p>That this Meeting re-affirms the importance of divisions as representing the voice of grassroots members, and insists that the divisions continue to have a voice at regional and national levels. (2009)</p>

178.	That this Meeting welcomes the review of regional structures being conducted by the Organisation Committee, recognises the crucial importance of communication between regional councils and divisions, and calls on BMA Council to encourage both its own members, and those of regional councils, to play as effective a role as they may in the activity of their local division. (2009)
179.	That this Meeting re-affirms the importance of the role of divisions to the BMA in general and demands that any future changes in strategy, communications and structure should continue to recognise the value of divisional input. (2009)
180.	That this Meeting recognises the imperative of supporting and encouraging medico-political activity at a local level and instructs Council to develop policy executives within each region to complement existing regional service staff to: (i) facilitate and support regional activity; (ii) co-ordinate local activity, linking where appropriate to national knowledge and strategy; (iii) develop strategic planning infrastructure. (2008)
181.	That the BMA should: (i) ensure that Regional Councils are established in all parts of England; (ii) transfer to Regional Councils the duties and powers of the Regional Fora; (iii) dismantle the Regional Fora; and (iv) confer upon Regional Councils duties and powers comparable with those of the National Councils of the devolved nations; (v) ensure that commensurate resources are made available to enable regional councils to fulfil their new functions. (2007)
182.	That this Meeting welcomes the opportunity for members from inactive divisions to become members of the BMA Representative Body, and calls upon those members to: (i) undertake to communicate the activities and decisions of the RB to the members of their local division, using the resources of the regional centres; (ii) represent the views and policies of the RB to their local members. (2007)
183.	That this Meeting: (i) congratulates the Dewsbury, Pontefract and Wakefield Division on its formation; (ii) thanks the regional staff; (iii) encourages other divisions struggling to maintain activity to consider availing themselves of the process to merge with neighbouring divisions. (2007)
184.	That this Meeting: (i) is seriously concerned at the large number of divisions which remain inactive; (ii) believes that members living in areas without an active division are at risk of being inadequately represented by the Association; (iii) calls upon the Organisation Committee to develop a mechanism for local decision making by regional bodies to enable inactive divisions to be merged into neighbouring active divisions; (iv) calls on the Association to continue its effort to reactivate all inactive divisions, using every means at its disposal. (2006)

185.	<p>That this Meeting believes that the use of post codes to determine constituencies or groups of constituencies for:</p> <ul style="list-style-type: none"> (i) BMA council elections; (ii) regional fora; (iii) reallocation of ARM seats must be reviewed urgently in time for any changes to be effective for the 2008 Council elections. <p>(2006)</p>
186.	<p>That this Meeting recognises the fundamental importance to the Association of effective local cross-craft structures and calls on the Association to promote the development of divisions by:</p> <ul style="list-style-type: none"> (i) establishing a constitutional role for divisions within the Association that clearly specifies the functions of the Association to be devolved to the divisions; (ii) ensuring that its divisional structure is used more systematically to gauge the opinion of the wider BMA membership on current issues of professional interest, in order to better inform BMA policy development; (iii) investigating ways of improving electronic communication between divisions and grass-roots members and the central BMA, and enabling divisional secretaries to communicate with their division members by electronic means (including email); (iv) raising the local profile of divisions by directing media enquiries towards the public affairs secretaries of divisions, who currently constitute an underused resource within the Association. <p>(2005)</p>
187.	<p>That this Meeting endorses the provision of adequate funding for the conduct of divisional meetings to promote good attendance and thereby maximise democratic accountability within the BMA.</p> <p>(2005)</p>
188.	<p>That this Meeting asks the Organisation Committee to undertake work to examine how local representative structures could be developed or supplemented with the aim of enhancing local activity and participation in medical politics and the promotion of medical and allied sciences to complement existing active local structures.</p> <p>(2005)</p>
189.	<p>That this Meeting believes that there is need for regular local meetings:</p> <ul style="list-style-type: none"> (i) that are open to all members; (ii) that these should foster cross craft interaction and debate; (iii) that there should be full support from the BMA secretariat; (iv) that new ways of holding meetings need to be explored including the use of modern communications e.g. virtual, video. <p>(2005)</p>
190.	<p><u>Membership services</u></p> <p>That this Meeting believes that student members are not always best served by existing BMA advice structures. With this in mind we call upon the BMA to:</p> <ul style="list-style-type: none"> (i) create and fund a BMA 'student advisory' service; (ii) renegotiate the service level agreement for askBMA to include service delivery to students. <p>(2007)</p>
191.	<p>That this Meeting calls upon the BMA to offer career counselling to its members.</p> <p>(2006)</p>

192.	That the BMA be congratulated on the excellence of the BMA Library, and considers it a good example of the importance of the professional side of BMA membership. (2005)
193.	That this Meeting demands that the BMA develop: (i) a central database of membership information designed in accordance with the Data Protection Act that is effective and useable; (ii) more effective ways of communication through e-mail with the rank and file membership, such as divisions, with the objective of developing more effective two way communication and which would reduce the need to hold meetings; (i) its website to enable better communication to, from and between its members. (2005)
194.	That this Meeting supports the continued development of the BMA library facilities which are a major asset of membership. (1991)
195.	That this Meeting reaffirms the BMA's belief that the representation of doctors, their pay, conditions of employment, and availability of posts should not be unreasonably affected by consideration of colour, race, creed or sex, etc. (1972)
196.	<u>Membership subscriptions</u> That the standard rate of subscription be increased by 2% according to the subscription ranges set out in Appendix VI with effect from 1 October 2013. (2013)
197.	That the BMA waive its subscription fee for refugee doctors facing financial hardship. (2000)
198.	<u>Officers of the Association</u> That this meeting notes the BMJ editorial of 30th March, and preceding news item from 23rd March 2019, on travel claims for spouses by BMA Chief Officers. We ask that the BMA: - i) commissions a fully independent enquiry into this practice; ii) ensures that in the future no such claims are permitted unless they are extraordinary and have prior approval of the Finance Committee. (2019)
199.	That this Meeting: (i) acknowledges the important role played by the Chairman of Council as one of the Chief Officers of the Association; (ii) recognises that the Chairman of Council generally has a higher public profile than the other Chief Officers of the Association; (iii) recognises that the media often refers to the Chairman of Council simply as "Chairman of the BMA"; (iv) believes that it is important that the Chairman of Council is elected with the support of a significant proportion of the membership of the Association; (v) is concerned at the potential risk of electing a Chairman of Council who lacks the support of a significant proportion of the membership of the Association, as a result of the voting membership of Council being reduced to less than 40 members; (vi) believes that the system for electing the Chairman of Council should be reviewed; (vii) calls on the Organisation Committee to review the system for electing the Chairman of Council and to produce proposals to be presented to the ARM in 2007.

	(2006)
200.	That this Meeting believes that the current BMA leadership has failed patients, the profession and the country by their failure to actively oppose the current wave of organisational and financial reforms, which are destabilising the NHS. This Meeting believes that the current policy of exposure of policy defects is not powerful enough and insists that it is replaced by a policy of active opposition and proper scrutiny. (2006)
201.	That this Meeting believes that the role of the Chairman of UK Council is to represent the views and policy of the BMA which have been arrived at democratically at both the Annual Representative Meeting and the UK Council, and that the personal views of any chairman of UK council, when acting in an official BMA capacity, should not be put forward as the BMA view or policy by that chairman when these are contrary to BMA policy. (2006)
202.	<u>Payments to members</u> That this meeting believes that the expenses, reimbursements and honoraria of all BMA committee and council members should be made available to:- i) individual members on personal request; (2017)
203.	That this Meeting believes that members of the BMA who earn less than £15,000 per annum and who incur expenses in pursuing BMA activities should not have to pay these expenses up front and the BMA should develop mechanisms for directly meeting these costs. (2006)
204.	<u>Publications</u> That this meeting calls for all papers relating to BMA ARM and AGM to be printed on either 100% recycled paper or 100% FSC-certified paper from sustainable sources. (2016)
205.	That this Meeting believes that future reports and statements should include declarations of any conflicts of interests held by members of the Board of Science and Education and/or the authors of Board reports. (2004)
206.	<u>Regional Services</u> That this meeting believes that strong local representatives, well supported by regional services, are essential for both an influential BMA and supporting individual doctors and calls for: - i) appropriate resourcing for regional services; ii) improved information, training and support for the roles of local representatives; iii) improved means of communications for local representatives. (2015)
207.	That this meeting:- i) requires that BMA regional offices should be retained and maintained according to the needs of members;

	<p>ii) notes that premises issues do not in themselves justify reduction or closure of regional facilities;</p> <p>iii) requires the BMA to maintain a full range of office-based regional services in the West Midlands.</p> <p>(2015)</p>
208.	<p>That this Meeting laments the failure of Council to implement existing policy on rolling out Regional Coordinators to support each and every BMA Regional Council, and calls on Council to ensure that, by the 2015 ARM, every Regional Council is served by a Coordinator.</p> <p>(2014)</p>
209.	<p>That this Meeting notes that the BMA employment advisors and BMA IROs work at a very high standard. We believe that The BMA should look into the workload of the BMA IROs and if found to be too high then action should be taken.</p> <p>(2014)</p>
210.	<p>That this Meeting is seriously concerned about the process undertaken in the changes to regional services including closure of Regional Offices and demands that:</p> <ul style="list-style-type: none"> (i) new changes are implemented in a way which will improve regional services and are not a cost cutting exercise; (ii) the BMA should not close or radically change local services without consulting the local membership; (iii) changes are independently audited and evaluated, with a report back to Council. <p>(2005)</p>
211.	<p><u>Representation of specific groups</u></p> <p>That this Meeting welcomes the work done by the BMA to improve the engagement of members across diverse groups, and in particular the work to improve the representation of women in medical leadership positions, and:-</p> <ul style="list-style-type: none"> i) recognises the potential for culture change arising from increased diversity in committees; ii) recommends modelling successful BMA careers in all genders to identify support mechanisms that would be useful for any future leaders; iii) calls for measures to renew and refresh representation within the BMA such as time-limited tenure within a particular representative role. <p>(2014)</p>
212.	<p>That this Meeting believes that local representation for academic staff is a vital component of the trade union function of the BMA. In support of this function we demand that:</p> <ul style="list-style-type: none"> (i) askBMA establish a robust method of communication over academic issues with MASC secretariat which enables MASC to monitor the type, location and resolution of members' queries; (ii) all LNCs in University hospitals have academic representation which is actively supported by the regional services network; (iii) Industrial Relations Officers are regularly updated and trained on academic issues; (iv) the BMA facilitates local divisional and regional representation of academic doctors where this is appropriate. <p>(2008)</p>
213.	<p>That this Meeting:</p> <ul style="list-style-type: none"> (i) notes with dismay the BMA's lack of support for regional craft committees of GPs; and (ii) insists that the BMA provide equitable support for all regional craft committees. <p>(2005)</p>

214.	That this Meeting believes that the BMA needs to acknowledge the under representation of women in its committee structures and should establish mechanisms to redress this. (2005)
215.	Secretariat That this Meeting condemns the unilateral imposition of 'forced ranking' for BMA staff and instructs BMA Council to withdraw this immediately. (2007)
216.	That this Meeting: (i) expresses its sincere thanks to the staff of the BMA for their hard work on behalf of the members; (ii) expresses its shame at some of the ways that the staff of the BMA have been treated; (iii) feels that a partnership should be developed between staff and management of the BMA to enable regular consultation and negotiation of the terms and conditions of BMA staff. (2005)
217.	That this Meeting requests that the BMA conduct fair and open negotiations in any matters related to pay and terms and conditions of its staff. (2003)
218.	That this Meeting strongly supports the BMA's policy on bullying, harassment and discrimination in the workplace and insists that the same policies should apply in relation to the BMA's own staff. (2003)
219.	That in future: (i) the Secretary of the Association; and (ii) the National Secretaries of the Association should not have to be medically qualified, experience of managing a large organisation being a more important factor. (2000)
	BOXING
220.	That in the light of the recent decision to grant a female boxer a professional licence, this Association reaffirms its opposition to amateur and professional boxing on the grounds of the hazards it poses to boxers of both sexes. (1998)
221.	That all forms of boxing should be banned. (1995)
	BREXIT/EU REFERENDUM
222.	That this meeting is concerned that a further peak of COVID-19 infection may occur at the same time as the Brexit transition period ends and that:- i) a departure from the single market and customs union will seriously threaten supply chains particularly in pharmaceuticals, medical devices and protective equipment and the NHS staffing shortage will be greatly exacerbated unless the problems of EU citizens' rights have been effectively resolved; ii) a departure from EU procurement arrangements and from Euratom could result in severe shortages of medical products and nuclear isotopes;

	<p>iii) the government has failed to make arrangements to replace the work previously done by UK membership of The European Medicines Agency;</p> <p>iv) medical research, including into COVID-19 and the production of appropriate vaccines, requires international collaboration, which will be severely damaged by the absence of the necessary structures;</p> <p>v) It therefore insists that the government take all necessary steps to avoid a no deal departure from the institutions of the European Union.</p> <p>(2020)</p>
223.	<p>That this meeting acknowledges the decision to leave the EU, and believes that the movement of doctors in and out of the UK strengthens health services in the UK and abroad, and calls on the BMA to lobby the UK government to uphold:-</p> <p>i) the right of residence to be granted to EU doctors and medical academic staff who are working in the UK;</p> <p>ii) the right of residence to be granted to UK doctors and medical academic staff who are working in EU states;</p> <p>iii) the right of medical students from the EU currently enrolled in UK medical schools to continue to live in the UK and work and train in the NHS after qualification;</p> <p>iv) the mutual recognition of professional qualifications;</p> <p>v) the common framework for training and standards;</p> <p>vi) the alert system for raising fitness to practice concerns.</p> <p>(2017)</p>
224.	<p>That this meeting believes that the close ties between the health service in Northern Ireland and the Republic of Ireland in terms of training, service delivery and research have been of mutual benefit and must be protected to ensure that doctors, medical students and patients are not disadvantaged in any post Brexit settlement. This meeting believes that:-</p> <p>i) doctors and students from either jurisdiction must be able to move freely to care for and treat patients;</p> <p>ii) the existing open border arrangements must be maintained;</p> <p>iii) mutual recognition of medical qualifications must continue;</p> <p>iv) all-island health services must be maintained to ensure patients in Northern Ireland have access to specialist care.</p> <p>(2017)</p>
225.	<p>That, with reference to the referendum on the European Union, this meeting believes:-</p> <p>i) that a remain vote must be followed by continuing pressures for reforms in procurement laws, more active social and environmental policies, less bureaucracy and a recognition that health is more important than markets;</p> <p>ii) that a leave vote should be followed by steps to ensure that employment, consumer and environmental protection in the UK do not fall below European standards and that new flexible collective social and environmental arrangements should be negotiated;</p> <p>iii) that the EU (in the case of a remain vote) or the UK (in the case of a leave vote) should not sign TTIP.</p> <p>(2016)</p>
	BRITISH MEDICAL JOURNAL
226.	<p>That this Meeting notes the high rate of gift authorship in biomedical sciences and the pressure on junior doctors to facilitate this practice. We therefore call for gift authorship to be actively resisted.</p> <p>(2012)</p>
227.	<p>That this Meeting calls on the BMJ to ensure that any articles in the publication which refer to aspects of terms and conditions of service are accurate.</p> <p>(2011)</p>

228.	That this Meeting would strongly support moves by the BMJ Publishing Group to introduce a standard patient consent for publication form which would be acceptable to the majority of journals, therefore avoiding the need for repeated consent forms, if an article is submitted to and refused by consecutive journals. (2009)
	CAR PARKING
229.	That this Meeting believes that NHS units should be required to provide adequate vehicle parking and calls on the Health Departments to issue instructions to NHS units to provide parking which is close to the work place; free for NHS staff and students; discounted for families of patients having long term treatment; well maintained and secure. Any profits made by NHS units from vehicle parking should be reinvested in improvements to parking facilities or public transport. (2006)
230.	That this Meeting condemns the extortionate car parking fees charged by some NHS trusts, and demands an end to this unashamed income generation at the expense of patients, visitors and NHS staff. (2004)
231.	That free designated parking for doctors undertaking duties at multiple hospital sites should be required of all NHS trusts on each site. (1999)
232.	That all doctors who work in single yellow line areas should have parking facilities as of right when attending to their medical duties. (1980)
	CERTIFICATION
233.	That this Meeting believes that quality assurance of doctors' training should be paid for by government and therefore doctors should not have to pay certification fees. It calls upon the BMA to open negotiations with the Health Departments to ensure that this is funded by the appropriate body. (2005)
234.	That this Meeting: (i) welcomes the government's intention to reform death and cremation certification believing that this is a key step following the third report of the Shipman Inquiry; (ii) believes that no system can ever provide complete protection against those intent on covering up criminal activity; (iii) believes that any reformed structure would be unable to operate successfully without significant additional resources. (2005)
235.	That in the view of this Meeting two cremation certificates (Forms B and C) are necessary as a safeguard for society.

	(1985)
	CHILD ABUSE/PROTECTION
236.	That this meeting opposes the use of isolation for children and young people who have been detained within the criminal justice system, save where such measures are used for their safety or protection, and calls for the government to similarly condemn this practice. (2017)
237.	That this meeting is very concerned about the adverse effects of child abuse, including child sexual exploitation, and:- <ul style="list-style-type: none"> i) condemns the abuse or maltreatment of children in all circumstances; ii) highlights the need for communities to do more to support and protect children; iii) calls for standardised child protection training programmes for all professionals dealing with children and families; iv) calls for a Health Needs Assessment to be undertaken in relation to child maltreatment in the UK; v) in principle, supports the introduction of “Mandatory Reporting” child abuse legislation and insists that any introduction is scientifically evaluated; vi) recommends that organisations working in the community on child abuse prevention programmes should incorporate material related to Adverse Childhood Experiences (“ACEs”); vii) insists that, following the introduction of the Modern Slavery Act 2015, statutory guidance, education and training for appropriate professionals, must be provided. (2015)
238.	That this Meeting believes that one of the primary goals of any society is to promote the welfare of children and protect them from harm, and that doctors have a key role in this regard. This Meeting therefore believes:- <ul style="list-style-type: none"> (i) it is essential that the dissolution of primary care trusts and their replacement by Clinical Commissioning Groups does not damage multi-agency arrangements to safeguard children; (ii) that Clinical Commissioning Groups should be required to fund an appropriate number of sessions for a Designated Doctor for Safeguarding Children, and a Named Public Health Professional for Safeguarding Children, in each area served by a Local Safeguarding Children Board; (iii) that the BMA should work with other relevant stakeholders to ensure that doctors undertaking child protection work have comprehensive access to appropriate training and mentoring programmes. (2012)
239.	That this Meeting notes the recommendations of the Care Quality Commission report 2009, which highlights the need for NHS bodies to assure the training of their staff in child safeguarding, and calls on the UK Health Departments to confirm: <ul style="list-style-type: none"> (i) that all commissioning bodies have responsibility for providing protected funding for child protection training; (ii) that named and designated doctors' job descriptions should include protected time for training staff within their organisation; (iii) that competence levels and training needs are not always the same across different medical specialties; (Lapsed 2015)

	<p>(iv) that Local Safeguarding Children Boards (or equivalent) must make engagement with paediatricians, general practitioners and patients a high priority for 2010-11.</p> <p>(2010)</p>
240.	<p>That this Meeting notes with great concern the report by Lord Laming into the death of Baby P in Haringey, and calls on Council to:</p> <ul style="list-style-type: none"> (i) lobby Health Departments for improved funding for training for health professionals in safeguarding children; (ii) press governments to introduce independent chairs for statutory safeguarding bodies at local level [such as Local Safeguarding Children Boards]; (ii) press governments to review their guidance such that statutory safeguarding bodies at local level have voting representation from paediatricians, child psychiatrists and general practitioners. <p>(2009)</p>
241.	<p>That this Meeting overwhelmingly supports Lord Laming's Inquiry into the death of Baby P and welcomes the resulting drive to increase the number of health visitors in primary care.</p> <p>(2009)</p>
242.	<p>That this Meeting:</p> <ul style="list-style-type: none"> (i) recognises that the welfare of vulnerable children is served by doctors prepared to work in child protection including expert witness work; (ii) expresses support for any doctor who fulfils their duty in safeguarding children; (iii) reiterates the 2006 ARM call for an enquiry into miscarriages of justice regarding cot death; (iv) believes that recent judgments have major implications for doctors who have previously relied on the presence of a chaperone for protection against allegations of misconduct. <p>(2008)</p>
243.	<p>That this Meeting applauds the Royal College of Paediatrics and Child Health for issuing guidance for named doctors for child protection. We believe that basic training in child protection is also a crucial part of induction for doctors, and:</p> <ul style="list-style-type: none"> (i) calls on the Health Departments to require all trusts to provide sufficient support for named doctors; (ii) calls on the BMA to liaise with the RCPCH, the RCGP, COPMeD and employers to secure such training for all doctors. <p>(2006)</p>
244.	<p>That this Meeting believes that the recognition and safeguarding of children in need of protection is a core responsibility for all doctors and health care professionals.</p> <p>(2005)</p>
245.	<p>That all doctors should have training to raise awareness of child protection issues.</p> <p>(2005)</p>
	<p>CHILD CARE FACILITIES / COSTS</p>
246.	<p>That this Meeting asks the BMA to highlight the under- investment in transition care for disabled children (from the paediatricians to adult physicians) and actively promote investment in transition by commissioners.</p> <p>(2012)</p>
247.	<p>That this Meeting believes that with reference to parental leave:</p> <ul style="list-style-type: none"> (i) the BMA should publicise doctors' rights to take parental leave;

	(ii) this entitlement should be included in all doctors' contracts. (2009)
248.	That the BMA calls on all NHS trusts and PCTs to provide comprehensive nursery care (24 hour where necessary for shift workers) for all NHS staff, including academic staff, which must be equally accessible to all. (2006)
249.	That this Meeting supports junior doctors who are in training to obtain childcare facilities at their respective hospital NHS trusts places of work. (2006)
250.	That the BMA requests the government to: (i) develop a comprehensive childcare strategy which will address the needs of the 21st century doctor and parent; (ii) provide 24 hour nursery and childcare places; (iii) ensure that primary care GPs and staff have full provision of childcare facilities; (iv) ensure that GPs who are self-employed, and other self-employed medical practitioners working in the NHS should be eligible for the childcare voucher scheme. (2005)
251.	That this Meeting believes that NHS trusts should provide 24-hour on-site childcare facilities for healthcare professionals required to work shifts, and calls on the BMA and other trade unions to lobby for this. (2004)
252.	That this Meeting believes that on-site childcare should be provided at the ARM and all major BMA conferences without exception. (2001)
253.	That every trust should have adequate and appropriate childcare facilities. (2001)
254.	That this Meeting calls for increased acceptance and provision of flexibility in training and career grade posts, and calls for: (i) adequate nursery/child care facilities at work to be made available to staff and students; (ii) recognition and funding of the cost of child care for periods of "on-call" work; (iii) the BMA to continue setting a good example for providing appropriate child care costs where necessary to attend meetings and to ensure that this policy is effective across the whole Association. (2000)
	CHILD HEALTH CARE
255.	That this meeting:- i) recognises the significant positive impact of a timely education, health and care plan on the child and their family and caregivers; ii) is disappointed by the unacceptable number of children and young people, waiting longer than the statutory 20 week deadline, for the educational support they are legally entitled to and need; iii) calls on government to collect and publish data on exactly how long children and young people are waiting for an education, health and care plan; iv) calls on government for greater financial support for the assessment and implementation of education, health and care plans.

	(2018)
256.	<p>That this meeting:-</p> <ul style="list-style-type: none"> i) calls on government to recognise the devastating long-term life-course effect of adverse childhood experiences and ensure adequate social support to children at risk; ii) calls on all NHS services to recognise that any child facing loss or bereavement needs specific support in school and out of school, including access to bereavement support. <p>(2018)</p>
257.	<p>That this meeting is dismayed that more than 34,000 children aged nine years and under have had tooth extractions in the last two years, 18,000 of which are five years and under. The avoidable risks of general anaesthesia and impact on morbidity is of serious concern. This meeting therefore:-</p> <ul style="list-style-type: none"> i) calls on the Departments for Education and of Health to facilitate the introduction of compulsory dental hygiene lessons into the primary school curriculum; ii) calls on the introduction of free toothbrushes to all children aged five years and under; iii) calls on the secretary of state for health and the Food Standards Agency to regulate for the introduction of health warnings on the packaging of children's foods where high sugar contents may contribute to tooth decay. <p>(2017)</p>
258.	<p>That this meeting believes that in view of the fact that most factors that influence child and adolescent health lie out with the health sector, and evidence of success in Finland of the application of a " Health in all Policies" approach, this meeting calls on the UK governments to mandate a " Health in all Policies" approach to incorporate health into all of their decision making areas.</p> <p>(2015)</p>
259.	<p>That this meeting deplores the ongoing practice of detaining children in police cells overnight, and believes that funding cuts to Child and Adolescent Mental Health Services (CAMHS) and social services are contributing to this issue. We therefore call upon the government to:-</p> <ul style="list-style-type: none"> i) ensure adequate funding for comprehensive CAMHS services nationwide; ii) ensure adequate age-appropriate health-based "places of safety" for children who are sectioned under the Mental Health Act; iii) ensure adequate social care funding so that appropriate alternative accommodation can be found when required for vulnerable children. <p>(2015)</p>
260.	<p>That this Meeting notes the warning from the Board of Science that the UK is failing to adequately protect and promote its children's health and wellbeing, and believes that austerity measures and welfare reform are disproportionately affecting families and children. We call on the government to:-</p> <ul style="list-style-type: none"> i) provide adequate resources for community and family support schemes; ii) increase investment in programmes aimed at providing good parenting skills, with targeted funding for parents whose children have behavioural problems; iii) strengthen the role of health visitors working closely with GPs in strong primary care teams; iv) increase and protect investment in child and adolescent mental health services (CAMHS), and ensure sufficient specialist CAMHS staff are available in each locality for assessments and interventions to be offered in a timely manner; v) improve the quality of social and other housing. <p>(2014)</p>

261.	That this Meeting calls upon all UK governments to monitor the impact of austerity and funding cuts on access to children's health services, especially those for disability. (2014)
	CLINICAL AUDIT
262.	That this Meeting welcomes the movement made towards clinical audit which must remain confidential and clinically led. (1995)
263.	That this Meeting believes that in order for clinical audit to be effective the process: (i) requires considerable further time and money if it is to raise standards; (ii) demands the provision of adequate clerical support for hospital doctors; (iii) should encourage education in audit to reduce wasteful expenditure; (iv) should ensure that due remuneration is made to part time medical staff to assist them to attend fixed audit sessions. (1992)
	CLINICAL GOVERNANCE AND RESPONSIBILITY
264.	That this meeting has no faith in the CQC. (2016)
265.	That this meeting asks the BMA to enter into discussion with the CQC in order for them to produce evidence based standards and clear criteria for their visits. (2016)
266.	That this meeting;- i) demands that CQC inspection teams always include professional members with experience relevant to the service or premises being inspected. ii) demands that professional members of inspection teams are in relevant active practice or with 2 years of such practice. (2014)
267.	That this Meeting deplores the lengthy delays in the investigation by health bodies of patient safety concerns raised by health professionals, and calls on health bodies to ensure that the systems for reporting their findings are timely and robust, and that the clinicians who originally raised the concerns are included in the distribution of the reports. (2014)
268.	That this Meeting recognises that, in supporting clinical governance, clear guidance from Royal Colleges and other academic medical bodies is important, and demands that clinical guidelines be made available to registered medical practitioners free of charge. (2008)
269.	That this Meeting demands a clear agreement about clinical responsibility for patients returning from NHS funded treatment abroad. (2002)
270.	That this Association: (i) supports the concept of properly evidence based clinical guidelines; (ii) does not support rigid application of these in all relevant clinical circumstances;

	<p>(iii) feels they should form only part of the complex decision making process between doctor and patient;</p> <p>(iv) believes that national service frameworks and similar policy documents must be accompanied by sufficient extra funding to cover drugs, administration and extra professional time required for their implementation.</p> <p>(2001)</p>
271.	<p>That this Meeting believes that all aspects of clinical governance need to be implemented in private sector healthcare.</p> <p>(1999)</p>
272.	<p>That this Meeting insists that the development of clinical governance within the NHS must:</p> <p>(i) be based on a bottom up approach;</p> <p>(ii) be part of local professional self regulation;</p> <p>(iii) be provided with identifiable resources by the Department of Health for its setting up;</p> <p>(iv) be such that it ensures that the responsibility for clinical standards remains with doctors.</p> <p>(1998)</p>
273.	<p>That clinical governance and evidence based medicine must not be allowed to develop into managed clinical care.</p> <p>(1998)</p>
274.	<p>That this Meeting believes that no health care professional should be allowed to administer chemotherapy unless he/she has completed a formal training programme for this.</p> <p>(1993)</p>
275.	<p>That this Meeting considers that decisions relating to the clinical management of patients, including priority for admission, should rest solely with responsible medical staff and not with lay managers.</p> <p>(1992)</p>
276.	<p>That the BMA should support junior doctors and medical students who refuse to perform procedures for which they are not adequately trained or adequately supervised.</p> <p>(1992)</p>
277.	<p>That this Association advises doctors to be cautious about joining multidisciplinary teams in which they are bound to decisions taken by majority vote or by consensus about their patients for whom they continue to bear full medical responsibility.</p> <p>(1988)</p>
278.	<p>That this Meeting places on record its firm belief that the diagnosis and treatment of patients are the responsibility of the doctor.</p> <p>(1986)</p>
279.	<p>That this Meeting urges the GMSC to use all means possible to reverse the trend towards the fragmentation of primary medical services into a number of splinter groups by our allied professions who do not have the total responsibility of the general medical practitioner.</p> <p>(1986)</p>
280.	<p>That this ARM is totally opposed to any restriction of clinical freedom by regulation without consultation with the profession.</p> <p>(1985)</p>

	COMMUNITY CARE
281.	That this meeting welcomes the recent increase in funding for perinatal mental health, however remains concerned about the current level of services and calls for:- i) no mother and baby to be separated for lack of beds in their area; ii) a medical professional to be involved in planning appropriate care for the mother, where a baby is removed by social services; iii) the BMA to work with stakeholders to develop guidelines on best practice in supporting mothers' who have their babies removed; iv) local authorities to ensure that there are appropriate support services available for mothers who have their babies removed. (2018)
282.	That this meeting welcomes the BMA's commitment to care workers receiving a living wage and through exploring with our fellow trade unions how we can support them to improve the terms and conditions for care workers. (2017)
283.	That this meeting believes that the government drive for earlier diagnosis of dementia without the corresponding support for those receiving such a diagnosis is pointless and only serves to increase distress for patients and families. (2016)
284.	That this meeting deplores the fact that our most vulnerable young people are being sent to inpatient units far from their local support networks, because of the continuing bed shortage, and demands i) that councils and providers work together with a sense of urgency for care closer to home and; ii) that funding for this purpose be an immediate priority. (2016)
285.	That this meeting recognises the need for more carers to provide care in the community and welcomes a commitment to care workers receiving a living wage and supports methods to increase the number of care workers and recommends: i) employed care workers receive nationally agreed terms and conditions of service; ii) care workers are considered to be key workers and given advantageous deals on housing. (2016)
286.	That this Meeting notes that evidence from the Netherlands and the UK casts serious doubt on the health benefits and cost effectiveness of Personal Health Budgets and calls for the full evaluation of Personal Health Budget pilots in England before this scheme is rolled out further. (2014)
287.	That this Meeting is disappointed that government has had little success in planning support for an increasingly elderly population and:- i) is appalled that many care homes and hospitals do not attain minimum nutritional standards or basic dignity standards for older people; ii) calls on the BMA to repeat its 2008 survey of members' opinions of care homes. (2013)

288.	That this Meeting is concerned with the difficulty hospital clinicians are experiencing in organising safe transfer of care and safe discharge of patients due to the speed of bed closures, pressure to discharge patients and lack of support in community. (2013)
289.	That this Meeting believes that the issue of how to fund personal care has been sadly neglected for many years and demands that the Westminster government: <ul style="list-style-type: none"> (i) establishes, as a matter of urgency, a cross-party working group to aim to achieve a consensus model to fund social care which should: <ul style="list-style-type: none"> (a) consider compulsory saving through a 'save as you earn' type deduction; (b) consider a partnership model; (c) balance incentivising saving for personal care and the need for a safety net for the neediest; (ii) make clear to the public: <ul style="list-style-type: none"> (a) the current eligibility for comprehensive free personal care; (b) the difference between healthcare free at the point of delivery and what people can be expected to pay for personal care. (2010)
290.	That this Meeting believes the lack of social workers and intermediate care in and out of hospital delays discharge of "medically fit" patients at great expense and calls on the BMA to lobby for more rehabilitation wards and intermediate care centres. (2009)
291.	That this Meeting: believes that a major factor in the deterioration of the health of patients with long-term health problems with consequent hospital treatment is non-compliance with their prescribed medication; <ul style="list-style-type: none"> (i) calls on government to ensure that the prevention of the deterioration of the health of patients with long term health conditions is given greater importance in health policy in the UK in order to reduce the very high costs of patient hospital treatment; (ii) asks government to put additional resources into a programme to assist patients with increasing their compliance with medication regimes in order to prevent deterioration in their health. (2006)
292.	That this Meeting, in view of Lord Warner's announcement of a new 'Public Capital Scheme' going into community hospitals, demands that the governments: <ul style="list-style-type: none"> (i) increase the resources to community hospitals; (ii) ensure centrally funded adequate GP remuneration negotiated by GPC; (iii) stop the threat of imminent closure to many community hospitals. (2006)
293.	That this Meeting is concerned about the detrimental effects on patient care of the continued decline in the number of nursing and residential home beds and: <ul style="list-style-type: none"> (i) supports the government's own target to eliminate widespread delayed discharge by 2004; (ii) believes that the solution is better resourcing of community care and an increase in the number of care home places and asks the Association to press the Departments of Health to increase funding for this. (2002)

294.	That it is inequitable to distinguish between nursing and personal care for those in need of long-term support and the BMA should urge government to follow the example in Scotland where this distinction has been abolished. (2002)
295.	That this Meeting requests Government to address and correct the underfunding of community care services. (1998)
296.	That this Meeting believes that the proper funding of community care is central to the success of the resolution of the bed crisis in secondary care. (1997)
297.	That this Meeting demands that there is no premature discharge of long term institutionalised patients into the community without adequate resources and support. (1997)
298.	That this Meeting: (i) recognises that the increase of care in the community of vulnerable elderly and the mentally ill is putting an intolerable burden on GPs; (ii) insists that more resources must be transferred to primary care and used to fund the community care service; (iii) insists that general practice should cease to be a safety net for grossly deficient services. (1996)
299.	That this Meeting holds that where continuing medical treatment is required following discharge from hospital, the NHS should continue to be responsible for this medical care, irrespective of where the care is provided, and should provide funding for such care. (1996)
300.	That this Meeting is concerned at the failure of the good concept of community care due to lack of funding. (1995)
301.	That this Meeting is gravely concerned about the new arrangements for the long term care of patients and: (i) the ambiguities surrounding the financing of long term care; (ii) ageist attitudes in the provision of funding of health care for the elderly in the climate of a competitive NHS. (1995)
302.	That this Meeting recognises and deplors the excessive burden placed on informal carers as a consequence of inadequate funding of community care. (1995)
303.	That this Meeting upholds the principle that resources and support for carers should reflect their contribution to care of patients at home. (1995)
304.	That this Meeting is concerned about the inadequacy of provision of community care for vulnerable groups and urges the Government to: (i) develop protocols to promote co-ordination between the agencies involved; (ii) provide adequate resources;

	(iii) monitor the process. (1992)
305.	That this Meeting believes that the Secretary of State for Health should be accountable for standards of all community care - including that contracted to groups and organisations outside the NHS. (1992)
306.	<u>Care of the elderly</u> That this meeting reaffirms the fact that elderly people deserve access to high quality health and social care, and demands that:- i) care homes are nationalised in order to achieve and maintain a national standard of residential and nursing home care; ii) care home staff are subject to NHS appraisal processes and terms and conditions of service; iii) home-based social care should be provided by NHS organisations; iv) there should be an increase in the provision of residential and nursing home beds, so that hospital patients in need of supported accommodation are not faced with long delays for supported living. (2019)
307.	That this meeting recognises the increasing incidence and reporting of elder abuse but many cases of elder abuse are not reported by health professionals looking after victims in a health care setting. This meeting:- i) supports the need for awareness and education of elder abuse for health professionals including medical students; ii) calls for an open and transparent process for reporting abuse and support for the whistleblower in the health care setting; iii) calls for a clear line of support from relevant bodies to make a referral for elder abuse. (2015)
308.	That this Meeting insists that necessary surgery in older people must not be hindered on grounds of age and asks the BMA to support the announcement of Sir David Nicholson that he will pursue fundamental improvement in the care of the elderly. (2013)
309.	That this Meeting is concerned about the care provided to housebound patients and patients in geriatric hospitals, nursing homes and residential homes. This Meeting calls for both an increase in investment and available services for these groups of patients, including:- (i) enhanced primary medical care; (ii) domiciliary specialist care; (iii) psychiatric services; (iv) occupational therapy and physiotherapy; (v) minimum nursing staff levels in applicable settings. (2012)
310.	That this Meeting notes with dismay the abuse of patients at Winterbourne view revealed by the recent BBC Panorama programme. We believe that the failure of the Care Quality Commission (CQC) to intervene is an example of how it is currently unfit for purpose and we demand the government carry out a review of the scope, staffing levels and resources of the CQC. (2011)

311.	<p>That this Meeting believes that increasingly reported levels of abuse of the elderly are not being sufficiently recognised in hospitals and within medical school curricula and calls for the DoH to:</p> <ul style="list-style-type: none"> (i) produce a document detailing the 'red flags' in abuse of the elderly cases similar to the information already available regarding child abuse; (ii) circulate this document among care providers and medical schools so that abuse of the elderly may be recognised early. <p>(2008)</p>
312.	<p>That this Meeting strongly believes that older patients should be treated with dignity and respect at all times.</p> <p>(2008)</p>
313.	<p>That this Meeting notes with concern the recent regulatory body report on care of older people and asks that older people should have equal access to specialist treatment and be treated with respect and dignity.</p> <p>(2006)</p>
314.	<p>That this Meeting deplores the lack of services available for frail elderly patients, including:</p> <ul style="list-style-type: none"> (i) emergency respite care; (ii) community nursing services; (iii) social services; (iv) rehabilitation teams; (v) hospital beds. <p>(2005)</p>
315.	<p>That this Meeting asks the government to discontinue means testing for elderly patients needing long term care.</p> <p>(2002)</p>
316.	<p>That this Meeting commends the Scottish example of fully funding the personal care element of long term care of the elderly. We deplore the Government's failure to introduce similar measures in England and call upon the Government to follow the Scottish example.</p> <p>(2001)</p>
317.	<p>That this Association:</p> <ul style="list-style-type: none"> (i) endorses the view of the Medical Royal Colleges and the British Geriatric Society that funding for long term care of the elderly is a national disgrace; (ii) deplores the failure of the Government to implement the recommendations of the Royal Commission on long term care of the elderly; (iii) insist that the Government implements these recommendations in full, forthwith. <p>(2000)</p>
318.	<p>That this Meeting believes that the Government should implement rapidly and in full the recommendations of the Royal Commission on long term care for the elderly.</p> <p>(1999)</p>
319.	<p>That this Meeting deplores the widespread loss of geriatric and psycho geriatric continuing care beds from the NHS.</p> <p>(1994)</p>
320.	<p>That the rising proportion of the elderly in the community with highly specialised medical requirements is liable to produce a crisis in geriatric medicine unless more doctors appropriately trained are induced to take up this specialty.</p> <p>(1975)</p>

321.	<p><u>Intermediate care</u></p> <p>That this Meeting supports the concept of intermediate care but insists that it is fully funded with new money and that clinical responsibility over the full 24 hours for patients under these arrangements is clearly defined. (2003)</p>
322.	<p>That this Meeting believes that intermediate care should be properly researched and states that:</p> <ul style="list-style-type: none"> (i) it must not start before manpower and financial considerations are properly thought through; (ii) it is no substitute for referral to acute services where clinically appropriate. <p>(2001)</p>
	<p>COMPLAINTS PROCEDURES</p>
323.	<p>That this meeting asks the BMA to call on the relevant bodies to review within twelve months the impact on doctors of the involvement in an NHS or other complaints procedure, in particular with regard to: -</p> <ul style="list-style-type: none"> i) impact on the health of doctors; ii) impact on patient care; iii) the part played in complaints by unrealistic expectations and how this can be addressed; iv) BMA council working with BMA patient representatives to review and propose a fair and streamlined complaints procedure; v) raising awareness of the pressures on the NHS and realistic expectation of the service and its staff. <p>(2019)</p>
324.	<p>That this meeting believes that most errors in medical practice ultimately are due to failures in the complex systems of healthcare itself and therefore calls for:-</p> <ul style="list-style-type: none"> i) government to stop blaming doctors for error resulting from system failures; ii) government to support the no blame culture required to ensure that all errors are raised to allow systems to be changed to improve safety for patients; iii) establishment of anonymous reporting systems for concerns about patient safety; iv) appointment of 'Freedom to Speak Up Guardians' as recommended in the Francis Report. <p>(2018)</p>
325.	<p>That, in respect of complaints procedures:-</p> <ul style="list-style-type: none"> i) a doctor who is the subject of a complaint should be fully informed and involved in the management of the complaint; ii) locum doctors in all settings should be treated equitably in respect of complaints; iii) all doctors are entitled to defend their professional reputation. <p>(2016)</p>
326.	<p>That this Meeting, in the light of the reported deaths of doctors while under GMC investigation, requires:-</p> <ul style="list-style-type: none"> i) that the GMC publish the results of its internal review of suicide in doctors facing GMC investigation; ii) that the outcome of the GMC-BMA pilot of support for doctors facing investigation be published; iii) that the BMA should offer more consistent support to doctors facing GMC investigations. <p>(2014)</p>

327.	That this Meeting deplores the proposal that unsubstantiated and anonymous complaints against doctors could be recorded by the GMC without the individual doctor being notified and instructs the BMA to campaign vigorously against any unfair attacks on doctors. (2009)
328.	That this Meeting condemns the increasing criminalisation of medical mishaps and calls on the Chairman of Council to meet with the Director of Public Prosecutions as soon as possible in order to agree a transparent threshold for manslaughter, at least at a level equivalent to 'reckless negligence'. (2005)
329.	That this Meeting insists that any investigation of the clinical competence of a doctor must be conducted with sensitivity and the use of appropriate criteria to avoid life threatening levels of stress. (2004)
330.	That this Meeting supports doctors who are unfairly dealt with by their trusts in disciplinary procedures and wants the BMA to assist them in re-employment once they are cleared by the procedures. (2004)
331.	That this Meeting believes. (i) that widespread "criminalisation" of unfortunate mistakes is destroying the lives and careers of many young doctors; (ii) that mistakes made by doctors are often symptomatic of system failures; (iii) that the doctors who make unintentional mistakes should be supported and retrained rather than punished. (2004)
332.	That this Association believes that doctors are sick of: (i) being held personally accountable for medical errors arising from being overworked and under-resourced; (ii) the negative media campaign at a time of crisis in recruitment and retention; (iii) rising complaints fuelled by Government "spin". (2001)
333.	That this Meeting proposes that when a family health services authority brings a breach of terms of service complaint against a GP, initiated by a patient or otherwise, then when any such allegation is shown at formal or informal proceedings to be unfounded, the expenses incurred by a GP in rebuttal of that complaint should be chargeable to the family health services authority. (1995)
334.	That Council should examine means of seeking restitution for doctors who are victims of unsubstantiated complaints. (1993)
335.	That this Meeting totally rejects the intrusion of the Health Service Commissioner (Ombudsman) into the field of clinical judgement. (1978, reaffirmed 1980 and 1986)

336.	<p><u>Suspensions/disciplinary</u></p> <p>That this Meeting mandates Council to work with the GMC and Government to formulate and implement a fair system where feasible for the rehabilitation and revalidation of doctors whose names have been removed from the medical register. (2000)</p>
	<p>CONSENT TO TREATMENT</p>
337.	<p>That this meeting notes that junior doctors are frequently asked to gain consent from patients for procedures that they are not able themselves to perform, or for procedures of which they have limited knowledge. This meeting therefore:</p> <p>i) acknowledges the GMC guidance “Consent: patients and doctors making decisions together”, which states the doctor undertaking the procedure should discuss it with the patient, or delegate this discussion to a suitably trained person with sufficient knowledge;</p> <p>ii) encourages junior doctors to refuse to gain consent for a procedure if they do not have sufficient knowledge of the procedure. (2016)</p>
338.	<p>That this Meeting calls on the BMA Council to emphasise the medical profession's commitment to discuss with patients all investigations before undertaking them whenever possible. (1988)</p>
	<p>CONSULTANTS</p>
339.	<p>That this meeting notes the early retirement of NHS consultants due to changes in pension legislation and:-</p> <p>i) recommends the re-employment of these experienced staff on terms to include the employer's former pension contribution to salary;</p> <p>ii) insists that these processes be streamlined to encourage and facilitate staff retention. (2018)</p>
340.	<p>That this meeting recognises that some consultant working patterns, particularly those commonly worked by emergency medicine consultants such as full shift 24 hour rotas, become increasingly difficult to sustain in the latter part of a typical consultant career. This meeting asks the BMA to:-</p> <p>i) ensure that this issue is taken into account during any further or future contractual negotiations with national NHS bodies in the UK;</p> <p>ii) ensure that this issue forms part of any workforce planning publications or lobbying or negotiations with national NHS bodies or the governments of the UK. (2018)</p>
341.	<p>That this meeting is:-</p> <p>i) concerned at the lack of time available for supporting professional activities (SPA) in the job plans offered to many new consultants and;</p> <p>ii) urges all new CCT holders to carefully consider the proposed amount of SPA time before accepting an offer of appointment. (2015)</p>
342.	<p>That this meeting:-</p> <p>i) believes that members in training at ST3 level and above working in non-GP specialties should be included in BMA consultations, correspondence or ballots relating to the re-negotiation of the consultants contract in the UK</p>

	<p>nation in which they work and;</p> <p>ii) demands that a vote cast in any consultant contract negotiation ballot by a doctor in training must have the same weight as one cast by a member on a Specialist Register.</p> <p>(2015)</p>
343.	<p>That this Meeting calls on the Consultants Committee negotiators to ensure that any changed or new consultant contract should:-</p> <p>i) reflect the large proportion of out of hours work done by consultants;</p> <p>ii) recognise the need to make out of hours working patterns attractive and sustainable;</p> <p>iii) recognise that any consultant out of hours provision needs to be matched by the availability of appropriate support staff and services.</p> <p>(2014)</p>
344.	<p>That this Meeting believes in the ethos of CEA awards and that such funding must remain as part of the remuneration package but believes there are wide variations in how these awards are allocated and calls upon the BMA to consider fairer more transparent processes.</p> <p>(2014)</p>
345.	<p>That this Meeting:-</p> <p>i) believes that the Report of the Francis Inquiry has demonstrated that too much focus on management targets harms patient care;</p> <p>ii) believes that the recommendations of the DDRB report into consultant remuneration with its managerial paradigm would greatly impede consultants' work and risk reducing quality of care and patient safety;</p> <p>iii) believes that the changes proposed by the DDRB on consultant remuneration and career structure will have significant detrimental effects on the recruitment and retention of secondary care doctors;</p> <p>iv) believes that negotiation on the basis of the DDRB report into consultant remuneration is not in the interests of patients and is therefore neither sensible nor prudent;</p> <p>v) condemns the DDRB recommendation that consultant pay progression and CEAs be dependent on achieving management targets at managerial discretion;</p> <p>vi) demands that government formally reject any link between managerial targets and consultant remuneration.</p> <p>(2013)</p>
346.	<p>That this Meeting deplores the actions of some NHS trusts who seek to undermine the national terms and conditions of employment for NHS consultants.</p> <p>(2013)</p>
347.	<p>That this Meeting supports changing consultants' working patterns, where there is evidence that such a change would improve patient safety and quality of care. This Meeting insists that this must be backed by the full support services for that work, and the contractual basis is equal to, or better than current provisions.</p> <p>(2013)</p>
348.	<p>That this Meeting believes that an attack on Clinical Excellence Awards is an attack on delivering quality in the NHS and:-</p> <p>(i) that abolition of CEAs will lead to demotivation, loss of innovation and leadership while achieving only relatively small savings;</p> <p>(ii) deplores the government's delayed release of the 2011 DDRB Review on compensation levels, incentives and the Clinical Excellence and Distinction Award schemes and demands that this review and the government's response to it be published immediately;</p>

	(iii) calls for the maintenance of a fair system for rewarding clinical excellence (2012)
349.	That this Meeting believes that transferability of consultants between the four UK countries is essential and therefore calls on the BMA to develop guidance on transferring accrued contractual rights and pension entitlements so that the process of movement of medical staff across the UK can be facilitated. (2012)
350.	That this Meeting believes that cuts in administrative and clerical staff within the NHS mean that all doctors pick up an increasing administrative burden, making their clinical work less efficient and productive. This Meeting calls upon the health departments to ensure that all doctors have adequate administrative and clerical support to enable them to deliver a quality and timely service to their patients. (2012)
351.	That this Meeting believes that future regional pay variations would be to the detriment of consultants and ultimately patients and calls on the BMA to resist attempts across the United Kingdom to erode the current pay of consultants. (2011)
352.	That this Meeting notes the effectiveness of the Clinical Excellence Awards schemes in supporting and encouraging contributions by consultants to innovation, education and research in the NHS and the development and improvement of quality and safety of patient care and:- i) deplores the reduction in funding of the national and employer-based schemes without consultation or negotiation; ii) believes that the abolition of CEAs would demotivate consultants and lead to loss of innovation and leadership while achieving only relatively small savings; iii) urges the need for greater transparency in the allocation of CEAs, with equal opportunities with respect to region, gender and ethnicity, and that awards be fairly represented across all specialities; iv) believes that the review of CEAs should ensure they remain fit for purpose and relevant. (2011)
353.	That this Meeting believes that the simplistic prohibition of consultant-to-consultant referrals by commissioners or providers of NHS services damages and delays patient care and that national guidelines should be developed for direct referral between consultants to ensure that patient care is not compromised. (2009)
354.	That this Meeting: (i) demands that NHS Foundation Trusts should only appoint consultants under the same regulatory regime and appointment of consultants regulations as applies to NHS trusts; (ii) believes that it is essential that there is always a Royal College Assessor (or National Panellist in Scotland) on all consultant appointment panels. (2009)
355.	That this Meeting believes the government must urgently undertake a comprehensive workforce planning programme and provide required consultant expansion: (i) to progress the development of good and effective healthcare; (ii) in a controlled and planned manner dictated by demand and not the present or future supply of qualified candidates;

	<p>(iii) to accommodate increasing workload pressures on consultants in both elective and emergency care. (2008)</p>
356.	<p>That this Meeting demands that any measures of medical 'productivity' must take into account improvements in quality, increased complexity and the manpower actually available, rather than a simplistic head count. (2008)</p>
357.	<p>That this Meeting condemns the widespread progressive reduction in supporting professional activities within consultant job plans which undervalues the contribution of the consultant-led service development of patient care. (2008)</p>
358.	<p>That this Meeting abhors the introduction of new post-CCT fellowship posts and insists that:</p> <ul style="list-style-type: none"> (i) the CCT remains the end point of training and is all that is required to demonstrate readiness for independent consultant practice; (ii) they have defined training objectives that genuinely could not be provided within CCT training programmes; (iii) they may only be created to meet a proven and unmet need for consultants with particular subspecialist skills; (iv) they are not used as a cynical ploy to introduce sub-consultant posts to meet service needs; (v) they should not continue beyond 2010. <p>(2008)</p>
359.	<p>That this Meeting believes that government policy is directed at producing sub-consultant grades despite statements to the contrary and it asks the BMA to condemn such cynical actions. (2008)</p>
360.	<p>That this Meeting continues to believe that supporting professional activities for consultants are essential to maintain high quality services for our patients and that if consultants have lower than 2.5 SPA (3.0 Wales), then job planning should be used to support and enable consultants to increase their supporting activity work up to this level. (2007)</p>
361.	<p>That this Meeting insists that as the Department of Health has stated that it has "absolutely no intention to create" a new post-CCT sub-consultant grade and that there "will be more consultants in the future" then the following must be delivered:</p> <ul style="list-style-type: none"> (i) sufficient consultant expansion to deliver on service objectives; (ii) sufficient consultant expansion to give patients the highest quality care from fully trained consultants; (iii) sufficient UK training places to feed the necessary consultant expansion; (iv) a system of career progression within the consultant grade with no artificial barriers; (v) public statements from the Presidents of all the Medical Royal Colleges opposing the introduction of any post-CCT sub-consultant grade. <p>(2006)</p>
362.	<p>That this Meeting:</p> <ul style="list-style-type: none"> (i) strongly believes in continuing medical education and professional development and believes that reducing the time available for supporting professional activities would put at risk the revalidation of doctors including consultants; (ii) condemns attempts by the government, trusts and other bodies to reduce the time that consultants have available for supporting professional activities and believes that these are being driven primarily for cost saving reasons;

	<p>(iii) believes that continuing medical education and professional development requires a minimum of 2.5 (3.0 in Wales) programmed activities per full-time consultant under the new contract to maintain the current high quality care that patients receive and to allow for development of patient services;</p> <p>(iv) demands that government ensures that no employing authority or trust reduces consultant supporting professional activities below a minimum of 2.5 (3.0 in Wales) programmed activities, per full-time consultant.</p> <p>(2006)</p>
363.	<p>That this Meeting calls upon the BMA to enhance its services available to consultants, particularly in relation to the multi-provider environment:</p> <p>(i) providing a more personally tailored package of membership; and</p> <p>(ii) reviewing the function, support and training of LNCs to ensure that they are equipped to meet the challenges of the multi-provider environment.</p> <p>(2006)</p>
364.	<p>That this Meeting regards it as fundamental that all consultants retain the option of referring their patients for an opinion anywhere in the NHS whenever they feel it clinically necessary as part of their continuing care of the patient or when there is any other clinical reason for the patient to be referred to a particular consultant or team.</p> <p>(2006)</p>
365.	<p>That this Meeting notes with dismay the reluctance of many trusts to recognise external duties appropriately in job plans. The NHS depends on the work of consultants in numerous external bodies for teaching, training, examining, standard setting, regulation and expert advice. We urge the Government to:</p> <p>(i) state unequivocally their strong support for such work; and</p> <p>(Lapsed 2011)</p> <p>(ii) direct strategic health authorities, trusts and equivalent bodies in the devolved nations to reflect that support by reasonable allocation of programmed activities for such duties.</p> <p>(2004)</p>
366.	<p>That trusts should not appoint new consultants without considering and providing the support services required.</p> <p>(2000)</p>
367.	<p>That this Meeting mandates the BMA to improve the lot of all career grade hospital doctors and encourages the formulation of a national policy for paid sabbatical leave.</p> <p>(1998)</p>
368.	<p>That the establishment of a comprehensive consultant-based service would be to the benefit of patients, doctors and the Government, the BMA therefore demands that the Secretary of State for Health in conjunction with the profession develop and implement a specific policy to this end.</p> <p>(1998)</p>
369.	<p>That this Meeting believes that consultant NHS contracts should incorporate a specific number of protected hours for teaching medical students and junior staff.</p> <p>(1997)</p>
370.	<p>That consultants should retain personal responsibility for individual patients; delegation of duties must remain the consultant's responsibility.</p> <p>(1995)</p>

371.	<p><u>Consultant contract</u></p> <p>That this meeting believes that the new (2016) junior doctor contract impinges on the working lives of many consultants in England and demands that NHS Employers agree an adequate programmed activity (PA) allocation for the following roles:-</p> <ul style="list-style-type: none"> i) guardians of safe working; ii) educational supervisors; iii) clinical supervisors. <p>(2017)</p>
372.	<p>That this meeting believes that all consultants, members on the specialist register and junior doctors of ST3 and above should be balloted on the new consultant contract proposals.</p> <p>(2017)</p>
373.	<p>That this meeting requests council to produce guidance to support consultants who continue to treat NHS patients but are no longer employed by NHS trusts.</p> <p>(2016)</p>
374.	<p>That this meeting believes trusts and Health Boards across the country are increasingly encroaching on SPA time to convert it to direct clinical working time. This meeting wants to express its disappointment, and urges the government to respect the consultant contracts.</p> <p>(2016)</p>
375.	<p>That this meeting regrets the obduracy of NHS Employers resulting in stalled negotiations around the consultant contract and recommends that governments and NHS Employers:-</p> <ul style="list-style-type: none"> i) stop pressing doctors to provide 7-day non emergency and elective care without providing appropriate resources and support to deliver safe patient care; ii) release the pay freeze and improve salaries, working conditions and morale of doctors. <p>(2015)</p>
376.	<p>That this Meeting insists that the consultant contract must retain the right of all consultants to publish independently research, audit and reviews of clinical services.</p> <p>(2013)</p>
377.	<p>That this Meeting recognises the value of the excellent work delivered by consultants and makes a firm stand criticising the drive by employers to reduce SPAs that is ongoing at a national level.</p> <p>(2011)</p>
378.	<p>That this Meeting calls upon Health Departments and employers to recognise the critical importance of clear and appropriate objectives and time for Supporting Professional Activities. This Meeting demands that these are protected and prioritised as part of a quality and safety agenda, as well as underpinning clinical leadership, service development, and revalidation.</p> <p>(2010)</p>
379.	<p>That this Meeting calls upon the Health Departments to recognise that clinical excellence awards (and their equivalents) are an integral part of consultant contracts that reward the outstanding performance made by consultants who go above and beyond expected levels of professional excellence in their NHS work, promoting innovation, research, education, and the highest possible levels of quality of patient care.</p> <p>(2010)</p>

380.	That this Meeting affirms that SPAs are a mandatory part of the new consultant contract and demands that these must not be tampered with by employers. (2004)
381.	That this Meeting insists that the consultant contract must allow sufficient time for consultants to participate in the teaching and training of medical students and junior doctors. (2004)
	COUNCIL FOR HEALTHCARE REGULATORY EXCELLENCE (Formerly CRHP)
382.	That in the interest of public and professional confidence in the regulatory process, this Meeting calls upon the Healthcare Commission to ensure that the work of investigation teams is free from interference and that its procedures are fair and consistent with the principles of natural justice. (2006)
383.	That in the light of likely further changes to the GMC's role in regulation, this Meeting calls on the government to scrap the Council for Healthcare Regulatory Excellence. (2005)
384.	That this Meeting notes with alarm: (i) the recent decision in the High Court that the Council for the Regulation of Healthcare Professionals (CRHP) can mount a legal challenge to not-guilty findings by the GMC, as well as "unduly lenient decisions"; (ii) that CRHP has already made referrals to the High Court on at least six occasions despite their previous assurance that such referral would only apply in extreme cases and would be infrequent. This double jeopardy is contrary to natural justice. This Meeting calls on the BMA (a) to monitor the performance of the CRHP; (b) to continue to support professional self-regulation. (2004)
	CYCLING
385.	That this Meeting recognises the considerable contribution that walking and cycling could make to addressing the problem of obesity and therefore: (i) calls for all highway authorities to create a safe comprehensive cycle network to include routes suitable for inexperienced cyclists and also better safety and usability of the ordinary roads; (ii) the inclusion of cycling in NHS exercise promotion programmes; (iii) greater facilities for the combination of cycling with rail travel so as to provide an alternative to the private car for many journeys thus reducing greenhouse gas emissions and increasing cycling. (2009)
386.	That this Meeting believes that BMA policy on cycle helmets should be based on a continuing review of all available evidence. (2006)
387.	That this Meeting calls on the BMA to promote cycling as a safe, healthy and sustainable alternative to car use. (2006)

388.	That this Meeting supports the compulsory wearing of cycle helmets when cycling: (i) for children; (ii) for adults. (2005)
389.	That this Meeting believes the main health hazard for cyclists is being hit by a motorised vehicle and that local and national government should prioritise integrated transport policies that require the introduction of safe cycle lanes in urban areas. (2005)
390.	That cycle helmets should be VAT exempt. (1999)
391.	That this Meeting welcomes the Board of Science and Education Report on Cycling and wishes to encourage safe participation in cycling by: (i) urging Government to support cycling as a means of transport; (ii) requesting Government to enforce an improved standard of lighting on bicycles; (iii) asking Council to press British Rail to widen its provision for bicycles to be carried on passenger trains; (iv) urging the urgent development of a network of cycle tracks. (1992)
	DISABLED PERSONS
392.	That this meeting notes with concern the increasing numbers of patients resorting to crowdfunding their own wheelchairs due to delays and cuts in wheelchair services, and the recent suggestion from Muscular Dystrophy UK that a 'postcode lottery' pervades such services across the country. We call on the BMA to work with NHS England, the Association of Directors of Adult Social Services and other relevant bodies to ensure that would-be wheelchair users have timely access to chairs suitable for their individual conditions. (2017)
393.	That this Meeting is disappointed at the inadequate and patchy public awareness of disability benefits and provision of facilities and adaptations for the disabled and in particular urges Government departments to work together effectively on behalf of this large section of the population. (1997)
394.	That this Meeting requests Council to press for further improvement in arrangements and facilities for disabled persons using public transport, particularly on public service vehicles, at railway stations including underground stations, and at airports. (1982)
	DRUGS
395.	That this meeting recognises evidence that the policies of decriminalising drug use and rehabilitating drug users have resulted in public health benefits in Portugal. Therefore, this conference calls upon the BMA to:- i) lobby the government to increase funding for services that treat drug addiction; ii) lobby the government to reduce barriers to research into currently banned substances; iii) create educational resources to enable medical students and doctors to better understand and meet the needs of patients with drug addiction. (2018)

396.	<p>That this meeting:-</p> <ul style="list-style-type: none"> i) believes that the dangerous increase in antibiotic resistance cannot be reversed until the widespread use of antibiotics in farming is severely curtailed; ii) calls on the BMA to lobby government to introduce urgent legislation to reduce antibiotic use in farming and to incentivise farmers to use measures such as improved sanitation and animal husbandry to reduce infection. <p>(2018)</p>
397.	<p>That this meeting acknowledges the global threat to human health posed by antimicrobial resistance and the firm linkage to inappropriate usage both in human health and in agriculture. As such we call on the BMA:-</p> <ul style="list-style-type: none"> i) to continue supporting the vision of the UK 5-Year Antimicrobial Strategy (2013-2018); ii) to support stakeholders in making sure that there is a subsequent strategy following on from 2018; iii) to support the One Health approach to antimicrobials, recognising that usage in human health only accounts for 50% of usage worldwide and encouraging responsible use in agriculture, engineering and other industries aside from human health. <p>(2017)</p>
398.	<p>That this meeting:-</p> <ul style="list-style-type: none"> i) notes the widespread problems of abuse and addiction with pregabalin amongst users of illicit drugs; ii) notes the contribution of pregabalin to bullying and violence in prison populations; iii) calls for the BMA to lobby the appropriate authorities to make pregabalin a controlled drug. <p>(2017)</p>
399.	<p>That this meeting welcome the recent report from Royal Society for Public Health and Faculty of Public Health as an important intervention in the debate on drugs policy. Noting the 2013 Board of Science report “Drugs of Dependence” and in anticipation of a new drugs strategy from the UK government, this meeting calls for:-</p> <ul style="list-style-type: none"> i) the UK government to move responsibility for drugs policy to the Department of Health; ii) legislative change so treatment and support are prioritised over criminalisation and punishment of individual drug users; iii) introduction of evidence based interventions such as heroin assisted treatment and supervised consumption rooms in areas of high levels of need. <p>(2016)</p>
400.	<p>That this meeting is concerned by the recent surge in availability and use of Novel Psychoactive Substances and the resultant societal harms. Whilst applauding the government’s desire to address this through the Psychoactive Substances Act 2016 the meeting wishes to express concerns that the use of these substances, in particular synthetic cannabinoids, has now become embedded within certain deprived population groups. We therefore call upon the BMA to lobby government to ascertain what provision will be made to provide the needed support and services to these communities in order to address the continuing use of these substances.</p> <p>(2016)</p>
401.	<p>That this meeting believes efficient and safe patient care requires the maintenance of supplies of medicines and calls for:-</p> <ul style="list-style-type: none"> i) the cessation of any arrangements between the pharmaceutical industry and governments to withdraw widely used and essential medicines; ii) direct intervention where necessary to ensure continuity of supply of medicines; iii) the ending of patent protections for specific indications;

	iv) the maintenance of price stability for generic products. (2015)
402.	That this meeting notes that in the USA there has been increasing mortality due to prescribed opioid analgesics and is concerned about the rising use of opioid analgesics for chronic non-cancer pain across the UK, therefore we call on the BMA to identify and explore factors that might support safer prescribing and more effective regulation of these medicines. (2015)
403.	That this Meeting is dismayed that problems in the pharmaceutical supply chain put patient safety at risk and discredit the NHS and asks BMA Council to lobby for a more secure system. (2014)
404.	That this Meeting believes that we are heading towards a post-antibiotic age, and calls i) on the government to introduce much tighter regulation to significantly reduce the use of antibiotics in farming practice; ii) on the BMA to press for much tighter antimicrobial prescribing rules both within the UK and internationally with the aim of preserving antimicrobial sensitivity for as long as possible; iii) on the Board of Science to consider the impact of tighter antimicrobial prescribing rules on medical practice; iv) for the government to review this issue and find ways to incentivise the development of new classes of antimicrobials as well as variations on existing ones. (2013)
405.	That this Meeting is concerned at the proliferation of patients being encouraged to manage their own medication whilst hospital inpatients and believes that:- i) adequate risk assessments need to be in place to identify suitable patients including assessment of capacity; (2013)
406.	That this Meeting highlights the unacceptable and novel commercial practices of the pharmaceutical industry and its supply chains to maximise their profits at the expense of drug availability for patients and requires Council to take the necessary actions to highlight these issues and to write to government requesting investigation and action to protect the NHS budget and the supply chain for patients' medications. (2013)
407.	That this Meeting notes the increased number of drugs unavailable in the UK as companies seek better prices elsewhere, and demands that government address this issue instantly. (2012)
408.	That this Meeting, in view of the promising clinical trial results and noting the legal action by Novartis against several PCTs to prevent the commissioning of Avastin as the drug of choice in the treatment of wet Age-related Macular Degeneration over Lucentis:- (i) affirms that it is the duty of clinicians and commissioners to achieve the maximum benefit for the use of NHS resources and that they should not be constrained in that objective by anticompetitive litigation by commercial suppliers; (ii) notes that the use of established medications for purposes beyond their initial licensed use is a well-established part of the practice of medicine; (iii) notes that the cost effectiveness of Avastin is superior to that of Lucentis; (iv) notes that use of Avastin in the treatment of wet Age-related Macular Degeneration has not been considered by NICE;

	<p>(v) believes that the failure to seek licences for new uses may be commercially justifiable but cannot be allowed to constrain evidence-based practice.</p> <p>(2012)</p>
409.	<p>That this Meeting deplores the increasing frequency with which essential medications become unavailable to NHS patients and:-</p> <ul style="list-style-type: none"> i) calls on health departments to ensure that stocks of medication should never again be subject to such shortages; ii) insists that the pharmaceutical industry be held to account for failings in their supply chain iii) urges the BMA to discuss with health departments how UK manufacturers and wholesalers of medicines can be required to maintain supplies for the UK market before they are permitted to export their products. <p>(2011)</p>
410.	<p>That this Meeting recognises the huge waste that occurs by the inability of patients to return dispensed but unopened medications to pharmacies; it calls on the BMA to explore whether it is possible for some medications to be safely returned to pharmacies, for re-use by new patients.</p> <p>(2011)</p>
411.	<p>That this Meeting believes that patients should be able to purchase medication that they cannot get on the NHS with their own funds and still receive NHS care without having to become a full private patient and calls on the Health Departments to change their rules to ensure that this is possible.</p> <p>(2007)</p>
412.	<p>That this Meeting is extremely concerned about the risks posed to the public through the ungoverned and unfettered availability of prescription drugs through the internet. It urges the BMA to convene a policy group with stakeholders such as the pharmaceutical industry, the Health Departments and Royal Pharmaceutical Society to regulate this growing industry and to safeguard public safety.</p> <p>(2007)</p>
413.	<p>That this Meeting believes that the BMA should recommend that retired clinicians and non-clinical doctors should retain their prescribing rights except for Schedule 4 Drugs. This will enable them to help in general emergencies, such as the possible expected pandemic influenza.</p> <p>(2007)</p>
414.	<p>That this Meeting requests that the board of science and education investigates the implications of the legalisation of drugs of misuse.</p> <p>(2006)</p>
415.	<p>That this Meeting calls for the abolition of VAT on medicines and medical equipment.</p> <p>(2005)</p>
416.	<p>That over-the-counter drug addiction is a growing public health concern that requires action now through:</p> <ul style="list-style-type: none"> (i) clear labelling on OTC medicines that contain addictive substances; (ii) training programmes for all medical professionals to raise awareness of the problem; (iii) clear clinical guidelines set out by the Health Departments on how drug addiction services should manage OTC drug dependent patients. <p>(2004)</p>

417.	That this Meeting believes that in view of recent events GPs should no longer prescribe opiate substitutes unless: (i) GPs have had additional training in such treatment; (ii) it is supported by a specialist team for updates and supervision; (iii) supervised consumption facilities are available. (2000)
418.	That this Meeting congratulates the BMA on its excellent report on cannabis derivatives and urges the BMA to advise Her Majesty's Government to allow wider use of these compounds for medical purposes. (1998)
419.	That this Meeting urges the Government to take appropriate measures to ensure the quality of imported generic drugs. (1989)
420.	That this Meeting urges that all drugs manufactured in the UK for export to developing countries should meet the high standards of safety and efficacy required in this country. (1986)
421.	That drugs for private patients should be on the NHS and that this Representative Body reaffirms this policy. (1979, reaffirmed in 1980, 1981, 1983 and 1984)
422.	That this Meeting urges the Government to ensure that the formulation of all drugs available for sale in this country conforms to a specified standard of therapeutic efficacy. (1972)
423.	That the Government be asked to oblige firms to have a standardized code for identification on their products. (1972)
424.	Prescribing That this meeting, noting the policy of the BMA is to support free NHS prescriptions, demands a review of prescription charges in England and asks for: - i) a review of FP92A (Application for Prescription Charge Exemption Form) as it is out of date; ii) the extension of conditions eligible for medical exemption; iii) a cap on the maximum charge to each individual patient in one year. (2019)
425.	That medicines supply shortages are becoming more frequent and the BMA should: - i) challenge the lack of NHS action to address the problem; ii) raise public awareness of the issue. (2019)
426.	That this meeting, with regard to the guidance issued by NHS England regarding prescribing for items that are also available 'over the counter':- i) believes that it will, if followed, place GPs at risk of complaint for breach of prescribing regulations, force GPs to make judgements about patients' willingness to purchase items themselves, and lead to conflict between doctors and their patients; ii) calls for the BMA discuss with NHS England and DHSC the consequences of amending the regulation requiring the issue of an FP10 for acute illness where effective treatment is available without prescription. (2018)

427.	That this meeting believes that there is an urgent need for the development of an electronic prescription service for hospitals, to enable hospital clinicians to prescribe remotely for patients to collect their prescription from a nominated community pharmacist, thereby enabling clinical responsibility to rest with the prescribing clinician, as well as reducing inappropriate demands on GPs to prescribe outside their competence. (2017)
428.	That this Meeting believes that prescription charges should be abolished in England. (2011)
429.	That this Meeting calls BMA to lobby the government for lifting prescription charges in England, following the decisions of the other nations: Scotland, Wales and Northern Ireland. (2011)
430.	That this Meeting proposes that hospitals should either directly supply or use FP10HP (GP10 in Scotland) prescriptions to patients to obtain an initial supply of medication, rather than requiring patients to obtain a prescription from their GP practice, which: <ul style="list-style-type: none"> (i) inconveniences patients to attend their GP surgery and/or make an appointment solely for the administrative purpose of receiving a prescription for a drug initiated by a hospital doctor; (ii) puts GPs' professional duty of care at risk by having to take clinical and legal responsibility to issue a prescription on the basis of a clinical assessment made by another doctor; (iii) adds delay to patients commencing their medication. (2010)
431.	That this Meeting once again calls for the abolition of the prescription charge in England to ensure patients enjoy the same benefits as those in other parts of the UK. (2010)
432.	That this Meeting believes that: <ul style="list-style-type: none"> (i) it is anomalous to make antibiotics available over the counter at a time of multiple educational initiatives aimed at reducing antibiotic prescribing; (ii) no more antibiotics should be made available over the counter for the foreseeable future. (2010)
433.	That this Meeting urges the government to abolish prescription charges in England as has happened in Wales and is happening in Scotland and Northern Ireland. (2009)
434.	That this Meeting: <ul style="list-style-type: none"> (i) recognises that not all treatments and medications are available to patients on the health service equitably across the UK; (ii) believes that patients should have the choice to purchase non health service treatments and medications if they wish and still receive the rest of their treatment and medication on the health service without being forced to pay for all their treatment privately; (iii) requires that the Health Departments recognise that banning co-payments denies patients treatments that may be to their benefit and forces patients to accept healthcare rationing; (iv) calls on the government to set up a Royal Commission to review all the evidence and implications for the NHS and patients and report with recommendations by summer 2009; (v) remains adamant that the introduction of such co-payments must not be a route to extend NHS user charges;

	(vi) requires that any co-payments be introduced only after a mechanism is devised to prevent the extension of NHS user charges. (2008)
435.	That this Meeting believes that, to ensure patient safety, prescribing by: (i) nurses; (ii) pharmacists should be limited, and in line with the training and experience of the individual professional. (2006)
436.	That there should be a review of the prescription charges system to remove inequalities. (2003)
437.	That ever rising prescription charges are resulting in patients not taking the needed drugs. The BMA wants the government to abolish this charge and bring equity for all patients. (2002)
438.	That this Meeting urges the government to review the prescription charging system to ensure and facilitate equality of access. (2002)
439.	That this Meeting insists that GP drug budgets be set at realistic levels to allow all GPs to treat all their patients according to their clinical need, and to avoid the situation where the majority of drug budgets are overdrawn before the end of the financial year. (2000)
440.	That this Meeting insists that to ensure high quality patient care continues, GP prescribing costs must not be cash limited. (1998)
441.	That there should be a fundamental overhaul of the system of prescription charges. (1998)
442.	That this Meeting urges the Government to recognise the anomalies of the present prescription charging structure and urges a review to set up a fairer system. (1998)
443.	That this Meeting believes that it is inappropriate for any GP to be asked to prescribe specialised medication unless the GP has the professional competence to monitor and alter the dosage of that medication according to shared care protocols and appropriate shared care arrangements have been agreed between the GP and specialist concerned. (1997)
444.	That any future limitations on prescribing should only follow full consultation with the profession. (1993)
445.	That this Meeting supports the encouragement of generic prescribing, provided that the standard of all generic preparations is monitored so that quality is assured. (1985)
446.	That this Meeting insists that under no circumstances should pharmacists be given the right to prescribe scheduled drugs. (1979)

	EMERGENCY SERVICES
447.	That this Meeting urges that clinical staff escorting NHS patients during air ambulance transfer and 'flying squad' doctors going to incidents by helicopter or plane should have insurance cover provided by the NHS. (2006)
448.	That this Meeting calls upon the government to balance the unrealistic media portrayal of the efficacy of CPR and to explain to the public: (i) that health professionals do not always attempt CPR in the event of cardiac arrest; (ii) the true effectiveness of CPR; (iii) that they may be asked to discuss this issue during hospital admission. (2005)
449.	That this Meeting welcomes proposed legislation in the Scottish Parliament to increase penalties for obstructing emergency workers (including doctors, nurses and paramedics) when attending emergency situations and calls for the Government to consider similar legislation across the UK. (2004)
	END OF LIFE ISSUES
450.	That this meeting is ashamed that people die in distress in the UK and calls for resources to be provided to palliative care for systems to fund support and provide better services to those with palliative care needs. (2021)
451.	That this meeting:- i) calls upon the BMA to lobby the Care Quality Commission to include scrutiny of CANH withdrawals in PDOC cases within its regular inspection regimes of NHS Trusts; ii) calls upon the RCP to expedite existing plans for a national PDOC register. (2021)
452.	That this meeting believes, in order to represent the diversity of opinion demonstrated in the survey of its membership, the British Medical Association should move to a position of neutrality on assisted dying including physician assisted dying. (2021)
453.	That this meeting calls for robust conscience rights to be included in any future legislation on assisted dying in the United Kingdom, believing that:- i) the right of conscientious objection should apply to all health, care and administrative staff; ii) the right of conscientious objection should include the right to not prescribe lethal doses of medication; iii) a clinician with a conscientious objection should still provide a factual report to any decision making body if appropriate and relevant; (2021)
454.	That this meeting notes the recent decision by the Royal College of Physicians to adopt a neutral position on assisted dying after surveying the views of its members, and:- i) supports patient autonomy and good quality end of life care for all patients; ii) recognises that not all patient suffering can be alleviated; iii) calls on the BMA to carry out a poll of its members to ascertain their views on whether the BMA should adopt a neutral position with respect to a change in the law on assisted dying. (2019)

455.	That this meeting condemns the wide variation in commissioning by clinical commissioning groups of end-of-life and palliative care services in England and calls on the government to support the Access to Palliative Care Bill. (2017)
456.	That this meeting recognises that, with large numbers of deaths now taking place in hospitals, familiarity with what dying is like is less widespread than was once the case; notes that the media focus on instances of poor health care or 'bad deaths' has the potential to generate irrational public fears of death and dying; and believes that a crucial part of good end-of-life care should be to ensure that terminally-ill patients and those who care for them receive clear, sympathetic and intelligible guidance on what to expect when someone is dying and have a designated health care professional to turn to about their concerns. (2016)
457.	That this meeting calls for government to provide sufficient additional new resources to enable the delivery of quality end-of-life care. (2016)
458.	That this meeting welcomes the BMAs recent report 'End of Life Care and Physician Assisted Dying' and is concerned by the shortcomings in current care that have been identified and calls for the BMA to work to ensure:- i) that those cared for in the home have access to needed pain relief at any time of the day or night; ii) that the end of life care available to those with non-cancer illnesses does not fall short of that provided for palliative cancer patients; iii) that medical staff are trained and confident to handle 'difficult conversations' with dying patient and their relatives. (2016)
459.	That this meeting welcomes the BMAs recent report 'End of Life Care and Physician Assisted Dying' and is concerned by the shortcomings in current care that have been identified. We therefore call for this work to serve as a starting point in working to optimise end of life care for the dying by ensuring:- i) that those cared for in the home have access to needed pain relief at any time of the day or night; ii) that the end of life care available to those with non-cancer illnesses does not fall short of that provided for palliative cancer patients; iii) that medical staff are trained and confident to handle 'difficult conversations' with dying patient and their relatives. (2016)
460.	That this meeting applauds the DH's concerns regarding the health of older people but insists that growing old should not be wholly medicalised and that people are allowed dignity during the natural dying process. (2015)
461.	That this Meeting recognises the value of clinical guidelines and standards in supporting best practice, such as end of life pathways and:- i) is concerned that such guidance, in the form of the Liverpool Care Pathway, has been withdrawn from the practice of palliative care; ii) is opposed to any financial incentives being involved when making decisions on end of life care pathways; iii) calls for the prompt introduction of new patient-focussed multidisciplinary clinical guidelines and standards, including communication skills training, for the palliative care management of dying patients.

	(2014)
462.	<p>That this Meeting believes that:</p> <ul style="list-style-type: none"> (i) in the event of a 'Do Not Resuscitate' order being made in hospital with the intention that it subsequently applies in the community, the patient/relevant carer(s) and the patient's GP must be informed in advance of discharge from hospital; (ii) the Medical Ethics Committee should include principles reflecting best practice in its guidance on 'Do Not Resuscitate' orders. <p>(2010)</p>
463.	<p>That this Meeting:</p> <ul style="list-style-type: none"> (i) recognises that persistent requests for assisted suicide and euthanasia are very rare when patients' physical, social, psychological and spiritual needs are being appropriately met; (ii) calls on the BMA to campaign for better training in palliative medicine for all GPs and hospital doctors involved in managing dying patients; (ii) calls on the BMA to campaign for better education of the public about what good palliative care can achieve. <p>(2010)</p>
464.	<p>That this Meeting:</p> <ul style="list-style-type: none"> (i) believes that the ongoing improvement in palliative care allows patients to die with dignity; (ii) insists that physician-assisted suicide should not be made legal in the UK; (iii) insists that voluntary euthanasia should not be made legal in the UK; (iv) insists that non-voluntary euthanasia should not be made legal in the UK; (v) insists that if euthanasia were legalised there should be a clear demarcation between those doctors who would be involved in it and those who would not. <p>(2006)</p>
465.	<p>That this Meeting believes that facilities for terminal care in the patient's own home should be equally good for malignant and non-malignant conditions.</p> <p>(2005)</p>
466.	<p>That this Meeting believes that advance directives should be available to people who wish to make one and:</p> <ul style="list-style-type: none"> (i) that medical students and junior doctors should have specific instructions on the use of advance directives and asks the BMA to lobby the relevant authorities to provide this information; (ii) that it should be the responsibility of patients to draw the attention of medical professionals to such documents; (iii) that the BMA should include this information in their guidance for patients. <p>(2005)</p>
467.	<p>That this Meeting believes that patients who lose their capacity but who have indicated in advance that they wish to receive artificial hydration and nutrition should have their wishes respected.</p> <p>(2004)</p>
468.	<p><u>Persistent vegetative state</u></p> <p>That this Meeting insists that, in the matter of advance directives, no doctor should be obliged by patients, relatives or hospital administrative staff to act contrary to his conscience.</p> <p>(1993)</p>

469.	That this Meeting calls upon the Government to provide and support facilities for the care of the dying and the relief of intractable pain, in whatever sector such care is undertaken. (1984)
470.	That this Meeting affirms that the position of medical practitioners who are in conscience opposed to euthanasia must be fully protected in future legislation should it occur and that no legal obligation in this respect should be allowed to be imposed unilaterally on any member of the profession at any time. (1977)
	ENVIRONMENT
471.	That this meeting declares that the climate emergency is a health emergency, and calls on the BMA to:- i) campaign for the UK to become zero-carbon by 2030; ii) lobby NHS Trusts and Health Boards to embed sustainability criteria into their tendering processes; iii) endorse the Green New Deal; iv) support the Health for a Green New Deal Campaign. (2021)
472.	That this meeting recognises the environmental and financial consequences of increasing demands of single-use plastic personal protective equipment (PPE) since the start of the Covid-19 pandemic. Single-use aprons, gowns and gloves are currently not recyclable or biodegradable. Plastics are incinerated causing further CO2 emissions. This meeting calls on the BMA to:- i) lobby the NHS, and NHS Supply Chain, to implement reusable and recyclable PPE as default where these products meet safety standards; ii) support initiatives that commit to trialling and introducing reusable and recyclable PPE and the environmentally-conscious treatment of waste; iii) lobby the Government to create recycling legislation to ensure that there are sufficient recycling bins in all clinical areas. (2021)
473.	That this meeting believes that immediate action must be taken as part of a solution to the climate crisis. This meeting calls on the BMA to:- i) campaign for the UK to become zero-carbon by 2030 including elimination of fossil fuel use by the NHS; ii) lobby for investment in public transport infrastructure so all NHS workers, on all shifts, have the ability to commute using public transport; iii) audit BMA policy to assess its impact on the climate and bring anything with a negative impact to ARM for review. (2021)
474.	That this meeting directs the BMA to act upon the IPCC report; to declare a Climate Emergency, to plan, campaign and cooperate to deliver carbon neutrality by 2030. (2019)
475.	That this meeting recognises the devastating impact which extreme events have on population health and health services, and the increase in the frequency and severity of such events due to climatic and societal changes, and therefore calls for UK governments to continue work to improve resilience of health care infrastructure in preparation for such events. (2016)

476.	<p>That this Meeting, recognising the Lancet Commission’s description of Climate Change as “the greatest threat to human health of the 21st century”, urges the BMA to:-</p> <ul style="list-style-type: none"> i) facilitate the widest possible alliance of healthcare bodies to ensure that the co-benefits to health and the economy of reducing greenhouse gases are more widely understood, and incorporated into health and economic policy; <p>(Lapsed 2019)</p> <ul style="list-style-type: none"> ii) transfer to electricity suppliers who are “100% renewable”. <p>(2014)</p>
477.	<p>That this Meeting considers the BMA's response to increasing evidence of global warming has been muted at best and calls on the BMA to:</p> <ul style="list-style-type: none"> (i) increase awareness in the profession of potential global health problems related to climate change; (ii) increase awareness of the public of potential global health problems related to climate change; (iii) lobby UK governments to act more decisively and quickly to introduce effective action on climate change; (iv) lobby UK Medical Schools to sign the Climate and Health Council Declaration; (v) encourage its members to sign the Climate and Health Council pledge; (vi) highlight the enormous carbon footprint of the NHS and the poor progress to date in reducing this; (vii) work with government to develop binding and enforceable carbon footprint reduction guidelines for the NHS. <p>(2009)</p>
478.	<p>That this Meeting recognises the negative effect that climate change will have nationally and globally and:</p> <ul style="list-style-type: none"> (i) calls for all new health sector buildings to be sustainable and carbon neutral; (ii) calls for a review of health sector processes to maximise re-use and recycling; (iii) calls on health sector employers to support staff in making sustainable transport choices; (iv) calls on the BMA to develop guidance for health sector workers on reducing personal and professional carbon footprints; (v) calls on the BMA to promote the public health benefits of low carbon living. <p>(2008)</p>
479.	<p>That this Meeting notes the overwhelming evidence that human behaviour is contributing to global warming. It calls upon the BMA to:</p> <ul style="list-style-type: none"> (i) affirm that climate change will have a significant impact on global health, particularly in developing countries where food and water shortages, and water borne, food borne and vector borne diseases, are all likely to increase; (ii) lobby the government to ensure that adequate resources are provided to developing countries so that they may cope with the effects of climate change; (iii) lobby the Health Departments to employ sustainable forms of transport for the NHS, its staff and patients; (iv) investigate what a realistic timescale for reducing its own carbon footprint to zero would be and commit to meeting this target within the timescale specified; (v) assist its members in reducing their own carbon footprint; (vi) support members in reducing carbon footprint in the workplace. <p>(2007)</p>
480.	<p>That pending the evaluation of environmental effect there should be no extension to discharging of untreated sewage into the sea.</p> <p>(1990)</p>

481.	That this Meeting calls on the BMA to use ecologically sound products, with the immediate implementation of the use of recycled paper. (1989)
482.	That this Meeting calls upon Government: (i) to produce a comprehensive national policy on the disposal of toxic waste; and (ii) to reduce immediately the quantity of toxic waste imported into this country. (1989)
EQUALITY AND DIVERSITY	
483.	That this meeting is appalled by the brutal death of George Floyd caused by a US police officer. This meeting stands in solidarity with the Black Lives Matter movement. (2020)
484.	That this meeting believes the Covid-19 pandemic and the Black Lives Matter movement has demonstrated the importance of addressing health inequalities and racism in the UK. This conference calls for:- i) increased funding for public health to tackle ethnic, geographic and gender inequalities in the UK; ii) greatly improved recording and analysis of ethnicity in the NHS; iii) specific action based on culturally sensitive research to address the health, social and educational problems caused to Black, Asian and minority ethnic schoolchildren and make recommendations to reduce these inequalities; iv) all NHS trust and organisation boards should reflect the ethnic make-up of the workforce of the organisation which they manage; v) every person involved in NHS recruitment should have training on diversity and unconscious bias; vi) a mentorship scheme for Black, Asian and minority ethnic NHS managers and clinical leaders should be developed; vii) there should be transparent recruitment and promotion systems in all NHS organisations. (2020)
485.	That this meeting affirms the rights of transgender and nonbinary individuals to access healthcare and live their lives with dignity, including having their identity respected and calls upon the government to:- i) allow transgender and nonbinary individuals to gain legal recognition of their gender by witnessed, sworn statement; ii) ensure that under 18s are able to access healthcare in line with existing principles of consent established by UK Case Law and guidelines published by the public bodies which set the standards for healthcare; iii) enable trans people to receive healthcare in settings appropriate to their gender identity; iv) ensure trans healthcare workers are able to access facilities appropriate to the gender they identify as; v) ensure trans people are able to access gendered spaces in line with the gender they identify as. (2020)
486.	That this meeting calls on medical schools to support students who have a child whilst at university and to make reasonable adjustments about clinical placements to meet their family's needs. (2016)
487.	That this meeting recognises the distinct difference between the proportion of female medical students and the proportion of women who hold consultant posts in surgery and calls on the BMA to work with appropriate bodies to:-

	<ul style="list-style-type: none"> i) promote women in surgery at medical school; ii) expose foundation trainees to female role models; iii) develop a resource to break down barriers for women in surgery; iv) create a forum for aspiring female surgeons, to empower them through networking and mentoring events. <p>(2016)</p>
488.	<p>That this meeting recognises the success of the BMA Committees Visitors Scheme in involving new grass roots members in its Consultants Committee. This meeting calls for this scheme be extended by:-</p> <ul style="list-style-type: none"> i) setting up a mentoring programme for visitors to committees; ii) facilitating the ease by which BMA members can visit committees by having a regular allocation of places at each committee that can be filled on a 'first come first served' basis; iii) that it be more widely advertised to increase uptake by wider membership. <p>(2016)</p>
489.	<p>That this meeting urges the government to ensure all NHS facilities have fit for purpose health care access for patients with disabilities, and to provide dedicated funding to achieve this.</p> <p>(2016)</p>
490.	<p>That this Meeting recognises the barrier that language differences can play in access to healthcare and calls for the BMA to lobby NHS Employers for:</p> <ul style="list-style-type: none"> (i) the institution of a register to accredit staff who are fluent in additional languages; (ii) recognition that staff who are on an accredited register of language skills may translate directly for those patients for whom they have clinical responsibility; (iii) provision of support for NHS professionals who wish to learn new languages. <p>(2010)</p>
491.	<p>That this Meeting calls on the BMA's Equality and Diversity Committee to commission research into the impact of the six diversity strands on specialty choice and progression of graduates within the medical profession.</p> <p>(2010)</p>
492.	<p>That this Meeting calls for all deaneries to implement appropriate policies for equality and diversity within their training schemes including:</p> <ul style="list-style-type: none"> (i) the responsibilities of employers to have protocols to deal with issues of conscientious objection without any individual being disadvantaged; (ii) the responsibilities of trainees to inform the employer of any conscientious objection issues in advance of taking up a post. <p>(2009)</p>
493.	<p>That this Meeting:</p> <ul style="list-style-type: none"> (i) supports the principle that trainees and doctors have a right to see their employment references as a matter of good practice; (ii) believes that employers must not make comments about or otherwise discriminate against trainees on the basis of their personal or religious beliefs. <p>(2009)</p>
494.	<p>That this Meeting calls upon the BMA to work with partners in order to integrate social models of identity and diversity in medical education, training, examinations and appraisal at undergraduate, postgraduate, and continuous professional levels.</p> <p>(2009)</p>
495.	<p>That this Meeting:</p> <ul style="list-style-type: none"> (i) reinforces the BMA's abhorrence of discrimination in all its guises;

	<p>(ii) applauds mechanisms to identify and address barriers causing discrimination, rather than advocating positive discrimination;</p> <p>(iii) calls upon the BMA to research and address any barriers to certain career paths or specialties which result in discrimination;</p> <p>(iv) mandates the BMA to work with relevant bodies to ensure medical careers have training opportunities and also facilities that are relevant to modern society, such as adequate childcare provision and flexible working.</p> <p>(2008)</p>
496.	<p>That this Meeting acknowledges that discrimination is apparent within the medical profession against colleagues with mental illness and addiction and calls upon the BMA to lobby:</p> <p>(i) the Council of Heads of Medical Schools to develop medical school curricula to address such issues;</p> <p>(ii) the Health Departments to develop supportive working practices for such doctors.</p> <p>(2007)</p>
497.	<p>That this Meeting believes that the BMA must engage with the Royal Colleges, PMETB and the GMC to ensure that:</p> <p>(i) doctors are aware of their duties under the disability discrimination act;</p> <p>(ii) doctors have an understanding of the social model of disability as well as medical models;</p> <p>(iii) individuals with disabilities have appropriate access to medical education;</p> <p>(iv) doctors with disabilities are enabled to have fulfilling and rewarding medical careers.</p> <p>(2006)</p>
498.	<p>That this Meeting calls on the BMA to lobby the Health Departments to ensure that training on culture and diversity awareness and on equal opportunities is available for all NHS staff.</p> <p>(2006)</p>
499.	<p>That this Meeting:</p> <p>(i) believes that the NHS and medical schools should accommodate the religious practices of staff and students, so long as patient care is not compromised;</p> <p>(ii) calls on the BMA to campaign for developments which facilitate religious practices of staff and students, for example the provision of materials to form a 'theatre hijab'.</p> <p>(2005)</p>
500.	<p>That given the multicultural nature of the NHS today, this Meeting calls upon the BMA to ensure that individuals are not penalised in any way for choosing to observe religious obligations.</p> <p>(2001)</p>
501.	<p>That this Meeting believes that all medical schools should have an equal opportunities policy which includes sexual orientation.</p> <p>(1996)</p>
502.	<p><u>Discrimination</u></p> <p>That this meeting calls for clearly publicised zero tolerance policies against racism in the NHS which specifically covers:-</p> <p>i) no patient has the right to choose a treating clinician based upon their race or ethnicity;</p> <p>ii) clear pathways for when care should be withheld to protect staff from racist patients.</p> <p>(2021)</p>
	<p>That this Meeting requests the government to acknowledge that the NHS is institutionally racist.</p> <p>(2004)</p>

503.	That this Meeting believes that it is fundamental to the principles of the NHS that patients with disabling and life threatening illnesses are equally entitled to the resources of the NHS and should not be discriminated against in this regard if their disease does not happen to be covered by a National Service Framework. (2002)
504.	That this Meeting believes that working as a doctor in the developing world should never count against career prospects in the UK. (2002)
505.	That racism and discrimination in any form must be eliminated in the NHS. (2000)
506.	That this Meeting affirms that it is unethical for elderly people to be discriminated against in the provision of national health services in the light of evidence recently published by Age Concern. (1999)
507.	That this Association should work actively to expose practices that disadvantage doctors from minority groups in the NHS. (1999)
508.	That this Meeting condemns instances of racial discrimination in the NHS, directs the Council to compile evidence and to take suitable action. (1993)
509.	That this Meeting reaffirms its policy that all persons entitled to use the NHS should be entitled to use any part of the service without suffering discrimination. (1980)
	FAMILY PLANNING
510.	That this Meeting deplores that the NHS is disinvesting in contraception and sexual health services and that there has been a recent reduction of services in 40% of clinics across the UK. (2007)
511.	That this Meeting feels that patients should continue to have the choice of attending either a family planning clinic or general practitioner for contraceptive advice. (1992)
512.	That this Association believes that the correct interpretation of the House of Lords judgement in the case of Gillick v. Wisbech Health Authority is as follows: (i) that children of under 16 must be entitled to expect that both the existence and the content of a consultation in connection with pregnancy or contraception will normally remain secret; (ii) that in the case of any departure from this rule doctors should be liable to justify their action. (1986)
	FEMALE GENITAL MUTILATION

513.	That this meeting condemns the practice of breast ironing. This meeting calls on the BMA to investigate the prevalence of breast ironing in the UK and to work with appropriate authorities to develop a policy to protect girls from this harmful practice. (2019)
514.	This meeting calls on the UK government to protect girls from the illegal practice of female genital mutilation and calls for:- i) schools and social services to be aware of the problem and give preventative protection and advice; ii) appropriate prosecution of perpetrators of the crime; iii) development of a joint strategy for protection shared by the police, health, social work and education services. (2016)
515.	That this Meeting calls on the UK Government to protect girls and young women from the illegal practice of female genital mutilation (FGM) and calls for:- i) promotion of joint training and strategy on FGM for health, education, social work, police and prosecution services; ii) appropriate prosecution of perpetrators of the crime. (2014)
	FORENSIC MEDICINE
516.	That this meeting believed the vast majority of post mortems (PMs) are performed in England and Wales under the jurisdiction of Her Majesty's Coroner. The Coroner PM examination and the storage of tissue removed during PM examination do not require consent from the family of the deceased. However once the coroners authority has ended, consent is required from the deceased's relatives to retain the slides and tissue. In practice this results in most histology slides and paraffin blocks of tissue taken at Coroners' PMs are disposed of and are lost for teaching, educational and audit purposes. This meeting: - i) believes this a loss to medical education and maintaining good medical practice; ii) asks the BMA to discuss with the Royal Colleges, Coroners' Society and other stakeholders the need to change the rules; iii) asks the BMA to lobby for a change in the Human Tissue Act and Coroner Rules in England and Wales to facilitate retention of the histology slides and paraffin blocks taken at Coroner's autopsy for teaching, education and audit without the need of deceased relatives' consent. (2019)
517.	That this meeting believes that painful control & restraint methods should be outlawed for use in secure children's homes. (2019)
518.	That this meeting asks the BMA to undertake negotiations with the coroner's service to widen the range of clinicians who are legally able to sign a death certificate or cremation form. (2018)
519.	That this meeting requires the BMA to campaign for immigrants held in detention centres to be given no less a standard of medical care than afforded to inmates in prison. (2018)
520.	That this meeting in the interests of the bereaved and the efficient use of NHS resources, instructs the BMA to lobby the government for a change in the law such that Coronial processes and demands are the same in each Coronial jurisdiction throughout England and Wales.

	(2018)
521.	<p>That this meeting notes the much delayed position of Medical Examiner (ME) in Cause of Death will most likely commence in April 2019 in England and Wales. It is expected that 800+ doctors from all branches of practice will be employed. In order to ensure that these posts are fit for purpose this meeting:-</p> <ul style="list-style-type: none"> i) calls for the BMA to negotiate clear, satisfactory national terms and conditions for this position with the appropriate government and local government bodies; ii) calls on BMA to consider the mechanism for local or regional negotiations for enhancement of national terms and conditions for these positions; iii) believes that there should be full support and involvement from the appropriate BMA secretariat and policy units; iv) believes that these new positions should be represented at appropriate local, regional and national committees of the BMA. <p>(2018)</p>
522.	<p>That this meeting regarding the mental state examination of children under arrest in police custody suites:-</p> <ul style="list-style-type: none"> i) is concerned at the lack of forensic physicians possessing membership of the Faculty of Forensic and Legal Medicine; ii) considers that it is non-equivalent compared with the care given to non-detained children; iii) calls for increased out of hours provision of child and adolescent mental health services (CAMHS) and youth offending teams to facilitate prompt liaison and diversion. <p>(2017)</p>
523.	<p>That this meeting regarding clinical forensic medicine in England and Wales:-</p> <ul style="list-style-type: none"> i) condemns the recent cancellation of the planned April 2016 transfer of commissioning responsibility from the Home Office to the Department of Health in England; ii) recalls that patients detained in police custody are entitled to equivalence of care when compared with non-detained patients; iii) reaffirms the BMA's established position that this provision should be commissioned by the National Health Service. <p>(2016)</p>
524.	<p>That this meeting calls for the proposed death certification process in England and Wales to be robust and adequately resourced through public funds, but through neither the imposition of a death tax on the relatives of the bereaved nor any kind of financial raid on the medical profession.</p> <p>(2016)</p>
525.	<p>That this meeting condemns the failure of NHS England to ensure that appropriate standards and funding are in place to deliver safe healthcare in police custody in England and Wales.</p> <p>(2015)</p>
526.	<p>That this Meeting is worried about the number of deaths during time in custody by restraint methods and urges the BMA to investigate and deal with it.</p> <p>(2014)</p>
527.	<p>That this Meeting calls for the teaching of Clinical Forensic Medicine in UK medical schools to include:-</p> <ul style="list-style-type: none"> (i) the incorporation of the basics of General Forensic Medicine into the core curriculum; (ii) the incorporation of the basics of Sexual Offence Medicine into the core curriculum; (iii) the development of Student Selected Components.

	(2012)
528.	That this Meeting reiterates its policy that clinical forensic services to police forces should be provided by the NHS, and insists that these are commissioned at a national level, and to standards set by the Faculty of Forensic and Legal Medicine of the Royal College of Physicians of London. (2011)
529.	That this Meeting: (i) welcomes the findings of Baroness Stern's national review of care for victims of sexual assault; (ii) is saddened by the patchy provision across the UK of sexual offence examiners who are trained to the standards set by the Faculty of Forensic and Legal Medicine and believes that this contributes to low rape conviction rates; (iii) calls upon all UK police forces to facilitate the setting up of Sexual Assault Referral Centres; (iv) calls for Sexual Assault Referral Centres to be staffed and run by fully-trained sexual offence examiners and not outsourced to profit-making private companies. (2010)
530.	That this Meeting insists that: (i) doctors completing Part 1 of the new Medical Certificate of Cause of Death (MCCD) should be properly remunerated from public funds; (ii) the new MCCD should be properly resourced from public funds to include the cost of an additional medical time; (iii) the Ministry of Justice does not seek to delay the introduction of the reformed coronial service as part of its requirement to meet the £325M savings announced on the 24th May. (2010)
531.	That this Meeting: (i) expresses concern about the Metropolitan Police Service's current management of 'reforms' to its forensic medical services; (ii) believes that police forces are not competent to deliver the clinical governance required for the safe healthcare of detainees; (iii) requests the BMA to press for the transfer of healthcare of people in police custody to the National Health Service. (2009)
532.	That this Meeting: (i) supports the deployment of only experienced, optimally trained doctors who have detailed knowledge of local NHS services in the provision of police forensic medical services; (ii) opposes the current trend to outsource police forensic medical services to private companies; (iii) supports the integration of police forensic medical services into the NHS. (2009)
533.	That this Meeting believes that the BMA's Forensic Medicine Committee deplores the lack of health regulation in respect to vulnerable patients detained in police custody. (2008)

534.	<p>That this meeting:</p> <ul style="list-style-type: none"> (i) firmly supports the establishment of the new Faculty of Forensic and Legal Medicine as this promotes the advancement of education and knowledge in the field of forensic medicine; (ii) acknowledges that the Faculty of Forensic and Legal Medicine is considered the best prospect of ensuring the future viability of its specialties at a time when the profession faces threats to their existence from a variety of external sources and increasing regulatory activity. <p>(2007)</p>
FREEDOM OF SPEECH	
535.	<p>That this Meeting:</p> <ul style="list-style-type: none"> (i) supports freedom of speech in science and research; (ii) calls on the BMA to publicly support and champion freedom of speech in science and research. <p>(2010)</p>
536.	<p>That this Meeting supports the principle that freedom of speech for or against the NHS is an inalienable right of individuals whether or not employed by the NHS.</p> <p>(2001)</p>
537.	<p>That this Meeting believes that all doctors should be free to publish comments on health affairs without restriction and deplores action to:</p> <ul style="list-style-type: none"> (i) restrict freedom of speech of doctors; (ii) introduce appraisal of professional performance of doctors by non-medical personnel; (iii) impose changes in the terms of service without consultation (as exemplified by HC (87)22). <p>(1989)</p>
FREEMASONS	
538.	<p>That this Meeting believes the myths surrounding the freemasonry movement and patronage in the medical profession need to be dispelled by requiring all doctors who are freemasons to declare this as an interest.</p> <p>(2003)</p>
GENERAL MEDICAL COUNCIL	
539.	<p>That this meeting believes that the professional regulatory processes discriminate against BAME doctors and demands a major review of the system.</p> <p>(2021)</p>
540.	<p>That this meeting urges the BMA to impress on the Government that the proposals on regulation of healthcare professionals must ensure that the GMC's right of appeal against MPTS decisions is removed.</p> <p>(2021)</p>

541.	That this meeting instructs council to obtain legal opinion clarifying the legal, GMC and contractual position of a doctor refusing to work knowing that they cannot guarantee patient safety due to system failure such as (but not limited to) significant clinical understaffing, IT failure, lack of support staff and to clarify the legal and GMC position if a doctor does work in these circumstances. (2019)
542.	That this meeting believes the GMC suffers from a top-down institutional lack of insight and demands that the BMA works to ensure that the GMC is reorganised with independent senior medical leaders overseeing its reorganisation. (2019)
543.	That this meeting deplores the approach of the GMC and insists that:- i) the GMC should not be able to appeal a Medical Practitioners Tribunal Service decision; ii) the GMC should always be required to reach an individual decision regarding the registration of a doctor following any conviction so that individual circumstances are taken into account. (2018)
544.	That this meeting insists that:- i) the BMA in consultation with GMC issues immediate medico-legal guidance on reflective practice; ii) the BMA negotiates with Royal Colleges, universities and the GMC to develop alternative reflective strategies such as the use of verbal face to face meetings; iii) reflection is only shared with an appraiser or training supervisor; iv) doctors retain full control over their appraisal information and access can only be made by the individual doctor or with their express consent; v) all appraisal information should be legally privileged. (2018)
545.	That this meeting expresses concern that the GMC is targeting individual medical professionals unreasonably without looking into wider perspective and therefore asks the GMC to:- i) commit to radical reforms of its structure and operations; ii) review the high number of black and minority ethnic doctors being investigated by the GMC; iii) investigate the high suicide and death rate amongst doctors under investigation by the GMC. (2018)
546.	That this meeting, in view of the widespread concerns about the adverse effects of the General Medical Council's actions in the Bawa-Garba case and its impact on NHS culture and morale:- i) declares that it has no confidence in the GMC as a professional regulatory body; ii) demands an apology from the GMC over its handling of that case; iii) calls for a public inquiry to review the GMC's conduct in the Bawa-Garba case. (2018)
547.	That this meeting demands, following the statement from the GMC and the joint statement from the BMA and the RCGP, that the government enacts legislation such that within the Medical Register general practitioners are treated equally with doctors in other specialties and are listed as specialists in their own right.

	(2017)
548.	That this meeting i) recognises that the hallmark of a profession is self-regulation; ii) deplores the increasing regulation of the profession through unelected and unaccountable members of the GMC and; iii) supports the return to the election of a majority of licensed medical practitioners to the GMC by the profession. (2017)
549.	That this meeting instructs BMA council to resist all attempts to create a single regulator for the health professions. (2017)
550.	That this meeting recognises that in an increasingly stretched and resource-starved health service, doctors are increasingly asked to work beyond their capacity, and that in so doing mistakes, errors and oversights become inevitable. We call on the BMA to lobby the GMC to amend its guidance to acknowledge that even good and competent doctors may cause harm to patients when working in such an environment, and to acknowledge that such mistakes can be a product of the environment and not the fault of the practitioner. (2017)
551.	That this meeting believes all GMC enquiries should be completed within twelve months of receipt. (2016)
552.	That this meeting is opposed to moving the point of full registration of doctors to the point of graduation from medical school and calls upon the GMC to retain the pre-registration year post graduation; (2015)
553.	That this meeting opposes new powers that allow the GMC to challenge the findings of the independent hearings carried out by the MPTS (Medical Practitioners Tribunal Service) and believe that this adds inequitable double jeopardy for doctors. (2015)
554.	That this meeting believes that professional regulation of doctors needs to be separate from the regulation of other professions and providers, and protected from political interference, and therefore calls for the GMC to remain independent. (2015)
555.	That this Meeting:- i) is disappointed that the document 'GMC Good Practice in Prescribing' fails to endorse the use of widely recognised and effectively used prescribing of drugs not licensed for particular conditions as reasonable alternative to licensed preparations; ii) notes with alarm that the GMC's current prescribing guidance regarding the use of licensed drugs for non licensed indications places doctors prescribing accepted treatments in jeopardy; iii) calls for urgent action from the GMC to allow doctors to continue clinically effective prescribing. (2013)
556.	That this Meeting:- (i) considers that a complaint or referral to the GMC can be extremely damaging;

	<p>(ii) insists that the General Medical Council urgently review its screening processes to ensure they do not cause avoidable harm and distress to the health and well-being of the doctor.</p> <p>(2012)</p>
557.	<p>That this Meeting calls on the GMC to:-</p> <p>i) implement a transparent, practical and straightforward process for doctors applying for specialist registration;</p> <p>ii) protect against all unfair discrimination against doctors who are on the specialist register via the CESR and CCT route.</p> <p>(2011)</p>
558.	<p>That this Meeting believes that the GMC registration fee is too expensive for its purpose.</p> <p>(2009)</p>
559.	<p>That this Meeting is disappointed to see that the medical members of the GMC, as appointed by the Appointments Commission, are predominantly academics, which has produced a situation firmly rejected by the profession in the early 1970s.</p> <p>(2009)</p>
560.	<p>That this Meeting believes that the medical profession should be self-regulating.</p> <p>(2009)</p>
561.	<p>That this Meeting:</p> <p>(i) believes that the new GMC will be neither led nor controlled by the profession;</p> <p>(ii) demands elected medical members within the GMC;</p> <p>(iii) believes that medical registration should be continued on a UK basis under the control of the GMC.</p> <p>(2008)</p>
562.	<p>That this Meeting notes the government White Paper, "Trust, assurance and safety – the regulation of health professionals in the 21st century" and:</p> <p>(i) believes that self-regulation is essential for the medical profession;</p> <p>(ii) believes that "beyond reasonable doubt" must remain the standard of proof in fitness to practise hearings for doctors;</p> <p>(iii) is opposed to the proposal for local GMC affiliates;</p> <p>(iv) is concerned about the importance attached to 360 degree feedback in proposals for relicensure;</p> <p>(v) believes that retired doctors have a vital role in healthcare and that revalidation proposals must support their continued contribution;</p> <p>(vi) insists that proposed pilots of the new system for regulating doctors must be genuinely and properly assessed before wider usage;</p> <p>(vii) calls on the BMA to lobby vigorously on these matters.</p> <p>(2007)</p>
563.	<p>That in the light of new, currently emerging evidence concerning the GMC's handling of complaints against doctors, especially those practicing in the contentious* fields of medicine, this meeting:</p> <p>(i) demands that the GMC restores effective screening procedures which involve doctors;</p> <p>(ii) demands that the GMC's tone and approach ceases to appear to be a presumption of guilt unless innocence is proven;</p> <p>(iii) demands that the GMC amend the tone of its communications to doctors under investigation accordingly;</p>

	<p>(iv) demands that the GMC does not de facto routinely remove a doctor's name from the publicly available register until full due process has occurred unless there is a prima facie evidence of immediate and real danger to the public;</p> <p>(v) demands that the GMC recognises that its proper role is to guide doctors and protect patients and is NOT one of ensuring patient satisfaction at any cost;</p> <p>(vi) insists that the GMC recognise that unless urgent steps are taken in this regard to restore doctors confidence in such matters then doctors will cease work in contentious areas to the ultimate detriment of society as a whole.</p> <p>* contentious fields of medicine include forensic, expert medico\legal, occupational health, and social security benefit work.</p> <p>(2005)</p>
564.	<p>That this Meeting reaffirms its belief that professional self regulation remains the most effective mechanism for ensuring competence for doctors to practise and the protection of patients from inadequate standards of medical care.</p> <p>(2000)</p>
565.	<p><u>Fitness to practise</u></p> <p>That this meeting is concerned about the stress, depression and other tragic consequences on doctors in the GMC's fitness to practise procedures. It demands that the BMA urgently seeks talks with the GMC on what steps it is taking to limit these damages and what extra support can be made available to these doctors.</p> <p>(2016)</p>
566.	<p>This meeting is concerned by plans to develop a 'passport to practise' and calls for:-</p> <ul style="list-style-type: none"> i) close BMA involvement in GMC national exam development; ii) immediate review of the SJT and PSA for potential assessment duplication; iii) Medical Schools Council analysis of the impact on students' final year of study; iv) the inclusion of a practical clinical skills and knowledge element if the exam is introduced. <p>(2015)</p>
567.	<p>That this meeting notes with concern the recent GMC report into the deaths of doctors in fitness to practise procedures, commends the BMA's Doctors for Doctors Unit and the Doctor Support Service and calls on the:-</p> <ul style="list-style-type: none"> i) GMC to make a public statement that affirms its duty of care to all registrants; ii) GMC to immediately implement changes to communications to registrants under investigation affirming the principle of presumed innocence until adverse findings are proven; iii) GMC to make changes to fitness to practise procedures, particularly where health is the major concern, to take more note of the views of doctors treating the individual; iv) BMA to commend the proposed two year pilot scheme into setting up a national support service for doctors; v) GMC to consult the profession on further improvements that could be made to enable the fitness to practise procedures to be less stressful for all concerned. <p>(2015)</p>
568.	<p>That this Meeting condemns the move to the civil standard of proof in GMC fitness to practise hearings and warns the UK government that this will lead to:</p> <ul style="list-style-type: none"> (i) a move towards a far more defensive style of medical practice in the UK; (ii) a huge increase in the costs of the UK health service due to clinicians being less willing to take or accept risk; (iii) a very likely increase in referrals to secondary care; (iv) a likely increase in unnecessary investigations;

	(v) a likely increase in unnecessary prescribing. (2008)
569.	That in the interest of public and professional confidence in the regulatory process, this Meeting calls upon the Healthcare Commission to ensure that the work of investigation teams is free from interference and that its procedures are fair and consistent with the principles of natural justice. (2006)
570.	That this Meeting requests that, when assessing a doctor's professional performance, the GMC includes consideration of any contributory personal or organisational ill health factors. (1997)
571.	That approval for remedial training for members of the profession should be granted speedily. (1997)
572.	<u>Medical school admissions</u> That this meeting:- i) believes the pause in appraisal and revalidation has not resulted in any detriment to patient safety or standards of care; ii) demands a reduction in the GMC regulation imposed by annual appraisal and five yearly revalidation to encourage experienced clinicians to retire later; iii) demands a proper independent audit of the processes of appraisal and revalidation to examine any alleged benefits and detrimental effects. (2020)
573.	That this Meeting believes the GMC should be granted statutory power to provide quality assurance of medical school admissions procedures as currently medical schools are not officially held to account on the issue. (2004)
574.	<u>Revalidation and appraisal</u> That this meeting notes the recommendations from the review of revalidation by Sir Keith Pearson and:- i) particularly welcomes the recommendation that local organisations should "avoid using revalidation as a lever to achieve local objectives above and beyond the GMC's revalidation requirements; and ii) calls on the BMA, medical royal colleges and GMC to reflect these recommendations in their guidance on appraisal; iii) demands that the appraisal process is made simpler and less time-consuming; iv) requires that the revalidation process be equally accessible to all doctors, regardless of the context of their medical practice. (2017)
575.	That this meeting demands that:- i) there is critical and peer-reviewed assessment of the appraisal process to ensure it is fit for purpose, equitable nationwide and does not discriminate against doctors in portfolio or non-standard careers; ii) there is robust and peer-reviewed evidence that appraisal and revalidation processes are actually producing outcomes of improved patient safety and patient confidence in the profession; iii) the appraisal system should be only for professional development and not for performance management;

	<p>iv) in the area of appraisal documentation the same standards of confidentiality are applied to medical practitioner information as to patient information;</p> <p>v) doctors' appraisal for the purposes of revalidation of their clinical role should be performed by doctors.</p> <p>(2016)</p>
576.	<p>That this meeting requests the BMA revises its guidance on appraisal and revalidation:-</p> <ul style="list-style-type: none"> i) to avoid "expectation creep" whereby unwritten or additional expectations are included in appraisal or revalidation requirements; ii) for doctors to help them avoid unwritten or additional demands from appraisal leads or Responsible Officers; iii) to address the concerns arising from the use of non-medically qualified appraisers. <p>(2015)</p>
577.	<p>That this Meeting is alarmed that the issue of remediation has slipped from view in the government's approach to appraisal and revalidation in England, and insists that its availability, structure and resourcing should once more have a central position in the discussions.</p> <p>(2014)</p>
578.	<p>That this Meeting notes that whilst doctors accept the principle of appraisal:</p> <ul style="list-style-type: none"> i) the present appraisal process is unduly burdensome, requiring doctors to spend too many hours in unproductive activity that does not enhance patient care, and; ii) the BMA must demand changes which make this much less time consuming and better for both doctors and patients. <p>(2014)</p>
579.	<p>That this Meeting recognises the importance of the appraisal process for all doctors. This Meeting:-</p> <ul style="list-style-type: none"> i) recognises the additional difficulties that freelance/locum GPs have in collating the necessary evidence for their appraisal from multiple locations; ii) is dismayed that some Area Teams have selectively withdrawn appraisal funding for freelance/locum GPs; iii) calls for Area Teams to re-instate proper resourcing for the appraisal process for locum GPs. <p>(2013)</p>
580.	<p>That this Meeting is seriously concerned about the variation of expectation amongst the Responsible Officers in making recommendations for revalidation to the GMC and requires the GMC to put in place an appeal mechanism for challenging:-</p> <ul style="list-style-type: none"> i) the action of Responsible officer; ii) the decisions of the Responsible Officer; iii) the constraint of choice of appraisal tool. <p>(2013)</p>
581.	<p>That this Meeting supports the principle of revalidation but is very concerned about the difficulty in collecting evidence faced by peripatetic doctors such as locum General Practitioners and GPs who work entirely for out of hours organisations.</p> <p>(2013)</p>
582.	<p>That this Meeting, while supporting the principle of professional revalidation; requires:-</p> <ul style="list-style-type: none"> (i) that the BMA liaise with the GMC to ensure that the revalidation is fair, transparent and easy to implement; (ii) that the cost of revalidation should be borne by the state and not by individual doctors;

	<ul style="list-style-type: none"> (iii) revalidation must not be introduced until there is clarity about the source of funding for remediation; (iv) remediation must not add financially to the burden of doctors who need it; (v) that multisource feedback must be fit for purpose and role specific; (vi) that it must not go ahead without the proper arrangements for all doctors. (vii) BMA participation in a transparent and full debate on the business case for revalidation in order to clarify whether it will provide value for money. <p>(2012)</p>
583.	<p>That this Meeting continues to insist that revalidation must be non-bureaucratic and simple to undertake if it is to be accepted by the medical profession.</p> <p>(2011)</p>
584.	<p>That this Meeting:</p> <ul style="list-style-type: none"> (i) supports revalidation in principle; (ii) insists that revalidation must be practicable, workable, enforceable and not be at the expense of patient care; (iii) insists that revalidation must not put additional financial burdens on doctors; (iv) insists that revalidation must be fully funded by central government; (v) insists that revalidation must not be introduced without the process of remediation having been fully funded; (vi) is concerned that revalidation will place an unacceptable and disproportionate burden on doctors who work less than full time; (vii) is concerned that revalidation will place an unacceptable and disproportionate burden on retired doctors; (viii) insists that revalidation must not have any conflict of interest issues; (ix) welcomes the decision by the Secretary of State for Health to delay implementation of revalidation. <p>(2010)</p>
585.	<p>That this Meeting condemns those Royal Colleges that:</p> <ul style="list-style-type: none"> (i) are attempting to set unrealistic quality benchmarks for revalidation; (ii) may be planning to use revalidation as an excuse to introduce yet more exams. <p>(2010)</p>
586.	<p>That, concerning Responsible Officers, this Meeting:</p> <ul style="list-style-type: none"> (i) demands that all doctors have a choice of at least two Responsible Officers; and instructs the BMA to negotiate accordingly; (ii) insists that every Responsible Officer must be a practising doctor licensed by the GMC. <p>(2010)</p>
587.	<p>That this Meeting supports a fair licensing and revalidation scheme which:</p> <ul style="list-style-type: none"> (i) ensures annual appraisal is central to revalidation, acting as a forum to promote the skills and attributes of the doctor; (ii) is not overly onerous on doctors but is sufficient to provide confidence that each doctor is fit to practice; (iii) must take account of the different working lives of doctors; (iv) has both direct and indirect costs funded by government; (v) will not require any group to undergo a more rigorous process than another; (vi) insists that adequate protected time is available for preparation and is fully resourced, and calls upon the BMA and the Royal Colleges and Faculties to work together to help ensure that the appraisal and revalidation process is fit for purpose for all doctors. <p>(2009)</p>
588.	<p>That this Meeting believes that any system of revalidation should:</p>

	<ul style="list-style-type: none"> (i) be applied equitably; (ii) apply to all doctors; (iii) be adjusted in accordance with the role of each practitioner; (iv) be implemented simultaneously for all registered doctors; (v) offer appropriate opportunities for retired doctors to revalidate, recertificate and relicense; (vi) ensure that formative appraisal, professional portfolio and feedback are adequate for revalidation. <p>(2008)</p>
589.	<p>That this Meeting calls on the BMA to lobby the government to ensure that the current proposals for revalidation:</p> <ul style="list-style-type: none"> (i) are only implemented after full consultation with all interested parties, including the medical profession and patients; (ii) are fully centrally resourced, not requiring fees from doctors; (iii) do not lead to the use of examinations in any future revalidation process. <p>(2007)</p>
590.	<p>That following the reports of the Shipman Inquiry this Meeting:</p> <ul style="list-style-type: none"> (i) calls on the UK government to ensure that the revalidation process is robust, practical, affordable and does not detract from delivery of patient care; (ii) believes that revalidation should be developed in consultation with interested and relevant professional groups; (iii) believes that appraisal and clinical governance can be usefully adapted to inform revalidation and commends this to government; (iv) has serious concerns regarding the diversion of time and resources away from direct patient care to any revalidation process which lacks the evidence base to justify it. <p>(2005)</p>
591.	<p>That this Meeting believes:</p> <ul style="list-style-type: none"> (i) the agreed system of appraisal must be totally supported by central funding; (ii) the BMA should monitor appraisal processes. <p>(2002)</p>
592.	<p>That this Meeting asserts that the formal appraisal of doctors should be a constructive exercise and be accompanied by protected time and the necessary resources for personal and professional development plans.</p> <p>(2002)</p>
593.	<p>That the BMA should ensure that the information gained from the appraisal process is used for support and personal development but not to impose sanctions.</p> <p>(2002)</p>
594.	<p>That this Meeting demands that the information collected through the process of appraisal should be used for the purpose of formative development of appraisees and not as a tool in disciplinary proceedings.</p> <p>(2002)</p>
595.	<p>That this Meeting reminds the Government that for annual appraisals to be effective they must:</p> <ul style="list-style-type: none"> (i) be adequately resourced centrally, with provision for cover for doctors being appraised; (ii) comprise of processes which are acceptable to and command the confidence and trust of the profession; (iii) be facilitative and enabling, not judgmental and punitive. <p>(2001)</p>

596.	That the introduction of appraisal for senior hospital doctors is to be welcomed, along with the greater emphasis on continuing professional development, although it will not be effective without proper resources, especially information and administrative support. (2000)
597.	That this Meeting supports the principle of revalidation provided that it is adequately resourced, practical and thoroughly piloted and evaluated. (2000)
598.	That this Meeting believes that in order to win the support of the profession, the process which is introduced for revalidation must: (i) pose no threat to registration other than through the GMC's "Fitness to Practise" procedures; (ii) be based only on valid, robust and verifiable evidence; (iii) be workable, fair and transparent; (iv) ensure safe clinical practice, being concerned solely with fitness to remain on the medical register; (v) not use information which is from any anonymous source; and (vi) believes furthermore that for senior hospital doctors all of these criteria would be met by the implementation of the CCSC's proposals for a system of revalidation based on appraisal. (2000)
599.	That this Meeting believes that, for doctors in training, revalidation or recertification on to the GMC's full register can only be successful through the strengthening of current appraisal and assessment mechanisms, and the development of competency-based assessments for all specialties. (1999)
	GENERAL PRACTICE
600.	That this meeting recognises that Primary Care did not shut during the pandemic, but appropriately changed working practices to protect both patients and staff, continuing to see patients face to face where this was necessary, and calls on the BMA to demand NHSE cease and desist from negative briefings suggesting otherwise. (2021)
601.	That this meeting notes that GP locums can be deemed not to be eligible for the full life assurance cover provided through an NHS Pension Scheme membership, should their death occur on a day when they are not scheduled to be working, and:- iii) deplores the fact that GP locums working for the NHS in England, Wales and Northern Ireland do not have access to a scheme similar to the temporary NHS Scotland Coronavirus Life Assurance Scheme (Scotland); iv) deplores the fact that no permanent solution has been implemented in any part of the UK to address the possibility of GP locums continuing to actively contribute to an NHS Pension Scheme but being deemed not to be in pensionable employment at the time of their death; v) demands that all governments in the UK take permanent action to ensure that GP locums are no longer subject to reduced death in service cover solely because death occurs on a day when no work had been scheduled. (2020)
602.	This meeting calls on the BMA to work with relevant organisations to ensure all CCGs and Health Boards in the UK can guarantee provision of a hoist, with appropriately trained staff,

	and appropriate examination couch in at least one practice within their groups, enabling timely and accessible examinations of patients with disabilities. (2019)
603.	That this meeting deplores the fact that GPs are having to wait longer and longer for emergency ambulances when dealing with seriously unwell patients in the community and calls on the BMA to highlight this issue with ambulance authorities to lessen GPs' exposure to this risk and minimise risks to patients. (2018)
604.	That this meeting is concerned that new online GP services are targeting healthy, less complex patients, the funding for whom is partly used to subsidise care for more complex patients on the registered list and calls on the BMA to:- i) demand a stop to the undermining of general practice by private companies who cherry pick the patients to whom they offer services; ii) demand that online consultation schemes do not become established unless they are prepared to provide a comprehensive package for all patients; iii) support general practice to explore innovative ways of providing health care; iv) demand the allocation of additional funds to NHS general practice to provide training, support and appropriate software and hardware in order to establish on line consultation services. (2018)
605.	That this meeting is concerned about the number of recent practice closures and:- i) believes that unmanaged dispersals lead to patient safety issues; ii) believes that more needs to be done to make the public aware of the mounting threat to the system of general practice; iii) demands details of the contractual arrangements to provide ongoing primary care after a practice closure, are made public; iv) instructs the BMA to take urgent action to ensure the protection of 'last man standing' GPs from any additional costs of resignation or retirement resulting from practice closure. (2018)
606.	That this meeting urges a sensible cap is agreed on the workload of a GP which can be expected to be safely delivered in a day for the safety of patients and sanity of GPs. (2018)
607.	That this meeting notes that the single shareholder of NHS Property Services (NHSPS) is the Secretary of State for Health in England and that NHSPS and agencies acting in its name are:- i) seriously threatening the financial viability of many NHS GP practices; ii) causing massive psychological distress and managerial work for GP partners diverting them away from caring for the sick; iii) behaving very badly as landlords in a manner unbecoming of either a publicly quoted company, or as one of Her Majesty's Secretaries of State. (2017)
608.	That this meeting opposes charges for patients:- i) to see a GP; ii) if an appointment is missed. (2017)
609.	That this meeting notes the regular declarations of "black alert" by hospitals and demands that a similar reporting system be created for general practice to indicate that maximum safe

	capacity has been reached and conference instructs BMA council and the GPC to construct such a system with or without government cooperation. (2017)
610.	That this meeting believes the current workload pressure in general practice is unsafe and unsustainable, that a rapid expansion in the general practice workforce is required to deal with this and therefore calls for sustained investment above the commitments made in the GP Forward View to be made available as a matter of urgency. (2017)
611.	That this meeting notes the recent statements, from UEMO last week and RCGP Council at the weekend, to demand the recognition of General Practitioners as specialists and asks that the BMA adds its vigorous support to correct this long overdue and anachronistic anomaly. (2016)
612.	That this meeting believes that the recent revisions to the firearms licensing arrangements:- (i) places an undue burden on practices, without any resource commitment, to report on every application for a gun license; (ii) leaves the element of discretion too broad in reporting 'depression'; (iii) places the GP in a vulnerable position in having to decide when to report any deterioration in the health of a patient flagged on their notes as a firearms holder; (iv) are dangerous; (v) need urgent revision to ensure certificates are only issued after GPs are involved; (vi) need urgent revision to ensure payment for the work involved. (2016)
613.	That this meeting believes that if general practice fails the NHS will fail. (2016)
614.	That this meeting believes that politicians irresponsibly fuel unrealistic public expectations of healthcare services for their own political ends, and:- i) deplores politicians' persistent and zealous pursuit of political dogma and ideology at the expense of patient care and without due regard to the view of clinicians, patients and the public; ii) welcomes the BMA council #NoMoreGames campaign asking all political parties to stop playing games with the NHS; iii) urges the governments to ensure their health commitments are made in the light of best evidence; iv) urges the governments to ensure any changes to healthcare and delivery are only made when this is evidenced to be in the best interest of patients. That this meeting is disappointed to note that the Secretary of State's announcement of a new deal for general practice fails these tests, putting at risk patient safety, continuity of care and the very existence of general practice. This meeting insists that government first focus on rescuing the current service to allow safe and sustainable care for patients. (2015)
615.	That this meeting believes there is a recruitment and retention crisis in General Practice, is concerned by the low levels of recruitment into General Practice training programmes and: i) calls on the BMA to identify key deterrents to GP recruitment; ii) calls on the BMA to implement strategies to improve student perceptions of General Practice; iii) demands that the UK governments find resources to fund new GPs; iv) challenges governments to evaluate the effects of the latest changes to the NHS Pension Scheme on the ability to train, retain and replenish the GP workforce.

	(2015)
616.	<p>That this meeting accepts that there has been repeated disinvestment in General Practice with increasing numbers of practices now threatened with closure by recent funding changes and:-</p> <p>(Lapsed 2020)</p> <ul style="list-style-type: none"> i) opposes the imposition of 'out of hospital providers' as proposed in the NHS Five Year Forward View; ii) urges the BMA to campaign for fair funding for all General Practice; iii) calls upon all branches of practice to support GPs to regain funding for Primary Care; <p>(Lapsed 2020)</p> <ul style="list-style-type: none"> iv) calls on the BMA to re-commit to a full blown "Save our Surgeries" campaign. <p>(2015)</p>
617.	<p>That this meeting believes sessional GPs should be seen as an asset by practice networks and federations and:-</p> <ul style="list-style-type: none"> i) insists they are employed/contracted by such organisations under favourable terms and conditions; ii) urges networks and federations to ensure such GPs have adequate access to career progression and development asks the BMA to strongly promote the use of the salaried model contract by these organisations. <p>(2015)</p>
618.	<p>That this meeting notes the catastrophic retention crisis in the primary care workforce and demands that NHS England immediately restores a fully funded, comprehensive and accessible occupational health service for GPs and their staff as one way of addressing this crisis.</p> <p>(2015)</p>
619.	<p>That this meeting believes that a discharge summary should be sent to the GP of every patient leaving an in-patient bed in a hospital, regardless of whether this is a planned discharge, a self-discharge or a death.</p> <p>(2015)</p>
620.	<p>That the current standard GP consultation time of ten minutes is out of date, takes no account of changes in medical practice, is not fit for purpose and should be increased.</p> <p>(2015)</p>
621.	<p>That this meeting calls on the BMA to continue reminding the Secretary of State that GPs do and always have provided a 24-hour service 7 days a week and:-</p> <ul style="list-style-type: none"> i) that GPs, due to the well known workforce crisis, are struggling to provide routine services during the week; <p>(2015)</p>
622.	<p>That this Meeting asserts that well-funded and fully resourced primary medical care is the foundation of a cost effective and clinically sound health service and demands that substantially increased resources are put into general practice in order to achieve a sustainably safe and improving service.</p> <p>(2014)</p>
623.	<p>That this Meeting:-</p> <p>(Lapsed 2019)</p> <ul style="list-style-type: none"> i) deplores the government decision to no longer fund an occupational health service for GP practices (unless there is a performance issue);

	<ul style="list-style-type: none"> ii) deplores the government decision that requires trainee general practitioners to now fund their own occupational health assessment before they can start work; iii) calls on GPC to strive for continued funding to maintain a high quality, long term service to GPs and their staff; iv) demands that NHS England ensure a comprehensive occupational health service is made available to all members of staff in GP practices; v) demands that NHS England ensure a comprehensive occupational health service is made available to all locum GPs on the performers lists. <p>(2014)</p>
624.	<p>That this Meeting calls on governments to take urgent action to address a developing crisis in general practice resulting from:-</p> <ul style="list-style-type: none"> i) an unmanageable increase in workload; ii) falling recruitment and retention; iii) recurrently inadequate financial resource; iv) worsening stress and morale. <p>(2014)</p>
625.	<p>That this Meeting believes that GP retention is more cost effective than training new GPs but, because of inadequate funding for induction, retainer and refresher schemes, GPs are lost to the workforce and calls on the BMA to demand that the UK governments fund these schemes adequately.</p> <p>(2014)</p>
626.	<p>That this Meeting deplores the continued lack of investment in primary care despite the ever increasing shift of work from secondary care and increasing complexity of general practice. We believe that:-</p> <ul style="list-style-type: none"> i) general practice has reached workload saturation and oppose any further increase in workload without sustainable long term investment; ii) the impending crisis in recruitment and retention of GP partners has now arrived. <p>(2013)</p>
627.	<p>That this Meeting:-</p> <ul style="list-style-type: none"> i) condemns the government's move to transfer the responsibility for paying employers superannuation for locums from PCOs to practices; ii) insists that all practices should treat locums fairly and pay employers superannuation contributions in addition to the locum fee whenever the locum is still in the pension scheme. <p>(2013)</p>
628.	<p>That this Meeting is concerned that the quality of GP training is being compromised and calls on the BMA to lobby COGPED to:-</p> <ul style="list-style-type: none"> i) ensure adherence to the current guidelines for GP training which include a minimum of 18 months training in general practice; ii) ensure, when four year GP training is implemented, a minimum of twenty four months training in general practice; iii) ensure hospital training posts are of an appropriate length for GP training; iv) publicly name the deaneries (or equivalent bodies) that are failing to adhere to their guidance. <p>(2013)</p>
629.	<p>That this Meeting believes that the progressive movement of complex and chronic care into the community has made the 10 minute GP consultation totally outdated, wholly inadequate and failing the needs of patients, and demands that there should be a deliberate workforce strategy for requisite GP numbers to enable longer consultations with patients.</p>

	(2013)
630.	That this Meeting requests that the BMA puts pressure on the DH to allocate prescribing numbers to locum GPs so they can assume responsibility for their prescribing. (2013)
631.	That this Meeting is very disappointed that the information cascade by PCT/CCG to locum GPs is not being implemented despite the resolution passed at the 2011 ARM and asks that the BMA ensures that the information cascade to locum GPs is implemented by the CCGs. (2013)
632.	That this Meeting believes that:- (i) the current amount of work being moved from secondary to primary care without appropriate movement of resources to support the work is unacceptable and unsustainable; (ii) local agreements must be made to define, control and resource hospital work shifted into the community before it takes place; (iii) any doctor deeming that a patient requires further investigation or treatment must take responsibility for arranging this and the follow up of results; (iv) commissioning bodies must recognise the significant workload pressures in general practice and that expecting practices to do more work without resources puts patients at risk; (v) in many cases premises are not fit for purpose to support this workload shift, and; (vi) the general practice workforce is demoralised by the incessant workload dumped on it. (2012)
633.	That this Meeting calls on the BMA to aid those who wish to return to general practice after a career break as they are a valuable resource and:- (i) recognises that clinical knowledge and skills may be maintained whilst working abroad; (ii) asks the Departments of Health to make available sustained help through funding and other support to assist these doctors (2012)
634.	That this Meeting, in respect of the stated intention of the NHSCB to vest in one individual the roles of responsible officer and primary care commissioning manager:- (i) insists that the role of Responsible Officer must be separated from any performance management role of GPs, contractual or otherwise; (ii) considers this will present GPs with a conflict between the interests of their patients and their own interest in revalidation; (iii) considers this will present an individual holding both offices with a conflict between implementing commissioning policies and independently making revalidation recommendations; (iv) deplores the proposal; (v) instructs the GPC to take action to prevent the implementation of the proposal. (2012)
635.	That this Meeting supports the principle of extending and enhancing GP training but insists that implementation must assure:- (i) high quality training posts tailored to training need; (ii) the supernumerary status of GP trainees in GP placements; (iii) that a strong incentive to provide high quality training is retained; (iv) funding sufficient to deliver all the aspirations of the proposals. (2012)

<p>636.</p>	<p>That this Meeting fears that the future of high quality medical education and training is at serious risk from changes imposed by budget cuts and healthcare reform and that the Health and Social Care Act will be detrimental to the training of future skilled medical practitioners:</p> <ul style="list-style-type: none"> (i) all providers of NHS services must be commissioned with contractual obligations to provide high quality education and training; (ii) commissioners and providers of NHS healthcare must guarantee the provision of education, training and research opportunities; (iii) the commissioning and provision of high quality training or research must be rigorously audited and reported; (iv) local commissioning of education must remain under the aegis of a national system; (v) national educational oversight systems must have representation from active clinicians. <p>(2012)</p>
<p>637.</p>	<p>That this Meeting recognises that many doctors' career paths will include a background of training in different branches of practice and specialties, acquiring skills that are transferable across specialities and training programmes. This meeting calls for those who design and oversee training programmes to:-</p> <ul style="list-style-type: none"> (i) recognise previously attained knowledge skills and experience; (ii) allow greater flexibility in the construction of individuals' training programmes to avoid unnecessary repetition; (iii) allow greater flexibility in the construction of individuals' training programmes to address training needs. <p>(2012)</p>
<p>638.</p>	<p>That this Meeting views the primary medical care of children as an essential part of core general practice and would oppose any attempt to replace that function with specialist children's GPs.</p> <p>(2011)</p>
<p>639.</p>	<p>That this Meeting believes that Care Quality Commission (CQC) registration for General Practice:-</p> <ul style="list-style-type: none"> i) should use only evidence -based requirements; ii) should not require registration criteria that are designed for hospitals; iii) will result in significant stress, workload and the diversion of attention from patient care. <p>(2011)</p>
<p>640.</p>	<p>That this Meeting, in respect of Sessional GPs,:-</p> <ul style="list-style-type: none"> i) calls for the BMA to negotiate arrangements for them to be included in NHS information cascades to general practitioners; ii) calls for the BMA to develop a toolkit for the creation of local Sessional GP groups; iii) calls for LMCs to scrutinise the performance of local GP commissioning consortia on compliance with GPC guidance on inclusion of Sessional GPs; <p>(2011)</p>
<p>641.</p>	<p>That this Meeting recognises recent concerns regarding the quality of GP out of hours services and:</p> <ul style="list-style-type: none"> (i) recognises that many out of hours services are providing high quality care; (ii) calls on GPs as clinical commissioners to ensure they work in co-operation with local out of hours services to ensure high quality clinical care is always provided for their local population. <p>(2010)</p>

642.	That this Meeting is opposed to the abolition of GP practice boundaries. (2010)
643.	That this Meeting believes that partnerships of general practitioners are the gold standard for the delivery of general practice care and the only way of ensuring the future of high quality general practice for our patients and <ul style="list-style-type: none"> (i) calls on the BMA to develop contractual incentives, in partnership with NHSE, which will encourage practices to recruit new GP partners; (ii) conference encourages practices to consider locally placed salaried/sessional GPs in their succession planning; (iii) the increase in salaried GPs represents a substantial threat to the future security of independent contractor status; (iv) calls on the BMA to ensure that any pressure to remove this tried and tested, high quality model is rebuffed. (2009)
644.	That this Meeting believes that, in many areas of the UK, current arrangements for provision of out-of-hours care are failing to meet demand and urges PCTs, PCOs and other commissioning bodies to ensure that adequate clinical standards are actually being achieved. (2009)
645.	That this Meeting recognises the invaluable contribution made by sessional doctors to the delivery of general practice patient care, and: <ul style="list-style-type: none"> (i) recommends that LMCs should continue to represent the interests of all GPs whatever their contractual status; (ii) whilst noting the increasing tensions between GP principals, salaried GPs and freelance GPs, urges all GPs to work together to design flexible career pathways that meet everybody's needs; (iii) recommends that all salaried GPs should receive terms and conditions of employment which provide security of tenure, reasonable pay to reflect their experience, qualifications and work, fair hours of work, redundancy and leave entitlements as per the model salaried GP contract; (iv) strongly encourages practices to appoint profit-sharing partners to practice vacancies. (2008)
646.	That this Meeting deplores the lack of substantive job opportunities for newly-qualified general practitioners and calls on the GPC to: <ul style="list-style-type: none"> (i) commission immediate workforce planning investigations with regards to GP trainees, GP retirement and substantive GP positions; (ii) encourage deaneries to create and support positions for newly-qualified GPs within surgeries with interests in further training of general practitioners; (iii) lobby all out-of-hours providers not to unreasonably deny requests by newly-qualified general practitioners to continue or commence work in the out-of-hours environment; (iv) pursue a media campaign to highlight the plight of unemployed, fully-qualified general practitioners. (2008)
647.	That this Meeting notes with dismay the government's activity in introducing a multitude of contributors to primary care delivery, and insists that the central role of GPs as cost effective providers of generalist care must not be undermined. (2008)

648.	That this Meeting deplores the no option tactics of the government in forcing general practitioners into an increase in out-of-hours work without an increase in the appropriate funding for their practices. (2008)
649.	That this Meeting believes that general practice is good for your health and that UK GPs have always and continue to put their patients before profit, quality before quantity and trust before targets and further believes that the health departments could learn much from this approach. (2007)
650.	That this Meeting demands the BMA and GPC actively oppose APMS. (2007)
651.	That this Meeting calls upon the BMA to press the government to augment investment in GP training as the only way to address the inevitable GP shortages posed by the imminent retirement demographic time bomb. (2006)
652.	That this Meeting (i) is proud of UK general practice; (ii) proclaims the achievement of clinical excellence within UK general practice; (iii) resents attempts by politicians to devalue the clinical generalist work of GPs; (iv) deplores any attempt to blame NHS problems on general practice's achievements; (v) deplores any suggestion that delivering high quality primary care is "over-performance". (2006)
653.	That this Meeting asserts in the strongest possible terms the commitment of British GPs to holistic, list-based, patient-orientated general practice and believes that: (i) patients of this country will never forgive any government which destroys the cherished GP registered list system; (ii) primary care needs of patients who work away from home can be provided for without the need to move away from registered lists; (iii) continuity of care is under a steady and growing threat and that every new policy initiative needs to be publicly measured against its benefit or threat to continuity; (iv) any development of health care outside hospital proposed in the forthcoming white paper must include the right of everyone entitled to NHS care to be registered with a single primary medical services provider which will be the primary provider of, and co-ordinator for, their health care. (2005)
654.	That this Meeting: (i) believes that the government is totally misguided on the value of large primary care "super-surgeries", and believes this is not what the UK public want; (ii) believes that super-surgeries will not improve quality, care or outcomes; (iii) strongly opposes any policy which gives financial or other advantages to super-surgeries over the traditional models of service; (iv) rejects the modernisation agency's plan for a reduction in the number of GP practices and the construction of a three tier primary care service; (v) directs the GPC to enter into urgent talks with the Health Departments to demand a balance between the widely trailed idea of very large GP "super-surgeries" by producing a complimentary, effective and costed policy for the support of smaller and single-handed practices. (2005)

655.	<p>That this Meeting believes that, properly used, community hospitals have an essential part to play in the full spectrum of care and:</p> <ul style="list-style-type: none"> (i) regrets that the development of a national contractual framework and the increased resourcing of GPs working in community hospitals, as recommended by the DDRB, has not been supported by the Health Departments; (ii) calls upon the GPC to negotiate a national model contract for GPs working in community hospitals, with the governments providing full funding of any settlement. <p>(2005)</p>
656.	<p>That this Meeting condemns the cuts in many deanery and WDC educational budgets and believes this will adversely affect current and future GPs and their staff and:</p> <ul style="list-style-type: none"> (i) demands that the Department of Health rectify the significant funding cut to training but not at the expense of other training and development funding streams for doctors and staff; (ii) believes failure to restore the funding will prevent the government's and profession's aspirations for high quality patient care; (iii) calls on government to guarantee sufficient funds in future years to support properly and expand the recruitment, training and retention of all GPs; (iv) believes the proposed cuts reflected a culture of "organisational prejudice" within the Department of Health against the purpose and values of general practice; (v) instructs the BMA to convey conference's lack of confidence with government's commitment to GP recruitment. <p>(2004)</p>
657.	<p>That this Meeting believes that strategic health authorities should ensure that primary care trusts invest the majority of new NHS resources in primary care, rather than use them to fund secondary care deficits.</p> <p>(2003)</p>
658.	<p>That this Meeting insists that the BMA intensifies lobbying for the protection of general practitioners against forced list allocations.</p> <p>(2003)</p>
659.	<p>That this Meeting calls on the BMA to investigate and address the serious concerns of discrimination against GP trainees in hospital posts, in particular:</p> <ul style="list-style-type: none"> (i) access to study leave; (ii) access to GP orientated training; (iii) inadequate assessment of training needs specific to GP trainees; (iv) the culture of portraying general practice in a negative light. <p>(2003)</p>
660.	<p>That this Meeting supports the view that patients should not be directly charged for consultations with NHS general practitioners.</p> <p>(2002)</p>
661.	<p>That the forty eight hour requirement for access of patients to their GPs with the current level of manpower is both inappropriate and unachievable.</p> <p>(2001)</p>
662.	<p>That this Meeting believes that for general practitioners to deliver safe, competent, high quality care:</p> <ul style="list-style-type: none"> (i) the average time allowed for consultations should be increased from 7 to 15 minutes; (ii) time must be allowed for necessary professional development; (iii) there must be an increase in GP and practice nurse numbers far in excess of Government projections;

	<p>(iv) the burden of bureaucratic paper work must be reduced;</p> <p>(v) and the Government and the BMA should open a meaningful dialogue in order to achieve this as a matter of urgency.</p> <p>(2001)</p>
663.	<p>That the BMA should call on the Government and the Health Departments to support the value of the doctor-patient relationship in primary care, and that any proposed changes that threaten this continuity of care should be opposed unless there is clear, objective evidence of benefit both nationally and locally.</p> <p>(2000)</p>
664.	<p>That this Meeting is supportive of moves to bring the duration of training for general practice required by the medical directive into line with that required by regulation in the UK and:</p> <p>(i) encourages GPC to continue its efforts in this area;</p> <p>(ii) urges representatives and LMCs urgently to make contact with their MEPs to persuade them of the case for so amending the directive.</p> <p>(2000)</p>
665.	<p>That this Meeting welcomes the independent inquiry into the murders by Harold Shipman and:</p> <p>(i) believes that practical measures to prevent a similar occurrence should be supported;</p> <p>(ii) believes that his acts of criminality should not reflect upon other general practitioners;</p> <p>(iii) believes that the protection of patients from criminal acts and from poor performance are separate issues and must not be confused;</p> <p>(iv) deplores attempts to drive through fundamental structural changes in general practice on the back of these tragic events;</p> <p>(v) asserts that the failure of the police and the local health authority to investigate adequately the concerns of his professional colleagues should not be misrepresented as a failure of self regulation.</p> <p>(2000)</p>
666.	<p>That the Government should take necessary steps as a matter of urgency to improve the inner city recruitment of GPs.</p> <p>(1999)</p>
667.	<p>That:</p> <p>(i) GP independent contractor status must be safeguarded in all negotiations with the Government on the future of primary care;</p> <p>(ii) the GMSC should prepare contingency plans to protect the national contract and independent status for all GPs wishing to remain within their current contract.</p> <p>(1997)</p>
668.	<p>That this Meeting deplores the anomaly whereby sex discrimination legislation applies to partnerships of any size whereas race discrimination legislation only applies to partnerships with six or more partners. It calls on BMA Council to take appropriate steps to persuade Parliament to rectify this anomaly by reducing the threshold at which race relations legislation applies to bring it into line with sex discrimination law.</p> <p>(1994)</p>
669.	<p>That this Meeting believes that general practitioners with their primary health care teams should remain the gatekeeper to secondary health care services.</p> <p>(1992)</p>
670.	<p>That this Meeting confirms the right of GP principals to retain the independent contractor status.</p> <p>(1992)</p>

671.	That this Representative Body believes that no general practitioner who has contracted to provide unrestricted medical services should be obliged or forced to accept a greater number of patients on his list than he feels he can provide an adequate medical service for, in the light of his own health and the circumstances of his life and practice. (1967)
672.	That assignment of patients under the allocation scheme is not acceptable to the profession and that no doctor under his terms of service be required to accept a patient on his NHS list except by free agreement between doctor and patient. (1967)
673.	That this Representative Body reaffirms that with proper arrangements for supervision by a consultant, access to hospital physiotherapy departments for urgent treatment should be available to family doctors where local circumstances demand it. (1965)
674.	That the hospital vacancies to be filled by general practitioners should be open to all practitioners in the area with suitable qualifications. (1956)
675.	<u>Diagnostic services</u> That this Meeting insists that GPs should have the same access as their secondary care colleagues to diagnostic services. (2002)
676.	That this Meeting deplores the lack of progress by the Department in ensuring widespread availability of general practitioner access to hospital diagnostic facilities. (1988)
677.	<u>Fundholding</u> That doctors should have no personal financial interest in purchasing health care for their patients. (1996)
678.	That this Meeting welcomes the GMSC statement of 20 February 1992 stressing the fundamental importance of GPs being able to influence the commissioning of care for their patients, and believes that, to achieve this: <ul style="list-style-type: none"> (i) adequate remuneration and reimbursement should be available from DHA/FHSAs and health boards for all GPs involved in these activities; (ii) participation in these activities should be regarded as protected time and should count towards a practitioner's hours of availability; (iii) all practices should have equity of access to the necessary support staff and systems to allow them to carry out these activities; (iv) LMCs should be helped and encouraged to provide the necessary framework through which these initiatives are advanced, taking into account the right of individual practices to formulate their own strategies in the interests of their patients and the communities they serve. (1992)
679.	That fundholding must be voluntary. (1992)

680.	<p><u>GP contract</u></p> <p>That this meeting feels that the Multispecialty Community Provider contract framework does not go far enough in:-</p> <ul style="list-style-type: none"> i) protecting the liability of individual contract holders from the implications of pooled budgets; ii) preserving the tenure of GMS and PMS contracts; iii) protecting GPs from further unfunded work being transferred from secondary care. <p>(2017)</p>
681.	<p>That this meeting acknowledges that the BMA salaried model contract has protected GPs against unfair terms and conditions since its inception and supports:-</p> <ul style="list-style-type: none"> i) a contract and associated terms and conditions of service suitable for all GPs in salaried roles regardless of employer; ii) a requirement to make the offer of this contract, or more favourable, a requirement on anyone wishing to employ a GP in a salaried post; iii) a formal pay scale that that both incentivises recruitment but also rewards retention of these doctors within the NHS. <p>(2016)</p>
682.	<p>That this Meeting:-</p> <ul style="list-style-type: none"> i) agrees with the principle that the introduction of MPIG in the 2004 GP contract was to avoid destabilising GP practices under the amended funding arrangements; ii) notes that MPIG was guaranteed to those practices until such time as it was no longer required; iii) is dismayed that the recent decision to end MPIG is leaving a number of GP practices so financially destabilised that they may be forced to close; iv) is concerned that, in order to survive and recruit new partners, such practices may be left with little option but to significantly reduce patient services; v) is further concerned at the impact of such service reduction on the patients registered with these practices; vi) calls for the MPIG to remain in place until a robust impact assessment has taken place on the likely short and long-term effects for those practices most severely affected. <p>(2014)</p>
683.	<p>That this Meeting believes that the UK-wide GP contract has been beneficial to patients in the four countries, and that this should be maintained in spite of the divergence in health systems.</p> <p>(2011)</p>
684.	<p>That this Meeting calls on the BMA to promote the use of the BMA model contract for:</p> <ul style="list-style-type: none"> (a) all GP trainees; (b) GMS, PMS and APMS providers; <p>(2010)</p>
685.	<p>That this Meeting insists that the Minimum Practice Income Guarantee (MPIG) is an integral part of GP income. Any efforts by government to demand extra work to retain the MPIG will be vigorously resisted.</p> <p>(2007)</p>
686.	<p>That this Meeting</p> <ul style="list-style-type: none"> (i) believes the only fair and secure way of funding general practice is to set a realistic global sum not reliant on MPIG; (ii) demands the revision of the Carr Hill formula for general practice resources should be expedited;

	<p>(iii) urges GPC to ensure the MPIG will continue until the global sum is adequately resourced;</p> <p>(iv) insists that the MPIG should be inflation proofed for as long as it needs to be in place;</p> <p>(v) demands that the GPC ensures that all new GMS contracts awarded in the future offer some financial protection like that provided by the MPIG for existing GMS contracts;</p> <p>(vi) believes that any alterations to the MPIG, or correction factors, must not be allowed to destabilise rural GP practices.</p> <p>(2006)</p>
687.	<p>That this Meeting believes it is best for GPs and their patients if the profession is united:</p> <p>(i) across the whole UK;</p> <p>(ii) across GMS and PMS;</p> <p>(iii) and calls for the GPC to be recognised by the government as the sole national negotiator for all forms of general practitioners contracts.</p> <p>(2003)</p>
688.	<p>That no new GP contract is acceptable which can be altered unilaterally.</p> <p>(2002)</p>
689.	<p>That this Meeting believes that demands for any increased availability of general practitioners for routine matters outside normal working hours must be accompanied by:</p> <p>(i) increased investment in GPs and practice nurses;</p> <p>(ii) increased investment in ancillary staff;</p> <p>(iii) increased investment in premises and security;</p> <p>(iv) increased routine availability of other services outside the normal working hours, particularly dental, pharmaceutical, nurses, laboratory and social worker's services;</p> <p>(v) measures to maintain continuity of patient care.</p> <p>(2000)</p>
690.	<p>That the independent contractor status for GPs should be maintained as an option.</p> <p>(2000)</p>
691.	<p>That, regarding the document "<i>Drug misuse and dependence - Guidelines in clinical management</i>", this Meeting:</p> <p>(i) reaffirms that the treatment of substance misuse is not part of core GMS;</p> <p>(ii) rejects as inappropriate the stated aim of involving more GPs in the treatment and maintenance of drug addicts without considering the service impact for other patients;</p> <p>(iii) rejects as unrepresentative the GP membership of the working group;</p> <p>(iv) condemns the coercive threats to GPs implicit throughout the document;</p> <p>(v) insists that any GP involvement in the treatment of drug addiction must be voluntary and fully resourced from outside GMS funds.</p> <p>(1999)</p>
692.	<p>That this Meeting believes that it is not helpful that when a craft intends to change the services that it provides, and this change will directly affect other crafts, this change is not subject to a period of notice allowing accommodation of the change by other crafts.</p> <p>(1997)</p>
693.	<p><u>GP hospitals</u></p> <p>That this Meeting wishes to reaffirm that community hospitals are a vital focus for health care in rural areas and should be maintained and developed further.</p> <p>(1997)</p>

694.	That this Meeting believes that general practitioner hospitals should be included in any overall strategy for primary care or hospital developments. (1986)
695.	<p><u>Personal medical services</u></p> <p>That this Meeting, following John Hutton’s letter, dated 5 June 2003, to all PMS GPs:</p> <ul style="list-style-type: none"> (i) finds ministerial delay in informing PMS practices about the effects of the proposed GMS contract on PMS until after the ballot was underway unacceptable; (ii) insists on clarity, by September 2003, on the exact mechanism and funding for those returning to GMS; (iii) on the basis that PMS remains a “separate, permanent, voluntary local option” seeks clarity from the government, by September 2003, as to whether the PMS practices who have been put on a “mainstream statutory basis” will have a permanent option to return to GMS at any time; (iv) believes PMS GPs should be entitled to an MPIG; (v) asks the GPC to ensure that a return from PMS to GMS is made as easy as possible. <p>(2003)</p>
696.	That this Meeting insists that there is transparency and equity of funding in resourcing development in GMS as there is for PMS. (2002)
697.	That this Meeting deplores the fact that the General Practitioners Committee still does not have the right to negotiate for GPs on national aspects of PMS contracts. (2002)
698.	<p>That this Meeting believes that:</p> <ul style="list-style-type: none"> (i) the Government’s discriminatory contractual proposals for single-handed practices as outlined in the NHS Plan for England are deplorable; (ii) patients have a right to be cared for by a new single-handed GP following the resignation of their existing single handed practitioner; (iii) all single-handed GPs have an equal right to retain independent contractor status under GMS; (iv) single-handed GPs should not be forced into PMS pilots. <p>(2001)</p>
699.	<p><u>Practice boundaries</u></p> <p>That this Meeting recognises that the current model of general practice where practices are responsible for a registered population and can provide continuity of care, including home visits during working hours if necessary, is a very effective and patient centred model of care. This Meeting believes the removal of practice boundaries would have serious adverse consequences for the organisation, provision and funding of NHS services, and for the integration of health and social services. This would threaten both equality of access and patient safety. The BMA should oppose proposals for the abolition of practice boundaries. (2011)</p>
700.	That this Meeting believes that the abolition of general practice boundaries will worsen health inequalities. More mobile, literate patients will be free to choose practices, while patients with higher health needs and less mobility will not be able to exercise choice. This will distort the mix of patients in practices, threatening the existence of some practices in deprived areas who may be left caring principally for people with long-term conditions, so

	resulting in less cross-subsidisation by patients with straight forward health needs. That this Meeting calls on the BMA to demands that practice boundaries are maintained. (2011)
701.	That this Meeting believes that the abolition of practice boundaries will lead to a deterioration of patient care and fundamentally compromise patient safety specifically in areas of mental health care and the safeguarding of vulnerable children and adults and calls on the Department of Health to abandon this flawed policy. (2011)
702.	That this Meeting believes the removal of practice boundaries would have serious adverse consequences for the organisation, provision and funding of NHS services, and for the integration of health and social services. This would threaten both equality of access and patient safety. (2011)
703.	That this Meeting believes that the abolition of practice boundaries will lead to a deterioration of patient care and fundamentally compromise patient safety especially in areas of mental health care and the safeguarding of vulnerably children and adults and calls on the Department of Health to abandon this flawed policy. (2011)
704.	<u>Referrals</u> That this meeting recognises the right and responsibility of general practitioners to refer patients for specialist opinion and regarding referral management systems:- i) requires legal confirmation that the clinical responsibility will rest with the individual making the decision that a referral may or may not proceed; ii) believes they are an unacceptable barrier to patients accessing appropriate secondary care; iii) believes the time involved is a poor use of the GP workforce; iv) demands that the government takes measures to ensure that the postcode lottery these create ceases immediately; v) calls upon the GPC England to oppose this false economy and allow GPs as highly skilled generalists to continue to act with professional autonomy. (2018)
705.	That this Meeting calls on the BMA to publicly campaign against the constant incentives of government to reduce GP referrals to hospital, in order to save money. GPs must have the freedom to refer patients to a consultant, in the patients' best clinical interest. (2012)
706.	That this Meeting reaffirms its view that in the re-organised NHS, GP to consultant referrals should reinstate the right to refer patients to named consultants. (2012)
707.	That this Meeting believes that it is vital for general practitioners to be able to freely and without interference refer patients directly to a named consultant for a specialist opinion in order to achieve a high standard of medical care and to maintain the trust of patients. (2012)
708.	That this Meeting believes that: (i) GPs should have the option to refer patients to named consultants and should not incur financial penalty by doing so;

	<p>(ii) replies to GP referrals should be addressed personally to the GP referrer and not merely be a copy of the letter sent to the patient.</p> <p>(2010)</p>
709.	<p>That this Meeting believes that:</p> <p>(i) it is the fundamental right of the GP to refer for a consultant opinion in an open and transparent manner, unimpeded by bureaucracy;</p> <p>(ii) financial incentive schemes to dissuade GPs from referring patients to hospital for a consultant consultation are unethical and will undermine the patient's trust in the NHS; and calls on the BMA to oppose these schemes.</p> <p>(2009)</p>
710.	<p>That this Meeting reaffirms the time honoured system whereby patients are only seen by specialists when they are properly referred by a family doctor's letter or with his knowledge and consent, except in case of urgency or where provided by recognised custom or statute.</p> <p>(1996)</p>
711.	<p>That this Meeting demands that clinicians have the right to make extra contractual and tertiary referrals on clinical grounds and that health authorities should set aside funds for such referrals falling outside established contracts, and that the Scottish system of notification and monitoring be adopted.</p> <p>(1992)</p>
712.	<p>That this Meeting insists that the only basis for a hospital referral should be the clinical choice of the medical practitioner and the patient, without the interference of the district health authority.</p> <p>(1990)</p>
713.	<p>That this Meeting believes that, normally, general practitioners should be informed if and when their patients receive specialist medical care.</p> <p>(1987)</p>
714.	<p><u>Remuneration</u></p> <p>That this meeting believes maternity pay in the NHS should be improved and:-</p> <p>i) calls for the NHS Staff Council to negotiate parity of eligibility criteria so that NHS maternity pay begins at the 11th week before the expected week of childbirth and employees are eligible after 26 weeks employment in line with statutory maternity pay.</p> <p>(2021)</p>
715.	<p>That this Meeting:</p> <p>(i) condemns the governments' lamentable failure to persuade the public of the safety of the MMR vaccine which continues to penalise GPs twice;</p> <p>(ii) urges the governments to accept that the target payment system is a significant contributory factor to the continuing lack of parental confidence in the MMR vaccine;</p> <p>(iii) deplores the attitude of the Chief Medical Officers to target payments for immunisations;</p> <p>(iv) insists that exception reporting, including informed dissent by parents, is allowed for all target payments, particularly with regard to MMR.</p> <p>(2003)</p>
716.	<p>That GP target payments are potentially harmful to the doctor/patient relationship and:</p>

	<ul style="list-style-type: none"> (i) where there is parental informed refusal, the child should be removed from the MMR target population; (ii) where there is parental informed refusal, the child should be removed from the target population for all immunisations; (iii) where there is informed refusal, the patient should be removed from the target population for that procedure; (iv) they should be abandoned forthwith. <p>(2002)</p>
717.	<p>That this Meeting requires the GPC to negotiate solutions to:</p> <ul style="list-style-type: none"> (i) the growing pay differential between GP registrars and junior hospital doctors; (ii) the anomaly whereby certain groups of doctors do not benefit from salary protection on entry to GP registrar posts, as the DDRB recommended in its 30th report; (iii) outstanding differences in the terms and conditions of GP registrars and junior hospital doctors, particularly those which relate to sick leave benefits, maternity leave and benefits, parental and adoption leave and compassionate leave; (iv) the current position concerning paternity leave for GP registrars. <p>(2001)</p>
718.	<p>That this Meeting believes that the derisory rates of pay offered to doctors for medical recommendations under the Mental Health Acts are a major disincentive to addressing the shortage of these doctors and requires that the BMA renegotiate these rates.</p> <p>(2001)</p>
719.	<p>That, where GPs carry out any work to assist in the running of the NHS, including the new primary care organisations, this Meeting requires the GPC to negotiate:</p> <ul style="list-style-type: none"> (i) payment commensurate with the quality and quantity of the work done; (ii) an adequate locum allowance to pay locums at the current market rate, whether an external locum is engaged or not; (iii) that payment for regular sessional work must be superannuated, with proper sickness and maternity arrangements. <p>(1999)</p>
720.	<p>That this Meeting believes that the calculation of the eligibility for seniority awards for general practitioners should be based on the total of all years worked in general practice, including time spent as non-principal GPs.</p> <p>(1998)</p>
721.	<p><u>Representation of GPs</u></p> <p>That this Meeting condemns the failure of the Departments of Health to negotiate a UK-wide contract for those doctors working in community hospitals and:</p> <ul style="list-style-type: none"> (i) deplores the appalling pay and conditions offered to GPs working in community hospitals; (ii) deplores the “blackmail” techniques used by trusts to ensure the continuity of medical staffing; (iii) demands that GPC negotiates clear, satisfactory national terms and conditions for GPs working in community hospitals; (iv) is very concerned that as yet the problem of out-of-hours cover for community hospitals remains unsolved. <p>(2004)</p>
722.	<p>That this Meeting believes that:</p> <ul style="list-style-type: none"> (i) the Scottish GMSC must have the power and resources to negotiate directly with a Scottish parliament;

	<p>(ii) an English GMSC should be established; (iii) a strong UK GMSC should be preserved. (1998)</p>
723.	<p>That this Meeting strongly supports the view that the LMC remains the essential and only democratic body at local level to represent the interests of all doctors working in general medical practice and:</p> <p>(i) invites the Government to confirm the LMC role when it introduces primary NHS legislation; (ii) demands that health authorities, health boards and primary care groups be statutorily required to consult LMCs on all matters relating to primary care provision. (1998)</p>
	HEALTH OF THE PUBLIC
724.	<p>That this meeting recognises and deplores the increase in domestic abuse that has occurred during the pandemic and calls on:-</p> <p>i) the government to bring in an offence of near-fatal strangulation and; ii) staff training to be instigated for all front-line staff in health and social care, in schools and in the police, to increase awareness of pointers to abuse. (2021)</p>
725.	<p>That this meeting recognises the recent WHO announcement of anti-vaxxers being one of the top threats to global human health in 2019, alongside Ebola, HIV and humanitarian crises. We urge the BMA to lobby the UK government to: -</p> <p>i) implement binding standards compelling social media corporations to actively prevent the dispersal of false or misleading information on the effects of vaccinations; ii) provide funds to enable vaccine providers (GPs and outreach services) to annually offer any missed childhood vaccines to children, who have not had them previously, up to the age of 16. (2019)</p>
726.	<p>That this meeting is seriously concerned by the increased number of homeless people living and sleeping outdoors across the UK and recognises the deleterious effects of homelessness on physical and mental health. We call on: -</p> <p>i) medical schools to ensure that the healthcare needs of this population are included in their curriculum; ii) NHS bodies to explore integrated models of healthcare for this population such as the pathway team; iii) NHS bodies to provide NHS clinical staff with local guidelines including admission and discharge procedures for patients from this population; iv) UK governments to commit additional resources to support the primary medical care of these vulnerable people; v) UK governments to ensure that no person completing a prison sentence is released to conditions of homelessness. (2019)</p>
727.	<p>That this meeting believes that everyone has the right to a decent, affordable home and: -</p> <p>i) welcomes the 2019 Shelter report "Building for our future: A vision for social housing"; ii) calls on all political parties to include a commitment to implement the Shelter report recommendations in their next election manifestos. (2019)</p>
728.	<p>That this meeting is extremely concerned about the growing presentation of knife crime in emergency departments across the UK. We therefore call on the BMA to: -</p>

	<p>i) support the work of national charities and projects that aim to tackle this as a public health issue and acknowledges the role healthcare professionals have in tackling this issue alongside other government initiatives;</p> <p>ii) ensure medical students are aware of the social impacts of knife crime on the individual and community via integration of a session into the medical school curriculum from e.g. charities / local projects that tackle this issue.</p> <p>(2019)</p>
729.	<p>That this meeting deplores the failure of government communication following the Salisbury incident on 4th March when Sergei Skripal was found poisoned, in particular:-</p> <p>i) the delay of 12 days before advice on managing potential contact with an unknown toxic substance was produced for GPs;</p> <p>ii) the failure to establish a dedicated poisons helpline immediately the nature of the poisoning was suspected.</p> <p>(2018)</p>
730.	<p>That this meeting recognises that reliable access to sanitary products is essential for the health and wellbeing of the menstruating population, and that the current system for distribution can leave those most vulnerable with no option other than to go without. We therefore call on the BMA to:-</p> <p>i) ensure all in-patients have access to sanitary products for the duration of their stay;</p> <p>ii) lobby the government to implement the free provision of sanitary products.</p> <p>(2018)</p>
731.	<p>That this meeting recognises the evidence that the policy approach of full decriminalisation of sex-work, as adopted by New Zealand, has resulted in public health benefits for both sex workers and wider society. This meeting therefore calls upon the BMA to develop educational resources to enable doctors and medical students to better understand and respond to the specific healthcare needs of sex workers, such as CPD events and BMJ Learning resources.</p> <p>(2017)</p>
732.	<p>That this meeting welcomes the working party report “Every breath we take: the lifelong impact of air pollution” produced by the Royal College of Physicians [London] and Royal College of Paediatrics and Child Health, and we call for:-</p> <p>i) further research into the economic impact of air pollution;</p> <p>ii) clearer information for consumers on emissions produced by new vehicles, including information on ultrafine particles and oxides of nitrogen;</p> <p>iii) effective monitoring of air quality and pollution;</p> <p>iv) the NHS to become an exemplar for clean air and safe workplaces;</p> <p>v) empowerment of local authorities to take remedial action when air pollution levels are high.</p> <p>(2017)</p>
733.	<p>That this meeting demands that certification of fitness to work (‘fit notes’) need not be done by a medical professional and that:-</p> <p>i) there should be an extension of self-certification for illness from 7 to 14 days;</p> <p>ii) a change in legislation is required to allow other health care professional such as midwives, allied health professionals and nurse practitioners to complete ‘fit notes’ for patients; and</p> <p>iii) the Department of Work and Pensions should establish their own means of determining benefits.</p> <p>(2016)</p>
734.	<p>That this meeting requests the board of science investigates the effect of travel distance and travel costs on the outcome of health care, especially for vulnerable groups of patients.</p> <p>(2016)</p>

735.	<p>That this meeting:-</p> <ul style="list-style-type: none"> i) recognises the relationships between poverty, social inequality, poor physical and mental health and reduced life expectancy; ii) urges UK governments to prevent poverty in order to reduce social inequality and to protect all members of society, especially children, from the negative effects of poverty and social inequality on their health and quality of life. <p>(2016)</p>
736.	<p>That this meeting believes that welfare reforms and the economic policy known as “austerity” lead to inequalities in health outcomes and calls for the BMA to lobby governments to do more to help those members of society who suffer a greater economic and health impact from austerity measures.</p> <p>(2015)</p>
737.	<p>That this meeting recognises that people who are homeless face some of the worst health inequalities in society, especially in terms of access to healthcare. Therefore we call upon the BMA to work closely with local Health and Wellbeing Boards, encouraging them to:-</p> <ul style="list-style-type: none"> i) commit to including the health needs of homeless people in their Joint Strategic Needs Assessments; ii) provide leadership on addressing homeless health with integrated responses and cross boundary working and; iii) ensure that local health services truly meet the needs of homeless people. <p>(2015)</p>
738.	<p>That this meeting believes that helium is a very limited resource that is vital for medical use (e.g. heliox, MRI scanners) and should not be wasted for things like party balloons, and calls on the BMA to campaign for a ban on frivolous use of the world’s non-renewable supply of helium.</p> <p>(2015)</p>
739.	<p>That this Meeting recognises the need to protect the future health of the population against the rising tide of obesity and increasing demands on the Health Service and calls on governments to:-</p> <ul style="list-style-type: none"> i) make significant investment in simple, practical and understandable health and nutrition education for all UK school pupils; ii) develop a requirement for all schools to introduce a new element to their curricula which educates young people across the UK in the appropriate, safe and effective use of health services, and raises awareness about responsibility for self management of health when required. <p>(2014)</p>
740.	<p>That this Meeting expresses concern that:-</p> <ul style="list-style-type: none"> i) health inequalities have continued to rise in the last three years; ii) reduction in welfare benefits will have detrimental effects on the health of those who are already disadvantaged. <p>(2013)</p>
741.	<p>That this Meeting:-</p> <ul style="list-style-type: none"> (i) recognises the government’s responsibility to reduce health inequalities by investing in public services such as the NHS and education; (ii) recognises the developed world’s duty to provide humanitarian aid to the third world; (iii) recognises the urgency involved in tackling climate change and its threat to global health; (iv) applauds the call for a Financial Transactions Tax or ‘Tobin Tax’ to address the above by former BMA president Sir Michael Marmot, Oxfam, Medsin UK, 39 Members of

	<p>Parliament (from all parties), UNISON, the NUT (National Union of Teachers), two Nobel prize winners for economics and the French and German governments;</p> <p>(v) calls upon the BMA to support a Tobin Tax of 0.05% on the banking sector to raise an estimated £20billion. This money would then be spent on public services (in particular the NHS), fighting climate change and overseas humanitarian aid;</p> <p>(vi) calls upon the BMA to lobby the government to implement the Tobin Tax.</p> <p>(2012)</p>
742.	<p>That this Meeting calls for strict guidelines to be drawn up for the use of “kettling” in other situations.</p> <p>(2012)</p>
743.	<p>That this Meeting believes that vitamin D deficiency in many groups within the UK population may be a significant underlying factor in a number of health problems, and:-</p> <p>(i) believes that deficiency is so common, particularly in those of South Asian ancestry, that this now represents a public health problem;</p> <p>(ii) notes the challenges facing clinicians in deciding when to test for vitamin D deficiency and in prescribing effective vitamin D supplements;</p> <p>(iii) asks the Board of Science to produce clear and simple guidance on the investigation and treatment of vitamin D deficiency.</p> <p>(2012)</p>
744.	<p>That this Meeting calls on the UK governments:-</p> <p>(i) to promote the culture of children playing outside in view of the health benefits associated with outdoor play;</p> <p>(ii) to instruct local authorities to stop selling off outdoor play spaces for development purposes and instead invest in the development and maintenance of these spaces to ensure they are safe, stimulating and easily accessible to all children in the UK.</p> <p>(2012)</p>
745.	<p>That this Meeting applauds the ready availability of voluntary and statutory services for basic and advanced life support and:-</p> <p>(i) notes the call by the BMA in 1999 for resuscitation to be taught in schools;</p> <p>(ii) regrets that the teaching of resuscitation in schools is not mandatory;</p> <p>(iii) applauds the efforts of healthcare and the third sector to provide such training;</p> <p>(iv) supports the call by the Resuscitation Council and the British Heart Foundation for this to become a mandatory component of the curricula of all schools in the UK and calls on the BMA to campaign for this;</p> <p>(v) calls for the governments to introduce the teaching of first aid in schools.</p> <p>(2012)</p>
746.	<p>That this Meeting is outraged that the Department of Health did not run an influenza publicity campaign in autumn 2010 to mitigate the effects of seasonal influenza, believes that this is not cost effective and demands that influenza immunisation publicity campaigns are run each year.</p> <p>(2011)</p>
747.	<p>That this Meeting applauds the Marmot Review: 'Fair Society, Healthy Lives' and strongly urges the BMA to lobby government to:</p> <p>(i) take forward the recommendation that expenditure on preventative services increase;</p> <p>(ii) increase the proportion of overall expenditure allocated to the early years to give every child the best start in life;</p> <p>(iii) set a 'minimum income for healthy living';</p> <p>(iv) adopt fiscal policies to narrow the income gap between our poorest and richest citizens.</p> <p>(2010)</p>

748.	That this Meeting recognises the positive health benefits of physical activity, and recommends that increasing walking and cycling in daily activity should be a public health priority for children and adults. (2010)
749.	That this Meeting believes that the BMA with its Patient Liaison Group should lobby government to provide adequate funding to allow doctors to make available to patients educational materials in a range of formats. (2009)
750.	That this Meeting believes that in the interests of promoting optimal healthcare for all children: (i) individual health visitors should be linked to GP surgeries; (ii) health visitors should have mandatory training in the prevention, recognition and management of childhood obesity. (2009)
751.	That this Meeting is concerned that health inequalities between rich and poor people will increase in the present economic climate and calls on all UK governments to ensure that traditionally deprived communities are not further disadvantaged. (2009)
752.	That this Meeting supports the recommendations arising out of the Health Select Committee inquiry into Health Inequalities that in order to ensure good value for money for the tax payer, policy should be evidence based or if evidence is not available should always be accompanied by evaluation programmes of sufficient quality and duration. (2009)
753.	That this Meeting deplores the plundering of funds required for disease prevention, health promotion and sexual health to reduce trust deficits or produce a financial surplus. (2008)
754.	That this Meeting believes that sex and relationship education (SRE): (i) should be delivered to a nationally standardised curriculum; (ii) should incorporate contraception and how it may be accessed; (iii) should incorporate sexually transmitted infections, their transmission and prevention, and how to access treatment services; (iv) should be delivered by specialist SRE teachers; (v) should begin at primary school entry. (2008)
755.	That this Meeting deplores the lack of government action to redress the gross health inequalities that continue to exist within Britain. (2004)
756.	That this Meeting believes that maternity leave entitlement (paid or unpaid) should be transferable between parents as best suits individual families. (2001)
757.	That Government should continue to confront the most potent cause of poor health - poverty. (1998)

758.	That this Meeting believes that increasing stress and decreasing morale in the population are becoming major public health issues, resulting in an unhealthy population attempting to support a so called "healthy economy". (1996)
759.	That this Meeting calls for the establishment of appropriate places of safety for police detainees who are the victims of alcohol or drug abuse and whose condition renders police custody unsuitable and referral to hospital inappropriate. (1989)
760.	That this Meeting believes that the cleanliness of public spaces, buildings and conveniences in the UK has deteriorated to a level which constitutes a national disgrace; it calls on all governmental, political and administrative bodies as well as individual Members of the Association to take firm action to ensure that already existing legislation is enforced. (1982)
761.	<u>Food</u> That this Meeting is appalled to observe the increasing number of Paediatric Hospitals selling "junk" foods, particularly those which are PFI builds and:- i) calls for tighter control over the selling of "junk" foods in hospital premises; ii) calls for a ban on the presence of fast food outlets on hospital premises; iii) calls for the BMA to lobby the DH and NHS to release policy on the sale of "junk" foods and presence of fast food establishments on hospital property. (2014)
762.	That this Meeting asks the BMA to lobby the DH and NHS Confederation to ensure that: i) all NHS premises should display clearly the health risks involved with junk food and drinks, especially in kitchen areas and on vending machines; ii) all NHS premises ban the sale of junk food and unhealthy drinks. (2013)
763.	That this Meeting recognises the health benefits of fruit and vegetables and:- i) calls on the BMA to campaign for a reduction in the price of fruit and vegetables; ii) urges government to extend free fruit and vegetable initiatives to include all primary school children and ensure these items are available five days a week. (2013)
764.	That this Meeting urges:- (i) the BMA to adopt a policy of supporting mandatory fortification of flour with folic acid to prevent neural tube defects in line with the recommendations of the Food Standards Agency and the Scientific Advisory Committee on Nutrition; (ii) the UK nations to form legislation to make it a requirement for folic acid supplements to be in flour and flour based products. (2012)
765.	That this Meeting calls upon all UK governments to: (i) ensure that food labelling clearly indicates the potential health impact of all foodstuffs; (ii) ban sales of food containing partially hydrogenated fats; (iii) impose a limit on salt in basic food items. (2012)

766.	That this Meeting is concerned about malnutrition in vulnerable patient populations in hospital. We therefore call for Health Departments to introduce schemes across all NHS hospitals which highlight those patients at risk, such as the 'red tray scheme'. (2009)
767.	That this Meeting believes that the Food Standards Agency should insist that: (i) when a food promoted as low fat has more calories than the standard version, that this should be clearly labelled on the front of the packaging; (ii) the 10% tolerance allowed on nutritional values in current food labelling should be made more strict and enforced; (iii) restaurant chains should be encouraged to advertise nutritional content in their menus. (2008)
768.	That this Meeting endorses the proposed system of "Traffic Lights" on foods proposed by the Food Standards Agency and asks that this system be made mandatory. (2006)
769.	That this Meeting congratulates Jamie Oliver on his excellent work on school meals, and calls on the government to: (i) legislate statutory standards for the nutritional value of school meals; (ii) ensure that adequate funding for healthy school meals is ring-fenced from the education budgets of schools and education authorities; (iii) employ Mr Oliver to improve the quality of food in the NHS for both patients and staff. (2005)
770.	That this Meeting believes that employers should cross-subsidise healthier eating options in staff canteens with less healthy ones. (2000)
771.	That this Meeting recognises the importance of diet to health and calls for national food and agricultural policies which take account of health issues in production, advertising, labelling and pricing of food. (1984)
772.	<u>Infectious and communicable disease</u> That this meeting believes that all doctors should be vaccinated against Covid-19, unless there is a medical contraindication. (2021)
773.	The Covid-19 crisis has highlighted that the UK was woefully underprepared to tackle a pandemic. Thousands of people have needlessly died or been harmed due to the virus. That this meeting calls for a wide-ranging public inquiry into the Covid-19 pandemic:- i) to be initiated without delay; ii) that includes, but is not limited to, full evaluation of the strengths and weaknesses of national public health system, the fitness of purpose of its health protection systems, the impact of the progressive loss of medical expertise, Government decision-making and advisory structures, procurement, vaccine development, vaccine delivery, lockdown measures and timing, PPE, public health delivery structures, investment in track and trace, protective measures for vulnerable people and communities, and management of outgoing and incoming travellers; iii) that has the ability to make recommendations for the planning, preparation and investment towards managing the next pandemic and so that lessons can be learned

	<p>and rectified under UK Health Security Agency (UKHSA) and health inequalities addressed by the Office of Health Promotion (OHP);</p> <p>iv) that recognises the essential role of health and social care workers, particularly those receiving poor pay and working in difficult conditions;</p> <p>(2021)</p>
774.	<p>That this meeting recognises the large numbers of people affected by Long-Covid and:-</p> <p>i) calls on UK governments to invest in the monitoring, research and treatment of Long-Covid;</p> <p>ii) urges the BMA to seek the recognition of occupationally acquired Acute Covid and Long-Covid in doctors as an occupational disease;</p> <p>iii) calls for a multidisciplinary approach to the management of Long-Covid to include primary, specialist and occupational medicine.</p> <p>(2021)</p>
775.	<p>Extra capacity for isolation/separation of Covid positive patients should be developed immediately in Primary Care, A&E, Inpatient wards and ICUs to protect patients and staff regarding future Covid waves and future local outbreaks.</p> <p>(2021)</p>
776.	<p>That this meeting notes that in the past few weeks, we have seen alarming rises in the rates of new COVID-19 infections to a higher level than when we went into lockdown, albeit in a younger population with a lower risk of admission to ITU and subsequent death.</p> <p>In order to prevent the need for further national lockdowns, with all of the adverse impacts that this may have on the education of our younger generation, the economy, older adults in care, mental health and social isolation, this meeting calls on governments to pursue a policy of near-elimination of SARS-COV-2.</p> <p>(2020)</p>
777.	<p>That this meeting commends the commitment and flexibility shown by doctors and healthcare staff in very difficult circumstances during the COVID-19 pandemic. They have worked outside their specialties, worked additional hours, and worked at increased risk to their health. This meeting mandates Council and the Branch of Practice Committees to pursue policies to:-</p> <p>i) ensure that temporary changes to job plans, working patterns and deployments cease with a return to pre-COVID-19 contractual requirements and job plans;</p> <p>ii) ensure that all doctors are adequately remunerated for additional work done during the COVID-19 pandemic;</p> <p>iii) ensure that no long term changes to job plans or contracts can be imposed without proper negotiations with local, Branch of Practice or national negotiating committees;</p> <p>iv) ensure that an additional reward is made to all healthcare staff to reflect the personal sacrifices and increase in risk to health made during this pandemic.</p> <p>(2020)</p>
778.	<p>That this meeting, in response to COVID 19, demands that government:-</p> <p>i) ensure that workers are not under pressure to attend work either for financial or workforce reasons while they are unwell or self-isolating and at risk of inadvertently passing on the disease;</p> <p>ii) provide the equivalent of day-one statutory sick pay to those on zero hours contracts;</p> <p>iii) allow the NHS to requisition private health care facilities to accommodate effective COVID-19 treatment and quarantine provision if needed;</p> <p>iv) ensure workers are paid in full while they are unwell or self-isolating.</p>

	(2020)
779.	<p>That this meeting insists that there must be a public enquiry into the UK governments' management of the COVID-19 pandemic in order to be better prepared for and to be able to follow best practice during any future overwhelming health crisis. As a minimum it should cover in its remit:-</p> <ul style="list-style-type: none"> i) the mismanagement of care homes; ii) the purchase, delivery, quality control and guidelines for PPE; iii) the testing strategy; iv) health & care staff wellbeing; v) the timing of interventions and the timing of the easing of restrictions. <p>(2020)</p>
780.	<p>That this meeting believes that the global pandemic has demonstrated the need for a well-resourced national health protection function to meet current and future communicable disease threats. This meeting, therefore, calls for:-</p> <ul style="list-style-type: none"> i) a government review of the fitness for purpose of the UK's current health protection systems; ii) Public Health England to be reconstituted as a fully independent arm's length NHS "Special Health Authority," integrated with the wider NHS and able to hold government to account on matters of public health; iii) the establishment of a national public health "infection" service as part of PHE; professionally-led and in charge of strategy, operations, education and training, with an appropriate budget and regional offices; iv) all consultants in public health to be employed on contracts equivalent to those of NHS consultants, with adequate guarantees of freedom to make professional advice public; v) all consultants in public health to be employed on contracts equivalent to those of NHS Consultants, with adequate guarantees of freedom to make professional advice public. <p>(2020)</p>
781.	<p>That this meeting congratulates the work of the Rotarians in their campaign PURPLE4POLIO for the complete eradication of polio.</p> <p>(2017)</p>
782.	<p>That this Meeting notes the increasing incidence of tuberculosis and of multi-drug resistant tuberculosis in the UK and calls on government to:</p> <ul style="list-style-type: none"> (i) ensure that primary care organisations in high TB prevalence areas can provide the resources to implement the TB National Action Plan 2004; (ii) fund appropriate training for healthcare workers involved in hospital and community care for these patients; (iii) increase public awareness of TB. <p>(2008)</p>
783.	<p>That this Meeting believes that hospital acquired infections, such as Clostridium difficile and MRSA , present a serious threat and calls on the government to promote research into the treatment and prevention of these infections.</p> <p>(2007)</p>
784.	<p>That this Meeting acknowledges the call by the World Health Organisations to provide hepatitis B vaccines to all children and calls upon the Department of Health to introduce the hepatitis B vaccine into the childhood schedule without further delay.</p> <p>(2007)</p>
785.	<p>That this Meeting deplores the high rate of hospital-acquired infection and the lack of cleanliness in NHS hospitals, and</p> <ul style="list-style-type: none"> (i) believes that high bed occupancy contributes to the problem; (ii) believes that contracting out of hospital cleaning services contributes to the problem;

	<p>(iii) deplores “naming and shaming” of hospitals with high infections rates;</p> <p>(iv) calls on the government to provide adequate new resources to tackle these problems;</p> <p>(v) calls for sensible controls on visitors.</p> <p>(2005)</p>
786.	<p>That this Meeting believes that, in the light of increasing rates of many sexually transmitted infections, more needs to be done to improve sexual health services, and it therefore directs that the BMA lobby the government to:</p> <p>(i) significantly enhance sexual health services;</p> <p>(ii) significantly increase funding to improve access to sexual health services;</p> <p>(iii) fund centrally all sexual health services;</p> <p>(iv) reduce waiting times in GUM clinics;</p> <p>(v) increase sexual health education in schools;</p> <p>(vi) introduce a campaign to further enhance awareness of sexual health diseases and services available once improvements to services have been made.</p> <p>(2005)</p>
787.	<p>That this Meeting requests that the BMA investigate the impact of new and emerging infectious hazards on the health of national and international communities.</p> <p>(2004)</p>
788.	<p>That this Meeting believes that universal immunisation in childhood for hepatitis B should be introduced.</p> <p>(1995)</p>
789.	<p><u>Obesity</u></p> <p>That this meeting notes that the Foresight Group and Royal College of Physicians in ‘Action on Obesity’ describe the unsustainable burden the obesity epidemic places on the NHS, and this meeting therefore:-</p> <p>i) is concerned by the rapid rise in childhood obesity;</p> <p>ii) recognises that obese adults and children often have complex medical, psychological and social needs;</p> <p>iii) calls for the appointment by government of one person to drive a coordinated obesity prevention strategy, including consideration of regulatory measures;</p> <p>iv) mandates the BMA to lobby for the commissioning of specialist multidisciplinary weight management units;</p> <p>v) recommends that education in obesity and nutrition be made an essential component of medical education curricula;</p> <p>vi) urges UK governments and agencies to adopt the recommendations in the BMA board of science paper on childhood obesity.</p> <p>(2015)</p>
790.	<p>That this Meeting believes that only by addressing proper movement skills and nutritional adequacy can we tackle the growing issues of low basic fitness levels, postural and movement inefficiency and childhood obesity. This Meeting therefore:-</p> <p>i) calls on the UK departments of education to ensure that all schools deliver an appropriate physical education curriculum that ensures our children have achieved basic movement skills on which to build regular exercise;</p> <p>ii) calls on the Westminster and devolved governments to have a commitment to promoting the health of our children by prioritising the importance of health, diet and nutrition in schools.</p> <p>(2011)</p>

791.	<p>That this Meeting believes that, in order to improve public health and fitness and tackle obesity in adults and children, there should be:</p> <ul style="list-style-type: none"> (i) no further reduction in the number of public swimming pools in the UK; (ii) expansion of safe cycle paths and networks; (iii) action at local level to ensure that recreational facilities are available to all regardless of their socio-economic status and level of physical and psychological ability; (iv) no discouragement for children who wish to play active games such as football and skipping etc in the playground; (v) more extensive use of the media, including children's programming, to promote healthy lifestyle messages. <p>(2009)</p>
792.	<p>That this Meeting believes that the United Kingdom is suffering from an obesity epidemic and that voluntary measures by food industry and media are unlikely to address the problem and:</p> <ul style="list-style-type: none"> (i) calls for legislation to ban advertising of unhealthy food to children and a reduction of salt, sugar and hydrogenated fats added to pre-prepared food; (ii) calls for a halt to the sale of assets such as school playgrounds and sports fields; (iii) deplores the promotion by sections of the Food and Drinks Industry of GDA (Guideline Daily Amounts) labelling to the exclusion of the "traffic light" system. <p>(2007)</p>
793.	<p><u>Water</u></p> <p>That this Meeting notes that only 10% of the UK population are supplied with artificially fluoridated water following fragmented local introduction schemes since 1968 and:-</p> <ul style="list-style-type: none"> i) acknowledges that this regional disparity has had detrimental effects on the dentition of areas where fluoridation is not routine; ii) calls for a universal approach to water fluoridation; <p>(Lapsed 2019)</p> <ul style="list-style-type: none"> iii) calls on Public Health England to renew its policy on water fluoridation, not just its guidance. <p>(2014)</p>
794.	<p>That the BMA remains committed to the fluoridation of mains water supplies on the grounds of effectiveness, safety and equity and urges the Government to require that water companies fluoridate water supplies wherever this is formally requested by health authorities following proper consultation as required by the 1985 Water (Fluoridation) Act.</p> <p>(1998)</p>
795.	<p>That this Meeting believes that clean wholesome uncontaminated tap water should be made available to all throughout the UK.</p> <p>(1990)</p>
	<p>HEALTH EDUCATION</p>
796.	<p>That this Meeting calls on the UK and devolved government education departments to ensure that all secondary school pupils receive Emergency Life Support Skills (ELS) training as part of the school curriculum.</p> <p>(2013)</p>
797.	<p>That this Meeting calls on the Education department and devolved nation governments to ensure that all school children receive training in Emergency Life Support Skills (ELS) within the curriculum as part of a community resuscitation programme.</p>

	(2013)
	HEALTH STRATEGY
798.	That this Meeting reinforces the view that evidence-based medicine must be supported by evidence-based policy-making and management, and that the Association calls on government to provide this. (2005)
799.	That this Meeting recommends that minimally invasive post-mortem examinations should not be promoted by the Department of Health unless: (i) the validity and reliability have been demonstrated by proper scientific studies; (ii) living patients are not disadvantaged where demand exceeds supply for radiological services. (2002)
800.	That this Meeting believes that the experience so far of enacting the national service frameworks has shown increased demands upon time, funding and personnel, and therefore insists that further frameworks be carefully planned and additionally resourced before being approved if they are to fulfil their ambitions. (2002)
801.	That this Meeting believes that Section 28 is detrimental to health and calls on Westminster to follow the example of the Scots and abolish it. (2002)
802.	That the Government should adopt a cool, strategic, long term approach to planning health care and not merely content itself with producing short term, popular and media-oriented initiatives. (2000)
803.	That this Meeting: (i) recognises that health is determined not only by health services, but also by political, social, environmental and personal factors; and (ii) calls for the development and wider use of health impact assessment in all public policy areas, both national and local. (1998)
804.	That this Meeting deplores the imposition of VAT on household fuels and urges that all people over 70 years of age be exempt from this tax. (1993)
805.	That this Meeting considers that: (i) any national strategy for improving health should: (a) be scientifically valid; (b) be adequately resourced; (c) not interfere with doctors' responsibilities for treating the sick; and that (ii) an independent expert committee should be set up to: (a) review present and future programmes; and (b) initiate appropriate research. (1992)

806.	That this Meeting believes a strategy for health, based on identified health needs, is an essential pre-requisite for the organisation of health care services. (1992)
807.	<p><u>Deprivation</u></p> <p>That this Meeting recognises that scientific public health analysis shows that austerity damages both health and economic growth and:-</p> <ul style="list-style-type: none"> i) recognises that such adverse impact on health is borne out by the clinical experiences of many doctors; ii) calls on government to take more account of this in its economic strategy. <p>(2014)</p>
808.	<p><u>Disaster planning</u></p> <p>That this Meeting urges our government to undertake effective disaster planning to react to natural disasters in this country and the rest of the world. (2005)</p>
809.	That this Meeting believes that the emergency planning arrangements within the NHS are inadequate and urgent action is required in the face of imminent terrorist attacks. (2004)
810.	That this Meeting is concerned about the inadequate preparation for the care of the population at risk of nuclear, biological and chemical war agents and other public health emergencies such as epidemic infections. This preparation should include comprehensive information to GPs. (2003)
	HOSPITAL SERVICES
811.	<p>That this meeting notes the backlog of planned care resulting from the COVID-19 emergency and the likely effect on NHS waiting lists, and calls on the BMA to:-</p> <ul style="list-style-type: none"> i) work with governments to develop a public information campaign on the likely timescale for the NHS to return to normal routine services; ii) demand adequate funding for the NHS to increase its capacity to address the backlog of planned care; iii) seek the return of public funds paid to the for-profit private sector to retain capacity which was under-used during the pandemic. <p>(2020)</p>
812.	That this Meeting calls for an integrated national service to inform of availability of paediatric neonatal intensive care cots and their associated obstetric units open to accept intra-uterine transfers for the safety of mother and baby. A data display, updated hourly, of neonatal paediatric units and associated obstetric units should be available to all units providing consultant obstetric care. The service should be fully funded from its inception. (2009)
813.	<p>That this Meeting believes that the social and psychological needs of in-patients are often neglected leading to increased morbidity and prolonged hospital stays and calls for:</p> <ul style="list-style-type: none"> (i) integrated programmes of activity to be available for appropriate patients in all hospitals; (ii) the Board of Science to research the benefits and examples of good practice in this area and to then lobby for widespread implementation. <p>(2009)</p>

814.	That this Meeting deplores the lack of foresight of the health departments in out-sourcing imaging investigations to private companies rather than funding NHS radiology departments to use their equipment to maximum capacity. This fails to recognise the role of the reporting radiologist in the multi-disciplinary team and compromises quality control and integration of imaging. (2005)
815.	That this Meeting demands that hospitals are held accountable and responsible for patients under their care or referred by a GP, by directly responding to patients enquiries regarding: <ul style="list-style-type: none"> (i) chasing up appointment delays and follow up; (ii) investigation results; (iii) the content of consultations with hospitals clinicians; (iv) immediate post-operative problems. (2004)
816.	That this Meeting is deeply concerned about the lack of consideration of rurality in the allocation of resources and its consequent effect on small geographically isolated district general hospitals. (1998)
817.	That this Meeting is concerned that centralisation of specialist facilities in hospitals serving many health districts may jeopardise important specialist facilities in district general hospitals. (1998)
818.	That this Meeting proposes that there should be a moratorium on any further closures of district hospitals until local consultation has resulted in agreed alternative provision. (1995)
819.	That this Meeting: <ul style="list-style-type: none"> (i) believes that the waiting time between GP referral and consultant appointment is as important as the waiting time between the consultant outpatient appointment and admission to hospital; (ii) calls on the Department actively to discourage the artificial distortion of waiting lists; (iii) insists that all waiting times must be measured from the day the GP refers a patient to secondary care, and not from the day a consultant places the patient on a waiting list. (1992)
820.	That this Representative Body has no confidence in NHS trusts which put financial considerations before the needs of patients. (1991)
821.	<u>Bed provision</u> That this meeting believes that trends in reducing hospital beds have gone too far and need to be urgently re-evaluated. (2016)
822.	That this Meeting believes that further reduction in NHS bed numbers will be counter productive in providing optimal healthcare and lead to staff and patient dissatisfaction/adverse outcomes. (2010)
823.	That this Meeting believes the discharge of healthy patients from acute wards, who no longer need care on these wards, should be facilitated and appropriate resources and solutions found. (1999)

824.	<p><u>Performance indicators/targets</u></p> <p>That this Meeting recognises the potential danger to patients' health when non-medically qualified managers put pressure on doctors to admit or discharge patients from A&E or wards to simply abide by government set targets. It believes that this practice is often against the patient's best interests, is reprehensible, counter-productive and wastes rather than saves the NHS money. We call upon all doctors to report all such incidents to the National Patient Safety Agency. (2006)</p>
825.	<p>That this Meeting deplores the negative impact on patient care caused by imposition from the centre of inappropriate targets and calls for an independent review of the advantages and disadvantages of targets. (2005)</p>
826.	<p>That this Meeting believes that achieving a target of 98% for waiting times of 4 hours in Accident and Emergency departments is unsustainable and unsafe. (2005)</p>
827.	<p>That this Meeting believes that in the current financial and political climate, positive incentives are much more likely to help health service employers achieve compliance with government guidance and targets, than negative ones such as threats of prosecution and fines. (2005)</p>
828.	<p>That in comparing performance between NHS trusts or services, this meeting requires that the context of demographic data, baseline resources and casemix is fully accounted for. (2005)</p>
829.	<p>That the mortality/morbidity data of a surgeon of any trust must be robust, rigorous and risk adjusted before it is released into the public arena. (2005)</p>
830.	<p>That whilst welcoming the Freedom of Information Act, this Meeting is gravely concerned that information about individual consultant's performance provided by Trusts will, in general, be based upon invalidated, inaccurate and misleading HES data with the potential to result in unjustified pillorying of clinicians. This meeting stresses that Trusts should collect clinical data that accurately reflects the performance of the healthcare team and not just of the surgeon concerned. We call upon the Government to:</p> <ul style="list-style-type: none"> (i) inform the public that HES data is not clinical data; (ii) ensure that trusts fund sufficient supported consultant time for clinical audit, including validation of current HES data; (iii) make immediate investment in the rapid development of national, risk adjusted, clinical databases similar to that of the Society of Cardiothoracic Surgeons for all clinical specialties. <p>(2005)</p>
831.	<p><u>Premises</u></p> <p>That this Meeting deplores the increasing practice of mixed sex wards. While recognising that it may be justifiable from an economic and staffing point of view, and also in certain small, specialised units, we call upon management and clinical staff to give careful thought and consideration to this increasing practice which, we strongly maintain, is not in the best interests of our patients' welfare.</p>

	(1996)
832.	<p><u>Waiting lists</u></p> <p>That this Meeting believes that waiting list priority should be based solely on clinical need and fully supports those members who resist the widespread interference that occurs in this process by managers and politicians. (2002)</p>
833.	<p>That waiting lists are not a good measure of performance. (2002)</p>
834.	<p>That this Meeting welcomes the Government's commitment to treatment being based on clinical need, and proposes that for appropriate clinical conditions hospital waiting lists should be subject to a clinical prioritisation scoring system rather than crude lengths of wait. (1998)</p>
	HUMAN ORGANS AND DONORS
835.	<p>That this Meeting supports the work of the Anthony Nolan Trust, and asks the BMA to:</p> <ul style="list-style-type: none"> (i) promote the voluntary recruitment of BMA members as donors; (ii) promote the voluntary recruitment of other doctors and medical students as donors; (iii) carefully consider the promotion and implementation of a voluntary, systematic programme of recruitment of patients as donors by general practices on a national basis. <p>(2006)</p>
836.	<p>That this Meeting asks the BMA's Medical Ethics Committee to initiate and/or co-ordinate actions to:</p> <ul style="list-style-type: none"> (i) clarify the legal standing of the wishes expressed by carrying an organ Donor Card; (ii) clarify the relationship of organ Donor Cards to Advanced Directives; (iii) raise awareness of these findings with relevant medical specialities; and (iv) communicate these findings to the relevant Governmental departments so that public awareness may be improved. <p>(2004)</p>
837.	<p>That this Meeting is against any moves to legalise the sale of donor organs. (2002)</p>
838.	<p>That this Meeting condemns organ donation for cash benefit by living individuals. (2001)</p>
839.	<p>That this Meeting:</p> <ul style="list-style-type: none"> (i) calls on Council to campaign for a change or clarification in the law so that the wishes of organ donors should be paramount by ending the practice of relatives being allowed to veto organ transplantation where pre-mortal consent has been expressed; (ii) notes the success of opt-out or presumed consent schemes in continental Europe in increasing the number of organs available for transplantation, thereby reducing the number of patients who die waiting for a transplant; (iii) calls for Council to lobby Government for such a scheme to be introduced in the United Kingdom following a public education campaign about the merits of organ donation; (iv) insists that organs donated to hospitals must only be accepted unconditionally and for any suitable recipient. <p>(1999)</p>

840.	That this Meeting believes that salvaging the ovaries of young women who have died is ethically acceptable and that the donor cards should include this option for would be donors. (1994)
	HUMAN REPRODUCTIVE CLONING
841.	That the BMA continues to believe that reproductive human cloning is morally wrong. (2002)
	INFORMATION TECHNOLOGY AND HEALTH INFORMATION MANAGEMENT
842.	The use of digital consulting has been essential during the pandemic for reducing the risk of infection in GP surgeries and in hospitals but there is a danger that those who have been arguing for a greater use of technology will change services in a way that impacts negatively on those most in need of care. We call on the Board of Science to examine the evidence base on the use of digital consulting and when this can be appropriately used. (2020)
843.	That this meeting welcomes the Secretary of State's announcements on stopping out of date technology, but believes that: - i) arbitrary dates to stop any technology without ensuring clinically safe and appropriate alternatives are in place put patients at risk; ii) relevant stakeholders including NHS England, NHS Digital, individual Trusts, and frontline clinicians should collate the advantages and disadvantages of all methods of communication currently in use within the NHS (including reliability, data security and cost), to identify areas of best practice; iii) where personal phones are required, expenses are claimable and the security of personal details should be GDPR compliant. (2019)
844.	That this meeting is appalled that the government requires the Department of Work and Pensions to develop a new digital system for the administration of "health related benefits" which would gather relevant data from general practice records by automated routine requests which would destroy the essential doctor/patient relationship of confidentiality and asks the BMA to demand that the government abandon this project. (2019)
845.	That this meeting recognises the detrimental effect social media has had on the lives of some young people in society, and the vulnerability that they experience when they feel isolated from the community that surrounds them. We ask the BMA to lobby the UK government to: - i) implement binding standards compelling social media networks to prevent the active promotion of self-harm and suicide as a means to deal with mental health issues; ii) mandate social media networks to implement mental health safeguards for any self-harm-related content visible to at-risk individuals, such as children and adolescents. These may include verification that the user is 16 or over, and promotion of child and adolescent mental health charities. (2019)
846.	That this meeting believes the BMA should have a strategy on monitoring the development and implementation of Artificial Intelligence (AI) in healthcare with particular reference to the impact on medical staffing and the wider ethical issues of such technology. (2018)

847.	<p>That this meeting believes that doctors feel highly exposed by the GDPR (General Data Protection Regulation) and:-</p> <ul style="list-style-type: none"> i) believes that in primary care it is no longer sustainable for the GP to be the sole data controller; ii) calls on the BMA to urgently explore the possibility of commissioning health organisations having one data protection officer for all GP practices in their area; iii) calls on the BMA to negotiate with the information commissioner's office on the application of GDPR to all doctors; iv) demands an appropriate uplift in the GP core contract to reflect the resulting impact of the new regulation. <p>(2018)</p>
848.	<p>That this meeting regrets that the Oriel application system, and speciality recruitment offices only provide email as means of contact for applicants. This meeting:-</p> <ul style="list-style-type: none"> i) rejects that email communication alone is sufficient for time-critical communication; ii) calls upon the relevant parties to provide clear and easily accessible contact details, including a telephone number for the most urgent enquiries. <p>(2017)</p>
849.	<p>That this meeting:-</p> <ul style="list-style-type: none"> i) recognises the critical part that IT infrastructure plays in delivery of health care; ii) is aware that vast parts of the United Kingdom have inadequate broadband links; iii) calls on the four UK governments to accelerate the provision of fast broadband to all areas of the country. <p>(2017)</p>
850.	<p>That this meeting notes and deplores the recently signed memorandum of understanding between the UK Department of Health, NHS Digital and the Home Office, which agrees to the transfer of patient administrative details including address for the purposes of immigration enforcement, without the consent of the patient and the knowledge of the GP. This meeting believes:-</p> <ul style="list-style-type: none"> i) this is a breach of patient confidentiality that undermines trust between patient and doctor; ii) this is not justified by the public interest; iii) that this may result in patients not coming forward for treatment with consequences for public health; iv) and calls on council to call on the Department of Health to cease this practice. <p>(2017)</p>
851.	<p>That this meeting is deeply concerned by the persistent and increasing faults with the Defence Medical Information Capability Programme (DMICP), which affect patient safety and undermine the professionalism of clinicians. We call on the BMA to lobby the Ministry of Defence to take urgent action to rectify the following issues:-</p> <ul style="list-style-type: none"> i) insufficient number of available IP addresses resulting in delayed start-up or an inability to access the system entirely without frequent software crashes or total loss of IT; ii) failure of the system to load previous history, as well as save current consultations; iii) system failure with regard to printer integration, leading to potential patient safety and confidentiality issues; iv) lack of secure integration with NHS IT systems. <p>(2017)</p>
852.	<p>That this meeting advocates the mandatory use of a universal unique identifier for each patient for NHS documentation, thus allowing available data, where not statutorily excluded, to be correctly linked and available to those caring for each patient.</p> <p>(2016)</p>

<p>853.</p>	<p>That this meeting believes that copies of hospital outpatient letters should be sent to both GP and adult patients and this should be the default position not an opt in system to receive copies:-</p> <ul style="list-style-type: none"> i) unless the patient wishes to opt out of receiving a copy letter; ii) unless it would harm the patient or another individual if a letter were sent; and iii) calls on council to petition all relevant authorities to effect this move in the interest of transparency and good communication. <p>(2016)</p>
<p>854.</p>	<p>That this meeting recognises the importance of health care apps which have the potential to improve efficiency and the care provided to patients; and that many of these apps including clinical pathways, care bundles and useful information on services, are only available locally. Therefore we call on the BMA to:-</p> <ul style="list-style-type: none"> i) review the current provision of health care apps and its usefulness in the work place; ii) lobby appropriate bodies to develop health care apps that can be used nationally, to improve patient care and workforce productivity. <p>(2015)</p>
<p>855.</p>	<p>That this meeting recognises that the use of IT can enhance patient safety and training for junior doctors and that there is currently wide variability between trusts (and their equivalents in the nations) regarding the use of IT in patient care. We call on the BMA to:-</p> <ul style="list-style-type: none"> i) recognise that electronic prescribing in the hospital setting improves patient safety over handwritten prescriptions; ii) calls for all NHS secondary care providers to employ electronic prescribing software by 2020; iii) recognise that electronic investigation requests in the hospital setting improves patient safety over handwritten requests; iv) call for all NHS secondary care providers to employ electronic investigation requests by 2020. <p>(2015)</p>
<p>856.</p>	<p>That this meeting applauds efforts to bring essential healthcare information to citizens in low resource settings, welcomes the BMA's ongoing support for the Healthcare Information for All campaign, and calls upon the UK government to prioritise support for initiatives that improve the availability and use of health information.</p> <p>(2015)</p>
<p>857.</p>	<p>That this Meeting agrees that the care.data system should not continue in its present form as:-</p> <ul style="list-style-type: none"> i) it lacks confidentiality and there is a possibility for individual patient data to be identified; ii) it carries the risk of GPs losing the trust of their patients who may feel constrained in confiding in them; iii) the future potential users of the data are not well defined; iv) it should be an opt-in system rather than an opt-out one; v) the data should only be used for its stated purpose for improving patient care and not sold for profit. <p>(2014)</p>
<p>858.</p>	<p>That this Meeting instructs the BMA to produce a comprehensive analysis on the implications of remote electronic consultations with patients, considering ethics, confidentiality, clinical safety and standards for all doctors who may consult with patients remotely.</p> <p>(2014)</p>

859.	That this Meeting deplores any move to use data from radiology department discrepancy meetings for any purpose other than quality improvement. (2014)
860.	That this Meeting is concerned about the growing proliferation of use of social media and associated guidance and believes that:- i) doctors who are using social media in a professional capacity should be conversant with GMC social media guidelines, identify themselves as a doctor and behave accordingly; ii) doctors who are using social media in a personal capacity should have their right to privacy protected provided that they do not breach the confidentiality of individual patients. (2013)
861.	That this Meeting calls on the BMA to condemn the practice operated by some insurance companies to request a copy of the patient's entire medical record rather than commission an appropriate medical report. (2012)
862.	That this Meeting:- i) welcomes concessions made whereby it has become easier for patients to opt out of the Summary Care Record; ii) is concerned that recent evidence questions the benefits of the Summary Care Record for patient care; iii) is concerned that continued changes of policy are confusing both to patients and healthcare professionals; (2011)
863.	That this Meeting:- i) deplores the lack of protection to identifiable patient data including patient medical records in the Bill; ii) is very concerned that the data flows proposed in the Bill and guidance will endanger the principle of confidentiality between doctor and patient which is a cornerstone of medical practice. (2011 Special Representative Meeting)
864.	That this Meeting deplores the accelerated roll-out of the SCR and: (i) believes that patients who wish their Summary Care Record to be uploaded centrally should be asked to give explicit consent to this; (ii) demands that general practitioners are appropriately funded to undertake the work generated in their practices by the Summary Care Record programme. (2010)
865.	That this Meeting believes that, to protect confidentiality of patient medical records: (i) a proper identity and access management system must be in place across the NHS; (ii) access to electronic views of patient records should be role based; (iii) access to clinical records should normally only be possible when there is a current clinical relationship with the patient. (2010)
866.	That this Meeting: (i) condemns the continued waste of money on the National Programme for IT which remains unfit for purpose in most applications; and (ii) believes that Connecting for Health (CfH) should now concentrate on developing specialty professional standard clinical datasets that are fit for purpose to support

	<p>professional clinical quality metrics, audit, research, revalidation, patient care and outcomes;</p> <p>(iii) believes that CfH should now release funds for locality clinical system purchase;</p> <p>(iv) demands an independent clinically led review of the whole CfH programme;</p> <p>(v) instructs the BMA to campaign for local IT solutions which can be implemented in a timely manner and integrated across the primary-secondary care interface.</p> <p>(2009)</p>
867.	<p>That this Meeting congratulates the BMA on its successful campaign to remove from the Coroners and Justice Bill the UK government's proposal to breach patient confidentiality by sharing identifiable patient medical records with other government departments and the private sector but condemns the government for reneging on its undertaking that patient information added to the national care record would never be shared with other departments.</p> <p>(2009)</p>
868.	<p>That this Meeting strongly supports the principles of clinical confidentiality and :</p> <p>(i) believes the GP role as the data holder of their registered patients' clinical records is fundamental to maintaining confidentiality;</p> <p>(ii) believes an opt-in approach by the patient (or their appropriate representative) empowers patients to understand the implications of any transfer of patient identifiable clinical information from their record to a third party;</p> <p>(iii) believes that when releasing information on named patients it is not sufficient to assume implied consent;</p> <p>(iv) believes patients should be able to ask for a list of the occasions that their Summary Care Record (SCR) has been accessed, and by whom;</p> <p>(v) deplores attempts to place obstacles in the path of patients wishing to restrict the distribution of their medical records.</p> <p>(2009)</p>
869.	<p>That this Meeting confirms that the principle of confidentiality as set out in the Declaration of Geneva is fundamental to all health care, and affirms that any patient must, where data may be used other than for their direct healthcare, be made aware of the details of every proposed use of their data and be able to give or refuse valid consent to the use of their identifiable data other than for their direct healthcare.</p> <p>(2009)</p>
870.	<p>That this Meeting:</p> <p>(i) deplores the misuse being made of the Choose and Book system by commissioners and providers to meet various targets;</p> <p>(ii) notes that the database of providers and services on Choose and Book is still deficient in data quality and poorly classified.</p> <p>(2008)</p>
871.	<p>That this Meeting believes that detailed electronic GP patient records:</p> <p>(i) should have one identifiable guardian;</p> <p>(ii) should only be editable by the host organisation;</p> <p>(iii) should never be accessible in total outside the host organisation without explicit patient consent and the knowledge of the host organisation;</p> <p>(iv) should allow explicit blocking of parts of the records from sharing outside the host organisation.</p> <p>(2008)</p>
872.	<p>That this Meeting believes that access to the electronic patient record must require explicit fully informed patient consent, and the extent of access to the record should be determined by the role in the care of the patient of the person seeking access.</p> <p>(2008)</p>

<p>873.</p>	<p>That this Meeting:</p> <ul style="list-style-type: none"> (i) notes the valuable contribution to patient care made by mobile telephones through improved communication in combination with hospitals' own bleep or phone systems; (ii) notes that many newer hospital buildings have markedly poor mobile phone signal reception within them and that this can pose a potential risk to patients if care is delayed through impaired communication between healthcare workers; (iii) calls on the BMA to work with the NHS and the Health Departments to ensure that the design and construction of all future newly-built or rebuilt hospitals permits good mobile phone reception indoors; (iv) noting the success of central bulk purchasing of drugs by the NHS, calls upon the NHS to negotiate centrally with telecommunication firms to procure cheap bulk-purchase rates for calls to mobile phones for clinical purposes from hospitals. <p>(2008)</p>
<p>874.</p>	<p>That this Meeting is aware that as government has demonstrated that it cannot be trusted to maintain secure confidential patient health records, there should be a national publicity campaign to warn patients of the dangers of consenting to their records being held on a national database.</p> <p>(2008)</p>
<p>875.</p>	<p>That this Meeting believes, in light of the increasing use of electronic patient records, that all medical students should have timely and appropriate access to these records as required for completion of their training and calls upon the relevant bodies, such as Connecting for Health and the NHS IT Working Party, and the Medical Schools Council to incorporate specific guidelines to allow this.</p> <p>(2007)</p>
<p>876.</p>	<p>That this Meeting:</p> <ul style="list-style-type: none"> (i) calls on those designing and implementing Connecting for Health or any such similar programme to ensure that patient safety be given much greater consideration in any such programme and elevated to be a core requirement of the programme; (ii) acknowledges that patients can be reassured that any doctor receiving confidential patient information from another doctor will maintain that confidentiality as is required by the professional duties of doctors as set out in Good Medical Practice; (iii) calls for the technology to embody a system of identifying unusual patterns of access and reporting them to a Caldicott Guardians equivalent. <p>(2006)</p>
<p>877.</p>	<p>That this Meeting acknowledges that, whilst there are benefits to patient care with integrated centralised health record systems, it has some serious concerns about the implementation of any such system in practice. Therefore this meeting:</p> <ul style="list-style-type: none"> (i) reaffirms the duty of doctors to maintain the confidentiality of patient information; <p>(Lapsed 2011)</p> <ul style="list-style-type: none"> (ii) supports, in principle, the concept of an integrated centralised health record system; (iii) believes that it is both urgent and vital that the profession and the public are consulted regarding any plan to transfer health records to a central electronic system; <p>(Lapsed 2011)</p> <ul style="list-style-type: none"> (iv) calls on government and the BMA to undertake wide public consultation prior to implementation of an integrated health record system to include: <ul style="list-style-type: none"> (a) whether patients should be offered an opt-in or opt-out consent to the sharing of their medical records; (b) whether the patient holds the information themselves or whether it is held in local or national database;

	<p>(c) what identifiable information is actually shared;</p> <p>(d) which healthcare professionals should have access to the patient information and in which circumstances;</p> <p>(e) who controls which healthcare professionals, government bodies and non-NHS organisations should have access to both identifiable and anonymous patient information and to what extent;</p> <p>(Lapsed 2011)</p> <p>(v) insists that the results of public consultation are well publicised and determine how any integrated centralised health record system is implemented;</p> <p>(vi) calls on government to ensure that any patient information is accurate and fit for purpose;</p> <p>(vii) calls on government to ensure that any records system is developed and implemented in partnership with both healthcare professionals and the public;</p> <p>(viii) insists that the security of patient information is paramount and should include protection against illegitimate access;</p> <p>(ix) insists that it is essential that the Caldicott Guardian(s) of an integrated health records system should be independent healthcare professionals who protect the rights of patients;</p> <p>(x) calls on government to ensure urgent and adequate training on patient confidentiality for all healthcare professionals and support staff.</p> <p>(2005)</p>
<p>878.</p>	<p>That this Meeting demands that before total dependence on joint electronic patient records is accepted the following must be achieved:</p> <p>(i) 100% accuracy of transfer of total patient information (including management information) held on all new and existing systems;</p> <p>(ii) consent procedures for data transfer and sharing;</p> <p>(iii) establishment of clear legal validity, liability for errors and responsibility for shared records and errors in transfers between systems;</p> <p>(iv) the system must be user friendly.</p> <p>(2004)</p>
<p>879.</p>	<p>That this Meeting believes that lack of a coherent approach to sharing relevant health care information between professionals involved in an individual's care can lead to second class care. It calls upon the BMA to lobby the Departments of Health to:</p> <p>(i) develop integrated systems that allow appropriate clinical information to be shared between relevant healthcare professionals; and</p> <p>(ii) engage with the public in both demonstrating the need for such information sharing and ensuring they are aware of the safeguards in place to facilitate this sharing.</p> <p>(2004)</p>
<p>880.</p>	<p>That the Information Technology Committee, (or its successor if renamed) must uphold the interests and privacy of the patient.</p> <p>(2004)</p>
<p>881.</p>	<p>That in order to improve the validity of hospital data:</p> <p>(i) the Department of Health should vastly improve provision of information technology within trusts;</p> <p>(ii) standardisation should be agreed for clinical coding;</p> <p>(iii) trusts should provide the skills necessary to analyse quality and performance data and to ensure that it is consistent in reflecting medical practice.</p> <p>(2002)</p>

882.	That clinical decision support systems should not become clinician monitoring systems, and this Meeting instructs the GPC to advise on any such developments. (2001)
883.	That doctors should have the right to the same levels of confidentiality as the rest of society with regard to information pertaining to their medical health. (2001)
884.	That this Meeting expresses its grave concerns re the potential breach of confidentiality with the passage of the Health and Social Care Act, allowing the Minister of Health access to patients' records without informed consent. (2001)
885.	That this Meeting believes that there should be continued vigilance with respect to patient confidentiality in a time of great technological and organisational change within the NHS. (1999)
886.	That in order for an information strategy to be effective then it is imperative to ensure that electronic patient record data is of high quality. (1999)
887.	That this Meeting supports the BMA position in protecting police surgeons' right to maintain medical confidentiality. (1996)
888.	That this Meeting is concerned about the security of patient identifiable data on the proposed NHS wide network and instructs Council: <ul style="list-style-type: none"> (i) to advise doctors not to sign up to the NHS wide network until confidentiality can be guaranteed; and (ii) to take all possible steps to ensure that personal medical information entered onto the NHS wide network remains confidential to those who hold the patient's fully informed consent to receive it. (1996)
889.	That any restriction of access to confidential information should recognise the need for, and facilitate access to, research. (1996)
890.	That this Meeting reaffirms its commitment to the overriding importance of the confidentiality of patients' personal medical records. (1995)
891.	That the BMA believes that all patients are entitled to expect a duty of confidentiality from all their carers and that duty extends up to and beyond death. (1995)
892.	That the Information Technology Working Party examine the use of decision support systems in clinical practice, with particular reference to the legal and ethical implications, and then investigate the setting up of a mechanism for evaluating such systems. (1994)
893.	That this Meeting supports Council's attempt to investigate and clarify the issue of ownership and confidentiality of medical records in general practice. (1990)

	INTERNATIONAL AFFAIRS
894.	That this meeting:- i) utterly condemns government proposals to send people seeking asylum in the UK abroad while their asylum claims are being considered; ii) demands that the BMA makes our condemnation widely and publicly known. (2021)
895.	That this meeting notes the UK's impressive COVID-19 vaccine rollout and the announcement on 13th September 2021 that all UK Governments will extend the programme to all 12-15 year olds. We further note that the UK Government's commitment, announced at G7 earlier this year, to send 100 million vaccines overseas to support efforts for global vaccine equity, with 30 million due to be sent by the end of 2021, has been widely acknowledged as insufficient by the international community. We therefore call on the UK Government to:- i) make an immediate assessment of how many vaccines are held in surplus over and above the amount needed to complete the planned domestic rollout and to make this information publicly available; ii) urgently publish detailed plans for ensuring that these surplus doses reach low-resource countries where priority groups, including healthcare workers, have yet to be vaccinated as soon as possible and ideally before the end of 2021; iii) work closely with the World Health Organization's COVAX initiative to ensure that vaccines are distributed equitably to those most in need and avoid engaging in vaccine diplomacy; iv) call for an emergency G7 summit to mobilise the world's most wealthy nations to immediately share surplus vaccine doses globally. (2021)
896.	That this meeting wishes to see a fair global distribution of Covid-19 and other vaccines in this and future years. (2021)
897.	That this meeting notes the possibility of an upcoming trade deal between the United States(US) and the United Kingdom (UK) and the threat it could pose to drug pricing and supply in the UK. This meeting therefore calls upon the BMA to lobby the relevant bodies to ensure such a trade deal:- i) does not result in a rise in UK drug prices; ii) does not weaken the ability of the NHS and related bodies to negotiate drug pricing with US companies; iii) does not adversely affect the safety and regulation of drugs and medical technologies distributed in the UK. (2020)
898.	That this meeting condemns the conditions being reported from within immigration detention centres in the USA, and the reopening of former internment Camp Fort Sill and: i) calls on the UK government to urgently condemn these conditions publicly; ii) calls for the UK government to lobby through diplomatic channels for the closing of these immigration detention centres; iii) calls for a boycott of US goods by the UK public until dehumanising treatment of people in these centres comes to an end; iv) calls for consultation with relevant organisations about proper definition of these detention centres. (2019)
899.	That this meeting: -

	<p>i) is horrified that the Home Office is attempting to embed immigration officers as part of an “enhanced checking service” into NHS trusts and local authorities;</p> <p>ii) calls on the BMA to demand that this practice is stopped.</p> <p>(2019)</p>
900.	<p>That this meeting notes the concerns raised in the "BMA Brexit briefings", also notes that the BMA is non-partisan but that there is a plurality of opinions within political parties on Brexit. We call on the BMA to:-</p> <p>i) support the UK remaining in the European single market;</p> <p>ii) support open border arrangements with free movement of healthcare and medical research staff;</p> <p>iii) support the UK remaining a member of Euratom to ensure the protection of supply of radioisotopes;</p> <p>iv) support the early adoption of the European Clinical Trials Directive in the UK;</p> <p>v) publicly announce that it is concerned that Brexit poses a major threat to the NHS and the nation's health;</p> <p>vi) support the idea of the public having a final say on the Brexit deal, now that more is known regarding the potential impact of Brexit on the NHS and the nation's health;</p> <p>vii) oppose Brexit as a whole.</p> <p>(2018)</p>
901.	<p>That this meeting calls on the BMA to:-</p> <p>i) recognise the current global refugee crisis and the unique health challenges that face refugees and asylum seekers;</p> <p>ii) campaign for better access to healthcare and health education for this group;</p> <p>iii) promote research into the physical and psychosocial aspects of refugees’ and asylum seekers’ health.</p> <p>(2017)</p>
902.	<p>That this meeting:-</p> <p>i) condemns the UK government for renegeing on the Dubs amendment so that by April 2017 only 350 unaccompanied minors had been allowed into the country;</p> <p>ii) demands that the government respects the Dubs agreement and admits the children;</p> <p>iii) demands that the UK take a proportionate share of the international obligation to provide sanctuary to people fleeing from war and persecution.</p> <p>(2017)</p>
903.	<p>That this meeting believes, in respect of eligibility for NHS treatment of overseas visitors:-</p> <p>i) government publicity about the cost of treating overseas visitors is a distraction from the under resourcing of the NHS;</p> <p>ii) urgent clinical care should not be delayed or prevented by eligibility checks;</p> <p>iii) medical staff should not be involved in ascertaining eligibility of patients for NHS treatment.</p> <p>(2017)</p>
904.	<p>That this meeting is concerned by limitations to healthcare provision in immigration and detention centres in the UK and calls for government:-</p> <p>i) to replace the use of immigration detention completely with alternate more humane means of monitoring individuals facing deportation.</p> <p>(2017)</p>
905.	<p>That this meeting is concerned about the impact of charging migrants for NHS services. We ask the BMA, the BMA council chair and the international committee chair to run training workshops for BMA members about the influence immigration legislation has on doctors’ clinical practice.</p>

	(2016)
906.	That this meeting asks the BMA to explore providing systems to assist members in volunteering their skills and knowledge internationally and locally. (2016)
907.	That this meeting believes that NHS staff do not have any role in policing immigration. This meeting calls on the BMA to:- <ul style="list-style-type: none"> i) issue clear instructions that the role of the doctor is to provide medical care when it is needed and that doctors should not involve themselves in any monitoring of immigration status; ii) provide robust support for any doctor who is victimised for refusing to partake in monitoring of immigration status. (2015)
908.	That this meeting:- <ul style="list-style-type: none"> i) congratulates the World health Organisation for its unanimous approval of the draft resolution "Strengthening emergency and essential surgical care and anaesthesia as a component of universal health coverage"; ii) welcomes the prominent position of the Association of Anaesthetists stand at this meeting; iii) supports the work of the Association of Anaesthetists in working towards safer, higher quality anaesthesia/ surgery in the developing world via its Lifebox campaign. (2015)
909.	That this meeting:- <ul style="list-style-type: none"> i) welcomes the deferral of a vote to introducing international scheduling of ketamine at the United Nations Commission on Narcotic Drugs in March 2015; ii) congratulates the BMA, WMA, AAGBI, RCOA and the UK government for being among over 80 organisations that lobbied for continued availability of ketamine for use in anaesthesia and palliative care around the world. (2015)
910.	That this meeting opposes moves within the United Nations to reclassify the anaesthetic agent Ketamine in ways which would severely restrict its availability for medical purposes particularly in low and middle-income countries and; <ul style="list-style-type: none"> i) notes that ketamine remains the only safe anaesthetic agent available for many remote or resource-limited populations; ii) congratulates the BMA and partner organisations in the UK and internationally for working together to oppose these moves; iii) calls upon the UK government to both lobby and vote against these proposals. (2015)
911.	That this Meeting believes doctors treating individual patients should not be responsible for deciding whether those patients qualify for NHS treatment on the basis of their immigration status, and calls on the BMA to lobby against any proposals which are contrary to these principles. (2014)
912.	That this Meeting insists that the NHS must not be part of a global trade deal (US/EU Free Trade Agreement) which could allow international corporations to have legal rights to buy lucrative parts of the NHS and demands that the BMA campaign against this agreement. (2013)

913.	That this Meeting believes that doctors should not become agents of the UK Border Agency or its successor and should not have a role in deciding whether someone is eligible or not for NHS care. (2013)
914.	That this Meeting notes with interest the decision of the UK government to sell UK- based specialty training to foreign nations as this Meeting has concerns that there has not been adequate due process and planning for this to occur safely and efficiently. We therefore call for:- i) a reliable quantification of excess training capacity within the UK; ii) the UK health departments and other involved parties to undertake a thorough, limited pilot of this programme, evaluated by external review; iii) the needs of patients and UK-based doctors in training, to be prioritised above political and monetary aspirations; iv) the BMA to oppose this programme until such time as it is satisfied that appropriate safety and training safeguards have been introduced and adequate planning has been undertaken. (2013)
915.	That this Meeting takes full cognisance of the World Report on Disability of 2011, published by the WHO and the World Bank, thereby making sure that disability issues across the world are mainstreamed and no longer left at the margins. (2013)
916.	That this Meeting believes that, in light of recent events in various parts of the world, the fundamental duty of doctors is to treat patients according to medical need without discrimination of any kind; including political allegiance and, i) insists that political or judicial interference in this duty is totally unacceptable; ii) condemns any persecution of health care staff for fulfilling this duty. (2011)
917.	That this Meeting:- i) recognises that it is paradoxical for the NHS to provide healthcare using instruments and resources which are manufactured under conditions which flout basic labour rights; ii) recognises that workers, often children, in developing countries should not risk their health and lives in order to provide our resources; iii) calls on the BMA to stand in solidarity with those working to bring fairer medical trade into the NHS by: a) raising awareness amongst the student body of the importance of fair trade in the NHS via a national campaign promoting the work of the "Medical Fair and Ethical Trade group." b) lobbying the NHS trusts and GP consortia to consistently purchase all of their surgical instruments from suppliers who are known to pay their employees a fair wage. (2011)
918.	That this Meeting welcomes the BMA's campaign for medical fair and ethical trade and now calls upon members to work with this campaign in order to: (i) encourage their employers to develop ethical purchasing policies; (ii) mandate the BMA to continue to lobby to broaden the scope of the products available. (2010)

919.	<p>That, in respect of medical work in the developing world, this Meeting:</p> <ul style="list-style-type: none"> (i) recognises the contribution of UK doctors who provide services to the developing world; (ii) believes that those undertaking such work should not be disadvantaged by making this contribution; (iii) believes that UK doctors taking career breaks to undertake such work should be entitled to return to work similar to the arrangements following maternity leave; (iv) believes that those working on a voluntary basis should receive financial support for continuing professional development and revalidation. <p>(2010)</p>
920.	<p>That this Meeting:</p> <ul style="list-style-type: none"> (i) recognises the desperate need to strengthen health systems in developing countries in order to sustainably improve health outcomes; (ii) recognises the UK government's commitment to doing this in their strategy 'Health is Global'; (iii) acknowledges the success of a number of UK medical schools in setting up academic international health links IHL to support the development of health workers' skills and healthcare systems in developing countries; (iv) calls upon the BMA to: <ul style="list-style-type: none"> (a) lobby Medical Schools that are not already part of an international link to initiate similar projects; (b) lobby the Health Departments to provide funds to support these initiatives; (c) work with the Medical Schools Council and Health Departments to create a 'start-up guide' for medical schools wishing to initiate a link. <p>(2010)</p>
921.	<p>That this Meeting:</p> <ul style="list-style-type: none"> (i) congratulates the International Department of the BMA for engaging with key stakeholders in medical education and NHS employment and producing the 'Broadening Your Horizons' guidance document which advises doctors on how to take time out of training and NHS employment to work in developing countries for professional and personal development; (ii) calls on the BMA to continue to support and raise the profile of these activities. <p>(2009)</p>
922.	<p>That this Meeting notes the importance of patient information but it is concerned with the potential within current European proposals for this to be manipulated into "direct to consumer" advertising and calls on the BMA to lobby to ensure proper regulation of patient information.</p> <p>(2008)</p>
923.	<p>That this Meeting:</p> <ul style="list-style-type: none"> (i) notes that access to clean water and sanitation is fundamental to health; (ii) notes the shamefully weak presence of the health sector in advocating for improved access to water and sanitation in the developing world; (iii) calls on the BMA and the health community to act as a leader in this field and bring all the sectors involved together; (iv) calls on the BMA to lobby the government to draw attention to the need for, and to increase the funding for, access to clean water and sanitation. <p>(2008)</p>
924.	<p>That this Meeting condemns:</p> <ul style="list-style-type: none"> (i) the ill-treatment of the people of Tibet; (ii) the exercising of inhumane programmes against the people of Tibet, and (iii) any involvement of the Chinese medical profession in the torture of Tibetan prisoners, and calls on the BMA to highlight this issue.

	(2008)
925.	That this Meeting calls upon the BMA to work with other stakeholders (including Water Aid) to raise awareness of the adverse health impact of poor sanitation and the significant health improvements which result from clean water supplies. (2007)
926.	That this Meeting deplores the death sentence passed in Libya on Dr Ashraf al-Hajuj and five nurses, and commends the action taken by Chairman of Council in writing to the Prime Minister and Foreign Secretary to call on them to raise the issue internationally. (2007)
927.	That this Meeting supports the expansion of the Global Fund for TB, Malaria and HIV, to include provision for strengthening primary health care networks that are not necessarily specific to these three infections and calls upon the BMA to lobby the government to support this philosophy in international negotiations. (2007)
928.	That this Meeting supports the WHO's Global Campaign for Violence prevention. (2007)
929.	That companies performing medical trials in the developing world should adhere to the same ethical standards as would be expected in EU and that the BMA should be active in ensuring an appropriate regulatory structure. (2006)
930.	That this Meeting believes that current World Trade Organisation legislation on trade-related intellectual property rights has resulted in restricted access to medicines when most needed by developing countries in order to maximise profits of pharmaceutical companies, and calls upon the government to support more generous exceptions to TRIPS legislation in health crises within the WTO. (2003)
931.	That this meeting calls on governments to recognise the increased health needs of refugees and asylum seekers by including health need with social service need when allocating resources for the provision of services to refugees and asylum seekers. (2016)
932.	That this Meeting welcomes recent proposals to extend access to secondary care for some refused asylum seekers but: <ul style="list-style-type: none"> (i) regrets that a charging system for refused asylum seekers and undocumented migrants will remain in place and the UK Border Agency will work with the NHS to recover debts; (ii) believes that a charging system for refused asylum seekers and undocumented migrants will not be cost effective; (iii) believes that restricting access to healthcare as a punitive immigration control measure is morally unacceptable, contrary to professional ethics, a hazard to public health and a misuse of health resources. (2010)
933.	That this Meeting believes that denial of access to free healthcare for refused asylum seekers risks additional costs in emergency care, and may lead to poorer communicable disease control. (2009)

934.	That this Meeting believes that it is not appropriate for medical staff to act as proxy immigration officers in seeking to determine the immigration status of people presenting for care and treatment. (2005)
935.	That this Meeting views the Government's policy of dispersal of asylum seekers, without adequate consideration of their specific medical needs, as being inhumane and calls on the BMA to oppose this policy. (2005)
936.	That this Meeting calls on the Department of Health to ensure that a full health impact assessment is carried out on the current asylum process and on any amendment to it, because we believe that the present system of applying for asylum in the UK can be very damaging to the physical and mental health of those applying. (2005)
937.	That this Meeting deplores the planned withdrawal of rights to medical care from asylum seekers whose applications have been refused. (2004)
938.	That this Meeting, with respect to refugees and asylum seekers: (i) deplores the creation by the Immigration Act 1999 of an underclass within the group, surviving on food vouchers and 70% benefits; (ii) demands that the Government implements a more efficient and compassionate approach, including a fully funded translation service; (iii) demands that the Department of Health monitors the health consequences of the Immigration Act 1999; (iv) rejects the current approach to the assessment of refugees and asylum seekers as inhumane and detrimental to health; (v) deplores the lack of co-ordination and planning in their health care and distribution to regions of the UK. (2000)
939.	<u>Human rights</u> That this meeting calls on the UK government to exert pressure on the Brunei government to reverse its decision to administer cruel, inhuman and degrading punishments, including public flogging of women who have had abortions and death by stoning for homosexuals, as part of its extension of Sharia Law within its criminal justice system. (2019)
940.	That this meeting re human rights believes that access to healthcare should be a fundamental human right, and calls on the BMA, through its International Department, to lobby for extension of the UN Convention on Human Rights to include access to healthcare. (2016)
941.	That this Meeting notes that doctors and healthcare professionals are often at the front line of defending the health-related human and humanitarian rights of others and: (i) deplores that doctors are sometimes targeted by repressive governments solely for the impartial exercise of their professional duties; (ii) notes, in particular, that healthcare professionals can be targeted by repressive governments for defending the health and sexual and reproductive rights of women; (iii) deplores any intimidation of medical staff in the discharge of their duties;

	<p>(iv) deplores any willful restriction of access to healthcare to the patients of doctors who work in conflict zones or under oppressive regimes;</p> <p>(v) expresses solidarity and support for the doctors who work under intolerable conditions in conflict zones or under oppressive regimes;</p> <p>(vi) urges the BMA to work closely with human rights organisations in support of health care professionals at risk.</p> <p>(2010)</p>
942.	<p>That the BMA deplores the fact that bullying and harassment of doctors remains part of the NHS culture. We call upon our members to ensure that action is taken against any doctor who behaves in this way, or who is in a position where lack of action on their part allows this to continue. We call upon the Health Departments to reduce this problem by:</p> <p>(i) using open structured references;</p> <p>(ii) informing medical students and doctors of their rights as part of induction;</p> <p>(iii) making the medical appointment process transparent;</p> <p>(iv) ensuring that allegations of bullying and harassment are acted upon.</p> <p>(2001)</p>
943.	<p>That this Meeting believes that, at interview, asking questions about a person's health or sickness record is intrusive, infringes candidates' human rights and undermines efforts to create a high quality occupational health service; it therefore calls upon the BMA to:</p> <p>(i) ensure that all members who take part on interview panels have full and proper training to do so;</p> <p>(ii) call upon COPMED to ensure that the skills necessary to interview job candidates are taught as part of SpR training programmes;</p> <p>(iii) collect examples of poor interview practice and represent the rights of members who have been discriminated against.</p> <p>(2001)</p>
944.	<p>That this Meeting deplores any regime taking action against doctors simply because of the political beliefs of their patients whom they are bound to treat in the cause of common humanity and according to the International Code of Medical Ethics.</p> <p>(1978)</p>
945.	<p>That the British Medical Association condemns the practice of using medical men to certify political and religious dissenters as insane and to submit them to unnecessary investigation and treatment.</p> <p>(1973)</p>
946.	<p><u>International conflicts</u></p> <p>That this Meeting has grave concerns regarding the use of munitions containing white phosphorus or depleted uranium which appear to have far-reaching and long-term health consequences on populations beyond their immediate military impact. This Meeting:</p> <p>(i) directs the BMA to lobby for an independent investigation into the long-term effects of such munitions, including teratogenicity and oncogenicity;</p> <p>(ii) demands a moratorium on the use of such munitions whilst such concerns exist.</p> <p>(2010)</p>
947.	<p>That this Meeting is gravely concerned about humanitarian crises in conflict areas and:</p> <p>(i) deplores any action by a standing army or other armed group which deliberately targets, or takes insufficient care to ensure the safety of, civilians;</p> <p>(ii) deplores any action by a standing army or other armed group which deliberately targets, or takes insufficient care to ensure the safety of, healthcare personnel and healthcare facilities;</p>

	<ul style="list-style-type: none"> (iii) deplores any use of white phosphorus, neurotoxic gasses and anti-personnel mines as weapons in urban environments; (iv) calls on the BMA to lobby the relevant bodies to ensure each party in a conflict allows for free passage of medical supplies to the victims; (v) calls on the BMA to lobby the relevant bodies to hold to account those who prevent access to healthcare; (vi) calls on the BMA to consider suspending contact with any national medical association which does not oppose the targeting of healthcare personnel and facilities or the denial of medical supplies. <p>(2009)</p>
948.	<p>That this Meeting demands that the UK Government support and fund an independent, objective, fully transparent investigation into the number of excess deaths among Iraqi nationals attributable to the previous regime and the excess following the invasion of that country by UK and US forces.</p> <p>(2005)</p>
949.	<p>That this Meeting condemns group and state terrorism and all acts of violence against civilians in areas of conflicts.</p> <p>(2004)</p>
950.	<p>That this Meeting believes that the BMA should lobby for strict adherence, regardless of circumstance, to international conventions created to protect civilian access to healthcare during times of conflict and war.</p> <p>(2004)</p>
951.	<p>That this Meeting insists that the principles of the Geneva Convention in respect of health and hospitals should always be upheld by all parties in any conflict in which our country is involved.</p> <p>(2003)</p>
952.	<p>That this Meeting, noting the health care crisis in Iraq, calls on the BMA to:</p> <ul style="list-style-type: none"> (i) continue lobbying the UK government to support health services in Iraq; (ii) work with partner medical and charitable organisations to identify areas where the BMA can offer assistance and advice; (iii) assist doctors working in Iraq in the reconstruction of the Iraqi health care system; (iv) provide individual members with relevant guidance should they wish to volunteer their services to assist. <p>(2003)</p>
953.	<p>That this Meeting utterly condemns the targeting of health personnel and health facilities in conflicts anywhere in the world and:</p> <ul style="list-style-type: none"> (i) demands that patients have access to medical care without discrimination; and (ii) calls on all combatants to respect the principles of international humanitarian law and medical ethics. <p>(2002)</p>
954.	<p><u>International sanctions</u></p> <p>That Council continue to highlight the plight of doctors in Iraq.</p> <p>(2001)</p>
955.	<p>That this Meeting whilst deploring the need for international political sanctions believes that sanctions:</p> <ul style="list-style-type: none"> (i) may be needed to restrain states that do not comply with international law;

	<p>(ii) should be targeted at the leadership of the state rather than the population as a whole, as described in the concept of 'smart sanctions'.</p> <p>(2001)</p>
956.	<p>That this Meeting asks Council to investigate ways of minimising professional isolation of doctors in countries subject to United Nations sanctions.</p> <p>(1999)</p>
957.	<p><u>Refugee doctors</u></p> <p>That this meeting in respect to refugee and asylum-seeking doctors, calls on the GMC and the Home Office to:-</p> <ul style="list-style-type: none"> i) recognise the talent and resource in refugee and asylum seeking doctors and other health care professionals; ii) provide them with targeted English Language teaching; iii) provide a clinical apprenticeship scheme for them to learn how the NHS works and to be trained in the management of conditions within the NHS; iv) waive examination fees for registration with the GMC; v) provide support to obtain residency and work in healthcare. <p>(2018)</p>
958.	<p>That this meeting re refugees acknowledges that, despite the many policy motions passed by this body since 1999, we are little further on in funding the training of refugee doctors to enable them to work within the NHS, including finding clinical placements, and calls once again on UK governments to direct appropriate resources to the continuing funding of programmes currently established to carry out this work.</p> <p>(2016)</p>
959.	<p>That this Meeting believes that the procedures for assimilating refugee, asylum seeking and other overseas doctors are unduly cumbersome, and urges the government to take all steps to incorporate this dedicated band of doctors within the NHS in order to help reduce the workforce crisis.</p> <p>(2006)</p>
960.	<p>That this Meeting sympathises with the plight of International Medical Graduates (IMGs) in attempting to secure jobs in this country post-PLAB and:</p> <ul style="list-style-type: none"> (i) demands that the GMC and Department of Health reappraises the difficulties that IMGs have in obtaining registration and insists that full and realistic information about employment prospects be available to them before they leave their own countries; (ii) deplores the difficulty fully qualified IMGs have in obtaining clinical attachments in primary and secondary care; (iii) believes that IMGs should not be charged for clinical attachments in the UK; (iv) asks the GMC and the health departments to implement a single competitive entry point into the UK; (v) asks the government to address with urgency the financial exploitation of IMGs. <p>(2005)</p>
961.	<p>That this Meeting demands that in view of the recruitment crisis in the NHS that the BMA engages with DoH, GMC and other bodies to seek to ensure that the most effective and humane use is made of refugee, asylum-seeking and other overseas doctors – including facilitating attachments, favourable rules on visas and benefits.</p> <p>(2004)</p>

962.	That this Meeting calls for the BMA to continue to pressurise the Departments of Health to introduce appropriate measures to utilise the skills of medical refugees and asylum seekers by addressing the many issues and problems raised by the UK benefit and work permit rules. (2003)
963.	That this Meeting applauds the work of the BMA Refugee Doctors' Liaison Group. (2002)
964.	That this Meeting requests that the Department of Health provide support and resources for training of refugee doctors to enable them to practice as medical professionals in the NHS. (2002)
965.	That this Meeting remains seriously concerned by the plight of refugee doctors (including asylum seekers). It: (i) condemns any arrangements whereby refugee doctors have to pay for clinical attachments; (ii) notes that clinical attachments may be classed as work by the benefits agency; (iii) condemns any organisation that is making money out of the plight of refugee doctors. (2001)
966.	That this Meeting commends the BMA for supporting refugee doctors. (2001)
967.	That this Meeting urges the Government to make adequate funds available to support training programmes and other needs of refugee doctors to assist them in finding work as a valued contribution to the understaffed NHS. (1999)
968.	That the BMA should lobby the UK government to increase its overseas aid budget to the recommended level of 0.7% of GDP. (2003)
969.	That this Meeting recognises the evidence from the United Nations that the education of women in developing countries is crucial to improving the health of their families and communities and urges the BMA to work with medical associations in these countries, the World Medical Association and international education bodies to prioritise policies to effect this education. (2003)
970.	That this Meeting recognises that poverty is a gender issue and requires the BMA to support the world-wide promotion of gender equality and the empowerment of women. (2003)
971.	That, while welcoming the new resources committed to the health service, this Meeting would also urge the Government to press the other G8 countries to commit more resources to improving the health of the world's poorest people through the cancellation of the third world debt. (2000)
972.	That this Meeting supports the World Medical Association's resolution on economic embargoes and health adopted at the WMA General Assembly in November 1997, which "urges national medical associations to ensure that governments employing economic sanctions against other states respect the agreed exemptions for medicines, medical supplies and basic food items". This Meeting instructs Council to campaign against embargoes which damage health. (1998)

<p>973.</p>	<p><u>Torture and execution</u></p> <p>That this meeting regarding the ill-treatment of prisoners:-</p> <ul style="list-style-type: none"> i) notes that the Council of Europe’s Committee for the Prevention of Torture publishes standards, which contain thresholds for defining various types of ill-treatment within European secure environments; ii) notes with concern that there are no published worldwide standards regarding the prevention of prisoner ill-treatment by which national signatories to the United Nations’ Optional Protocol to the Convention Against Torture must abide; iii) calls for the United Nations’ Subcommittee on Prevention of Torture to publish standards that define various types of ill-treatment within worldwide secure environments. <p>(2017)</p>
<p>974.</p>	<p>That this Meeting notes the new US military guidelines on forced feeding of prisoners on hunger strike published on 13 May 2013 and:</p> <ul style="list-style-type: none"> (i) condemns any participation of doctors and nurses in forced feeding or any other cruel, inhuman or degrading treatment and supports any clinician who challenges such treatment; (ii) calls upon governments worldwide to ensure that all prisoners have access to confidential, independent medical treatment. <p>(2013)</p>
<p>975.</p>	<p>That this Meeting:</p> <ul style="list-style-type: none"> (i) believes any torture of prisoners held in Guantanamo Bay or HMP Belmarsh is inhumane and contrary to the Geneva Convention; (ii) condemns the force feeding of prisoners in Guantanamo Bay under the direct supervision of US doctors; (iii) urges the UK government to seek direct and unfettered access to detainees, including several former UK residents, by an independent team of UK doctors and the results of such visits be made public; (iv) notes with considerable concern the lack of publicly visible action from the WMA over the role of doctors in Guantanamo Bay with as yet no discussion in WMA Council. <p>(2006)</p>
<p>976.</p>	<p>That this Meeting:</p> <ul style="list-style-type: none"> (i) believes that the BMA should take a high profile position against any doctors collaborating in torture; (ii) asks that Chief Officers of the BMA write to relevant national bodies asking that they censure doctors collaborating in torture; (iii) demands that the BMA publicly support any doctors who take a stand against participation in torture and, in doing so, defy their employers, superiors or governments. <p>(2005)</p>
<p>977.</p>	<p>That this Meeting views with dismay the illegal use of medical records during the incarceration of detainees in Guantánamo Bay and failure to report abuses of human rights by some doctors. We call on all national medical associations to condemn the role of doctors and the misuse of medical records in perpetuating torture.</p> <p>(2004)</p>
<p>978.</p>	<p>That the BMA is opposed to the death penalty worldwide.</p> <p>(2001)</p>
<p>979.</p>	<p>That this Meeting believes that the involvement of doctors, either directly or indirectly, in the implementation of the death penalty is morally wrong and runs counter to the ethics of modern</p>

	<p>medical practice. We therefore call on the BMA to support medical associations in countries with the death penalty which oppose the involvement of doctors in its implementation, and to put pressure on those medical associations which do not.</p> <p>(1998)</p>
980.	<p>That this Meeting calls on the BMA to support fully all organisations which campaign for the release of doctors held as political prisoners, especially where imprisonment has been as a direct result of their medical practice.</p> <p>(1998)</p>
981.	<p>That this Meeting is appalled that some medical practitioners are practising the policy of human torture to help their ruling authorities and asks the BMA to support the doctors who resist getting involved in such practices.</p> <p>(1998)</p>
982.	<p>That this Meeting deplores the involvement of doctors in torture worldwide.</p> <p>(1998)</p>
983.	<p>That this Meeting believes that doctors anywhere in the world witnessing torture and other inhuman and degrading treatments should, as far as possible, inform human rights organisations and the professional associations.</p> <p>(1997)</p>
984.	<p>That this Meeting believes that the manufacture, sales, and supply of any instrument in the UK specifically designed for torture should be prohibited.</p> <p>(1997)</p>
985.	<p>That the BMA opposes the involvement of doctors in judicial execution.</p> <p>(1992)</p>
986.	<p>That this Meeting strongly supports the view of the Working Party on Torture that it is important to maintain a proper distance between the medical professions and the apparatus of the state and recommends that:</p> <ul style="list-style-type: none"> (i) the BMA should provide support whenever possible both to medical associations and to individual doctors in this country and abroad, who are faced with problems of conscience or believe they have evidence of torture and need help; (ii) the BMA should make provision for professional censure of medical associations which acquiesce in torture. <p>(1986)</p>
987.	<p>That this Representative Body deplores the continued abuse of medical skills and ethics for political ends in contravention of the principles of the Declaration of Geneva.</p> <p>(1976)</p>
988.	<p><u>Overseas healthcare workers, doctors and medical students</u></p> <p>That this meeting recognises that “The Hostile Environment Policy” has a detrimental impact on the health of patients, doctors and minority groups whilst also threatening public health and calls for the BMA:-</p> <ul style="list-style-type: none"> i) to lobby for undergraduate and postgraduate training on how the hostile environment policy impacts doctors’ clinical practice; ii) to provide clear guidelines for doctors considering supporting patients and patient groups affected by the hostile environment policy;

	<p>iii) to ensure that full support is offered to its members who are penalised for advocating for those whose health is threatened by the hostile environment policy. (2021)</p>
989.	<p>That this meeting insist that the BMA recognise the huge contributions of NHS staff from overseas to the UK and the psychological impact of not being able to look after elderly parents abroad. There has been instances where the NHS lost staff as visas were refused to dependent parents because the criteria to prove dependency are absolutely onerous. Hence BMA must lobby the Home Office to make the visa procedures more easy for elderly parents of overseas NHS staff. (2021)</p>
990.	<p>That this meeting calls upon the Department of Health, Health Education England, the GMC, Royal Colleges, the BMA and other stakeholders to work together to improve the professional and pastoral support offered to overseas doctors, particularly those that are recruited via online or other “virtual” facilities, to ensure that they are properly equipped to adjust to the high pressure environment in an unfamiliar country and fully enabled to fulfil the expectation of working within the NHS. (2019)</p>
991.	<p>That this meeting is concerned by current Home Office policy which limits overseas applications for NHS jobs despite growing medical and clinical workforce shortages and calls on the government to review or withdraw the cap for Tier 2 skilled non-EU workers. (2018)</p>
992.	<p>That this meeting celebrates the enormous contribution of overseas medical graduates to the NHS and:- i) urges governments to recognise this at a time of severe recruitment and retention difficulties; ii) in respect of doctors, rejects the recent report from the Migration Advisory Committee; iii) asks the BMA to negotiate the exemption from the Immigration Health Surcharge of NHS staff covered by the new visa regulations. (2016)</p>
993.	<p>That this Meeting recognises the valuable contribution that the international students of UK Universities make to NHS Service delivery and is concerned that planned changes to UK immigration rules by the UK Border Agency (UKBA) would prevent these doctors from progressing to Foundation Programme, and subsequent completion of their training with progression to specialist training. In turn this Meeting calls upon the UKBA to:- i) ensure that any changes to the immigration rules provide the 3,000 international medical students and doctors already committed to studying and training in UK with a clear pathway that will enable them to take up specialty training posts if they wish; ii) ensure that decisions about such changes made are published far in advance of July each year in order to avoid stress and anxiety for doctors who are applying for specialty training posts; iii) provide clear information on the prospects for postgraduate medical training in the UK for international students who are considering applying to study medicine at UK Universities from October 2011 onwards. (2011)</p>
994.	<p>That this Meeting believes that any doctor who comes to the UK to practice medicine should: (i) have an acceptable command of the English language;</p>

	<p>(ii) have acceptable equivalence of breadth and depth of clinical skills, training and knowledge normally associated with UK practice of their specialty;</p> <p>(iii) have sufficient knowledge of the operation of the NHS;</p> <p>(iv) be governed by the normal regulatory processes applicable to doctors practising primarily in the UK.</p> <p>(2010)</p>
995.	<p>That this Meeting recognises the risks of employing non-UK EEA doctors to provide locum and out of hours services who may have an inadequate command of the English language and poor knowledge of the UK healthcare service.</p> <p>(2010)</p>
996.	<p>That this Meeting:</p> <p>(i) remains concerned at the plight of non-EU medical graduates caused by changes to immigration rules, calling upon the government to address this;</p> <p>(ii) supports non-EU doctors in the need for reform of HMG policy to allow completion of studies and higher qualifications on an equal footing;</p> <p>(iii) supports doctors from non-EU countries already training and working in the UK to be allowed to continue.</p> <p>(2007)</p>
997.	<p>This Meeting endorses the following policy statement:</p> <p>A That the BMA deplores the active recruitment of healthcare workers from developing countries.</p> <p>B That the BMA:</p> <ol style="list-style-type: none"> 1. Recognises that the lack of healthcare workers in developing countries is a global emergency that requires urgent action. The impact of health worker migration from developing countries is a significant component in this crisis, and is a contributing cause of the spiral of poverty and disease. 2. Appreciates the important contribution that internationally qualified healthcare workers can make to their destination countries and in particular, the contribution they have made to the NHS. 3. Recognises that concerted action by the governments and national medical associations of developing and developed countries is required to resolve this global problem. <p>C That the BMA calls on governments:</p> <ol style="list-style-type: none"> 1. In developed countries, to commit the necessary resources to achieving self-sufficiency, graduating the healthcare workers needed for their own countries' requirements. 2. In developed countries, to provide readily available and accurate information on job availability in the different areas and stages of medicine, to inform healthcare workers of realistic career prospects. 3. In developing countries, to prioritise the resources required to meet the healthcare needs of their populations. 4. In developing countries, to prioritise the retention of healthcare professionals in their own countries by optimising their career opportunities there. <p>D That the BMA calls on national medical associations:</p> <ol style="list-style-type: none"> 1. To defend the rights of individual healthcare professionals to migrate, should they choose to do so. 2. To support appropriate international twinning and educational exchange programmes. 3. To lobby nationally and internationally to ensure that this global crisis is addressed as a matter of urgency. <p>E That the BMA calls on the GMC:</p>

	<ol style="list-style-type: none"> 1. To make PLAB available at overseas locations, thereby avoiding the need for an expensive trip to the UK. 2. To ensure internationally qualified doctors can make informed choices about their employment prospects in the UK based upon their results. 3. To consider establishing a common application and entry procedure for internationally qualified doctors seeking training in the UK. <p>F That the BMA challenges the G8 and developing countries to work together to provide increased funding and improved infrastructure, to achieve the WHO goal of healthcare for all.</p> <p>G That the BMA challenges all governments to implement the Millennium Development Goals by the stated target date and believes that this will require them to address the skills drain and its root causes.</p> <p>(2005)</p>
998.	That we deplore the active recruitment of health care workers from the developing countries when there is a disadvantage to the host nation. (2004)
999.	That this Meeting is alarmed by the severe delays experienced by overseas doctors seeking to work in the UK, and in view of the present recruitment and retention crisis, demands that the Home Office does all in its power to lessen the delays. (2003)
1000.	That this Meeting calls upon the Department of Health to publish quality and cost-effectiveness outcomes for its overseas recruitment and treatment programmes and the use of visiting overseas surgical teams. (2003)
1001.	That this Meeting condemns the commercial poaching of health workers from developing countries and calls for the immediate cessation of the practice. (2001)
1002.	That this Meeting deplores the fact that doctors who have passed the PLAB test cannot get appointed to training posts. (2000)
1003.	That this Meeting asks the Government to consider measures to improve the training and career structure of overseas doctors to facilitate their recruitment and retention in the NHS. (2000)
1004.	That no doctor should be registered to practise within the United Kingdom without satisfactory evidence of a sufficient command of English. (1977)
1005.	<p><u>International medical associations</u></p> <p>That this meeting calls on the BMA to support the American Medical Association in opposition to the Texas laws Senate Bill 8 and Senate Bill 4. (2021)</p>
1006.	That this meeting fully endorses the BMA's continued membership of the World Medical Association for the opportunity it provides to support and influence the development of global health policy. (2019)

1007.	That this meeting calls on the BMA to keep members informed of its activities at the World Medical Association (WMA) by means such as alerts on new developments, providing a link to the WMA website, and reporting on debates at the WMA General Assembly. (2016)
1008.	That this Meeting congratulates the Board of Science and Education on its many reports enhancing the leading role of the BMA in promoting the nation's health and requests the BMA through its worldwide involvement to encourage other national medical associations to enhance their influence similarly by increasing their public health role. (1997)
1009.	That this Meeting strongly supports the continuation of the Commonwealth Medical Association. (1987)
	INTIMATE BODY SEARCHES
1010.	That this Meeting believes that no medical practitioner should take part in an intimate body search of a subject without that subject's consent. (1989)
	JUNIOR DOCTORS
1011.	That this meeting expresses its huge thanks to junior doctors redeployed during the pandemic who missed out on a significant amount of training and recognises the need to prioritise specialty training needs and to ensure transparency and consistency in approach between specialties. (2021)
1012.	That this meeting recognises that practical barriers can discourage doctors from exception reporting and calls for electronic reporting systems: - i) which are compatible across all platforms; ii) which are accessible outside the workplace; iii) which are free to use; iv) which are demonstrated as part of induction programmes; v) whose login details are provided at, or prior to, induction. (2019)
1013.	That this meeting recognises the disparity in travel expenses policies between different deaneries, lead employers and local education training boards and we ask that the BMA lobby relevant bodies to create a simpler and fairer standardised expenses policy for all junior doctors. (2019)
1014.	That this meeting believes that training on patient 'fit notes' should be an essential part of all hospital inductions for junior doctors. All doctors should have easy access to issue 'fit notes' and they should be routinely considered for patients on discharge from all hospital episodes. (2018)
1015.	That this meeting recognises the difficulties in recruitment and retention of junior doctors and welcomes the publication of the '8 high impact actions' from NHS Improvement. We call upon the BMA to lobby NHS Employers and relevant stakeholders to develop key performance indicators with associated funding attached for each of the following:- i) adequate rest and sleep facilities;

	<p>ii) access to hot food 24 hours a day, seven days a week;</p> <p>iii) rota templates that are compliant with contract requirements;</p> <p>iv) receipt of work schedules with a minimum of eight weeks notice.</p> <p>(2018)</p>
1016.	<p>That this meeting calls on Guardians of Safe Working to, in relation to exception reporting:-</p> <p>i) go out and seek information from junior doctors;</p> <p>ii) look for juniors working beyond their rostered hours;</p> <p>iii) hold responsibility for ensuring junior doctors are supported to exception report.</p> <p>(2018)</p>
1017.	<p>That this meeting calls on the BMA to:-</p> <p>i) lobby relevant stakeholders to ensure that junior doctors are given adequate high-quality clinical supervision;</p> <p>ii) remind regulatory bodies, royal colleges and other relevant stakeholders, that junior doctors should be able to reflect openly and honestly, and without fear of recrimination as part of ongoing professional development and;</p> <p>iii) remind members of the sources of support available, and the appropriate channels to follow, if they have concerns regarding supervision or support in the workplace.</p> <p>(2018)</p>
1018.	<p>That this meeting calls for a mandatory nationally agreed minimal period of protected administrative time (relevant to the level of training and duties) built into junior doctors work schedules. This would be above and beyond that protected for teaching and training and intended for the purpose of completing paperwork tasks, mandatory training, portfolio tasks, audit, guideline reviews and other required educational, teaching or management tasks currently having to be completed in that doctors own time without recognition or pay.</p> <p>(2017)</p>
1019.	<p>That this meeting continues to support junior doctors, and:-</p> <p>i) calls upon consultant members of the BMA to endorse exception reporting as a tool for the improvement of terms and conditions of trainee doctors;</p> <p>ii) asks its members not to suppress in any way the fair use of the exception reporting mechanism by junior colleagues.</p> <p>(2017)</p>
1020.	<p>That this meeting:-</p> <p>i) recognises the significant contributions and personal sacrifices made by medical students and junior doctors during the course of their degree and further medical education;</p> <p>ii) recommends that the government should seek to understand why junior doctors might leave the NHS;</p> <p>iii) rejects the secretary of state's proposal that doctors should be required to work for the NHS for 4 years after registration or pay back the "cost of their training";</p> <p>iv) opposes any move to impose a minimum period of NHS employment.</p> <p>(2017)</p>
1021.	<p>That this meeting:-</p> <p>i) is concerned by the inconsistency in the implementation of support for junior doctors with dyslexia following workplace assessment and condemns delays to implementing support which can often lead to support being lost when junior doctors rotate;</p> <p>ii) calls for the BMA to lobby HEE to look into this issue as a matter of urgency and to ensure that problems are addressed;</p> <p>iii) demands that HEE implements a system where support follows the trainee rather than being tethered to a particular rotation or placement.</p> <p>(2016)</p>

<p>1022.</p>	<p>That this meeting supports the decision made by junior doctor representatives in 2014 to suspend contractual negotiations, and:-</p> <ul style="list-style-type: none"> i) publicly condemns government suggestions that doctors working until 10pm on a Saturday and Sunday night are not working unsocial hours; ii) calls on the BMA to lobby for basic needs including access to hot food and more than one 30 minute break in a 10-hour shift; iii) invites governments to work constructively with the BMA on a contract that protects the welfare of patients and doctors. <p>(2015)</p>
<p>1023.</p>	<p>That this meeting is appalled by the latest GMC survey stating nearly 10% of trainees experience bullying and harassment and believes:-</p> <ul style="list-style-type: none"> i) it is unacceptable that some members of staff (both medical and non-medical) believe that it is acceptable to humiliate juniors; ii) there should be greater support for trainees to raise bullying and harassment concerns; iii) there should be training for staff implicated in bullying and harassment so that they are able to recognise the impact of their behaviour. <p>(2015)</p>
<p>1024.</p>	<p>That this meeting recognises that the current 'prospective cover' clause in the junior doctor contract is limited in its ability to provide a safe level of junior doctor cover. We call on the BMA junior doctors committee to investigate on the feasibility of an alternative system, based on the New Zealand model where 'relief' doctors are employed in all hospitals to cover both planned and unplanned absences.</p> <p>(2015)</p>
<p>1025.</p>	<p>That this Meeting notes the frustrations and difficulties faced by junior doctors due to the lack of advance information about, or last minute changes to, future training posts. We therefore call on the BMA to explore, with employers and education providers, incorporating the "Code of Practice: Provision of Information for Postgraduate Medical Training" into the Terms and Conditions of Service within any new junior doctors' contract.</p> <p>(2014)</p>
<p>1026.</p>	<p>That this Meeting believes that no junior should be out-of-pocket due to travel expenses necessitated by short-term, pre-allocated rotations within a training scheme and that the JDC must renew the fight for fair reimbursement of such expenses.</p> <p>(2012)</p>
<p>1027.</p>	<p>That this Meeting notes the tough financial circumstances surrounding junior doctors and expresses regret that Royal Colleges have not seen fit to take sufficient account of these when substantially raising fees imposed on junior doctors for courses and examinations. It asks that Council ask the Colleges to encourage a fairer and more equitable approach in the future.</p> <p>(2012)</p>
<p>1028.</p>	<p>That this Meeting believes that there has recently been much confusion and disinformation regarding doctors' professional duties with regard to accepting and declining offers of employment including at least two incidences of junior doctors being reported to the GMC. We call upon the BMA to issue guidance to all junior doctors outlining the rights and duties with regard to accepting and declining offers of employment.</p> <p>(2010)</p>
<p>1029.</p>	<p>That this Meeting is concerned with the increasing number of vacant junior doctor posts.</p> <p>(2010)</p>

<p>1030.</p>	<p>That this Meeting believes that the contracts between postgraduate deaneries and employers for the training of junior doctors should include targets for training, based upon demonstrable evidence and include financial sanctions if these targets are not met. These targets should be informed by the relevant College/Faculty. These targets should be phased in, implemented with junior doctor input and this scheme reviewed regularly by a review group with JDC input and should cover all four administrations. (2009)</p>
<p>1031.</p>	<p>That this Meeting with regard to the proposals and conduct of the 2008 recruitment rounds believes that:</p> <ul style="list-style-type: none"> (i) there is a potential for 2008 to be worse for junior doctors than 2007; (ii) it is vital that the future recruitment process is adequately and appropriately planned well in advance to minimise disruption, which could jeopardise patient safety and fairness to doctors; (iii) sufficient time must be allocated to advertise posts and allow completion and submission of application forms, especially when applying to more than one region; (iv) the Criminal Records Bureau check is vital for patient safety and every effort must be made to prevent unnecessary duplication which leads to delays and is of no benefit to patients, doctors or employers. <p>(2008)</p>
<p>1032.</p>	<p>That this Meeting calls upon the BMA to investigate the effect of frequent and unpredictable relocation on the health, physical and social wellbeing of Junior Doctors. (2006)</p>
<p>1033.</p>	<p>That this Meeting believes that medical students should be consulted before future alterations to pay and working conditions for junior doctors are accepted. (2004)</p>
<p>1034.</p>	<p>That this Meeting deplores the fact that trusts are still ignoring re-banding protocols, and calls upon the postgraduate deans to hold such trusts accountable. (2004)</p>
<p>1035.</p>	<p>That this Meeting believes that the current practice by which junior doctors in some trusts can only gain access to emergency drugs and take home drugs for patients out of hours by visiting the pharmacy in person without an escort is:</p> <ul style="list-style-type: none"> (i) leaving them open to potential legal and disciplinary procedures and, in the case of PRHOs, contrary to established legal precedent; (ii) potentially harmful to patient care; (iii) not part of juniors' job descriptions, nor should it be. <p>(2001)</p>
<p>1036.</p>	<p>That this Meeting believes that SpRs in palliative medicine should have honorary NHS contracts whilst working in non-NHS units. (2001)</p>
<p>1037.</p>	<p>That this Meeting supports the retention of national terms and conditions of service for all hospital medical staff in training posts and opposes local pay bargaining for juniors. (1994)</p>
<p>1038.</p>	<p>That this Meeting insists that all hospital junior doctor appointments are regulated by the current agreed model contract which may, from time to time, be mutually renegotiated between the DHSS and the medical and dental profession. (1974)</p>

1039.	<p><u>Hospital accommodation</u></p> <p>That this Meeting calls upon the British Medical Association to preserve the right of F1 doctors to have access to free hospital accommodation if that is their wish. (2009)</p>
1040.	<p>That this Meeting believes that accommodation for medical students and junior doctors remains too expensive and is not up to standard. (2009)</p>
1041.	<p>That this Meeting is appalled that the Doctors' and Dentists' Review Body have failed to recommend a pay uplift to compensate Foundation year 1 doctors for the unilateral removal of free accommodation and:</p> <ul style="list-style-type: none"> (i) is disgusted that NHS Employers have refused to negotiate with the JDC on this matter; (ii) calls on the UK nations to re-introduce free F1 accommodation in time for August 2008, or make alternative arrangements to compensate juniors' via a suitable increase in monthly salary; (iii) recognises that a pay rise of £4,800 would be adequate compensation for the loss of accommodation, and considers failure to award such a pay rise or the reinstatement of accommodation unacceptable; (iv) mandates the BMA to enter into immediate negotiation with NHS Employers to either have a pay rise implemented or to have free accommodation reinstated by inclusion in the terms and conditions of service as originally envisaged by Joint Negotiating Committee (Juniors) (JNC(J)) in 2004; (v) supports the JDC in raising this with the Minister and further would, in light of a failure to negotiate a satisfactory agreement, support the relevant branches of practice to take what action they may deem necessary to publicise, protest and resolve the situation, and calls on the BMA to support financially any such action; (vi) recognises that the DDRB decision is the cause of a massive amount of anxiety and stress for the approx. 7000 final year students due to start their jobs in August 08, now faced with significant unexpected financial burdens and potential difficulty of sourcing their own accommodation, and mandates the BMA to recognise the urgency of this situation, to act as quickly as possible, and to provide any possible support and information to these students. <p>(2008)</p>
1042.	<p>That this Meeting believes that it is scandalous that doctors are still expected to live in substandard accommodation with poor catering facilities and that, given the recent advice of the Advocate General to the European Court of Justice:</p> <ul style="list-style-type: none"> (i) the BMA should ask the Departments of Health to instruct trusts to provide New Deal compliant sleeping accommodation for all doctors working at night; (ii) doctors should contact their local authority health and safety advisers when confronted with substandard accommodation; (iii) the BMA deplores the continuing practice of charging rent for such accommodation contrary to national guidance. <p>(2003)</p>
1043.	<p>That this Meeting deplores the use of waivers by trusts in order to deny junior doctors their rightful pay or suitable standards of accommodation. It calls on the JDC to name and shame such trusts publicly and do all it can to ensure all junior doctors are made aware of their rights. (2003)</p>
1044.	<p>This Meeting reaffirms that all junior doctors' accommodation (whether compulsory or not) should be subject to the agreed standards and inspection, monitoring and enforcement mechanisms, and rejects the attempts by the Department of Health to withdraw from the</p>

	agreements as discriminatory, family unfriendly and raises significant concern over the good faith with which the Departments of Health enter into such negotiations. (2002)
1045.	That this Meeting believes that: (i) hospital accommodation for medical staff not meeting the minimum accommodation standards of 'Improving Working Lives' should be vacated immediately and the occupants rehoused until appropriate upgrading measures are taken; (ii) doctors who make complaints about inadequate hospital accommodation and highlight that hospital facilities are below that fit for human habitation, should not be victimised by colleagues or trust management. (2001)
1046.	That this Meeting insists that adequate facilities including clean linen, towels and suitable food are provided for hospital doctors on call. (2001)
1047.	That this Meeting is concerned at the quality of accommodation for junior doctors and medical students in hospital and calls upon the BMA to campaign to: (i) accelerate implementation of the minimum standards of accommodation for junior doctors laid down in the New Deal; and (ii) ensure that these minimum standards of accommodation also apply to medical students. (1992)
1048.	That this Meeting believes that pressures to pursue foundation trust status may encourage hospitals to manipulate hours monitoring processes for junior doctors. By such actions morale, health and safety of staff may be put at risk and patient care compromised. (2009)
1049.	That this Meeting believes that many current rota patterns impede the ability of junior doctors to take their annual leave. We call upon the Board of Science to investigate different rota patterns, their use in other 24/7 services and in other countries. In particular we call for investigation of the use of "floating doctors" and the impact of rotas on junior doctors quality of life and training. (2009)
1050.	That this Meeting believes juniors should not be bullied into altering the documentation of hours declared worked to ensure rota compliance during rota monitoring audits. (2007)
1051.	That this Meeting deplores the continuing bullying and harassment that doctors are being subjected to surrounding hours monitoring exercises and call on the BMA actively to investigate any episode brought to their attention and to pursue further action where necessary. (2004)
1052.	That this Meeting believes that junior doctors should not be bullied into working excess hours (beyond their contractual banding) simply to fit in with their consultants' working patterns and trust managers' targets. (2003)
1053.	That this Meeting calls on the royal colleges and postgraduate deans to ensure that all junior doctors have protected teaching time included within their working week across all types of work pattern including those compliant with the New Deal and the EWTD. (2003)

<p>1054.</p>	<p>That this Meeting reiterates its support for nationally agreed banding and monitoring procedures and:</p> <ul style="list-style-type: none"> (i) condemns deaneries and trusts which try to deviate from the procedures; and (ii) calls on the BMA to support ever more vigorously doctors who are victims of these illegal and discriminatory practices. <p>(2002)</p>
<p>1055.</p>	<p>That this Meeting regrets the massive expansion of non-standard posts, whilst recognising that some of these posts actually provide a valuable education and may be helping in the reduction of junior doctors' hours.</p> <p>(2002)</p>
<p>1056.</p>	<p>That this Meeting believes that doctors work best during daytime hours Monday to Friday and that all routine work should be scheduled for these times.</p> <p>(2001)</p>
<p>1057.</p>	<p>That the BMA should actively and vigorously encourage purchasers to include compliance with all aspects of the New Deal when setting service specifications in contracts.</p> <p>(1995)</p>
<p>1058.</p>	<p><u>Training</u></p> <p>That this meeting notes that trainees who move between different deaneries face problems in continuity of benefits like maternity allowances and childcare vouchers.</p> <p>(2019)</p>
<p>1059.</p>	<p>That this meeting believes that all trainees appointed to a training programme should have a single lead employer for the whole of the programme, so that their continued service is recognised with the protections thereby afforded including, but not limited to:</p> <ul style="list-style-type: none"> i) whistle blowing; ii) travel expenses; iii) parental leave; iv) negating the need for repeated DBS checks; v) employer taking full responsibility for ensuring legal working hours across changeover between posts. <p>(2016)</p>
<p>1060.</p>	<p>That this Meeting is angered by the recent announcement of increases in fees for training, and is particularly amazed at the 22% increase in fees for registration with the Joint Royal Colleges of Physicians Training Board. We call upon all organisations that charge fees to trainees to:</p> <ul style="list-style-type: none"> (i) publish their full accounts in an easily accessible manner on their websites; (ii) develop and publish mechanisms for maintaining strict cost controls in this time of national austerity; (iii) include clear trainee representation in mechanisms for controlling costs; (iv) limit all increases in fees to no more than the level of the annual increase in pay recommended by the DDRB. <p>We mandate the BMA Junior Doctors Committee to work with the Royal Colleges and other organisations to implement these recommendations.</p> <p>(2010)</p>
<p>1061.</p>	<p>That this Meeting believes junior doctors should be given adequate notice, that is at least three months, of any change in post required for their training rotations.</p> <p>(2010)</p>

<p>1062.</p>	<p>That this Meeting calls upon the MSC and JDC to lobby employers to request that if the induction and orientation programme for F1 year begins before employment officially starts, that appropriate remuneration is given. This would ensure consistency across the country and would ensure patient safety is maintained during the first week of August. (2009)</p>
<p>1063.</p>	<p>That this Meeting believes that future application processes for medical training posts must:</p> <ul style="list-style-type: none"> (i) have the consensus support of the medical profession; (ii) allow applicants to apply for posts based on smaller geographical areas; (iii) allow reasonable opportunities for families to remain in the same geographical area; (iv) assess the application as a whole and not in disjointed segments; (iv) be based on objective and standardised criteria; (v) recognise specialty specific training needs; (vi) allow applicants to apply for a greater number of options; (vii) have defined rotations and job plans which can be applied for individually as places become available; (ix) allow recognition of all achievements and experience. <p>(2007)</p>
<p>1064.</p>	<p>That this Meeting is outraged by the recent announcement that there will be far fewer specialty training posts in 2007 than there are doctors eligible for them and:</p> <ul style="list-style-type: none"> (i) believes that many doctors will choose to leave UK training rather than be forced into a sub-consultant grade; (ii) believes that this is incompatible with a consultant delivered service; (iii) calls upon government to delay the implementation of the run through grade until enough posts are confirmed; (iv) mandates the JDC to take all necessary action to ensure that sufficient training program posts are provided. <p>(2006)</p>
<p>1065.</p>	<p>That this Meeting believes that junior doctors should not be coerced into changing hours monitoring information in order to achieve New Deal compliance or face disciplinary action if they breach New Deal regulations due to clinical needs and calls on the BMA to continue to inform junior doctors about their rights and calls on the NHS Counter Fraud Agency (CFSMA) to investigate and act upon any instances brought to their attention. (2005)</p>
<p>1066.</p>	<p>That this Meeting opposes any move to reduce the standing of the UK CCST, and the introduction of a sub-consultant grade, by the backdoor route of post-CCST specialist training following a shortened period of specialist training. (2002)</p>
<p>1067.</p>	<p>That this Meeting rejects any proposal to create a new and separate junior non-career “service” grade and calls on the BMA to oppose any revamp of the SHO grade which includes a period of service without training as this would be a distraction from the essential principle of medical care being delivered by fully trained doctors. (2001)</p>
<p>1068.</p>	<p>That this Meeting believes that the NHS needs more consultants and calls on the BMA to oppose any moves to develop a junior doctor service grade instead. (2001)</p>
<p>1069.</p>	<p>That postgraduate deans should withdraw training approval from posts that continually fail to comply with the New Deal.</p>

	(2000)
1070.	<p>That the postgraduate deans should be responsible for establishing consultant trainers, as in general practice, and that:</p> <ul style="list-style-type: none"> (i) the consultant trainers should be appropriately trained in education and appraisal; and (ii) consultant trainers should be remunerated for this additional responsibility; (iii) consultants who are not trainers should have less access to juniors' time. <p>(2000)</p>
1071.	<p><u>Working conditions</u></p> <p>That this meeting recognises the negative impact on junior doctor wellbeing when timely annual leave requests are not accommodated by employers and deplores that junior doctors are expected to find their own cover. We therefore call upon the BMA to lobby for contractual change on this basis.</p> <p>(2019)</p>
1072.	<p>That this Meeting notes that NHS Employers have unilaterally published a model contract for new doctors undertaking shadowing for FY1 posts and regrets that this deviates from the Workforce Availability Policy and Programme Implementation Group (WAPPIG) and Health Education England (HEE) guidance for shadowing and has not been negotiated with the BMA. This sets an unacceptable precedent and therefore this Meeting calls for:-</p> <ul style="list-style-type: none"> i) an urgent meeting between the BMA and NHS Employers to address this problem; ii) the immediate withdrawal of this model contract; iii) any negotiated solution to meet the WAPPIG and HEE requirements as a minimum. <p>(2013)</p>
1073.	<p>That this Meeting notes that increasing numbers of trusts/hospitals are seeking PFI new builds: as a result many new builds have been designed in short sightedness without the adequate provision of mess facilities and on-call/rest rooms: and</p> <ul style="list-style-type: none"> i) urges all trusts/hospital to reconsider their short sighted behaviour and ensure that adequate facilities are put in place to promote safe working conditions; ii) calls on the BMA to include the provision of mess facilities in any future amendments to the junior doctors contract; iii) calls upon the BMA to update and promote its guidance on minimum requirements in accordance with HSC1998/240. <p>(2013)</p>
1074.	<p>That this Meeting is deeply worried by the changes that have occurred in the UK medical workforce over the last 12 months and in particular we note with dismay the increasing number of vacant slots that are seen on rotas around the UK:</p> <ul style="list-style-type: none"> (i) we call upon BMA to ensure that any trainees who are working on short staffed rotas: <ul style="list-style-type: none"> (a) are aware of their contractual rights; (b) are not pressured to provide inappropriate or unsafe cover; (c) have the quality of their training maintained; (d) are appropriately financially recompensed for any additional work they undertake; (ii) we believe that if a short staffed rota cannot be made safe for patient care then an urgent local review of how, and what, patient care is delivered should occur and that this may have to include cuts to services. <p>(2008)</p>
1075.	<p>That this Meeting deplores the trend to remove rest rooms from on call staff in hospitals. We believe that such action is not compatible with the provision of an effective service or patient safety and call on the BMA to press for action where this facility is not provided.</p> <p>(2005)</p>

1076.	<p>That, this Meeting calls on the government and the Departments of Health to:</p> <ul style="list-style-type: none"> (i) recognise publicly that all doctors unfit to drive home after a period of prolonged duty, must also have been unfit to treat patients towards the end of that duty; (ii) put in place procedures and mechanisms to ensure patients are not put at risk by over tired doctors; (iii) provide appropriate resting facilities for doctors to use at the end of their duty and to ensure these facilities meet the minimum Improving Working Lives guidelines; (iv) ensure arrangements are in place for doctors to travel home in safety after any intense duty period; (v) enforce all aspects of the New Deal for junior doctors, and the European Working Time Directive for all doctors, to ensure all break and rest requirements are available for doctors. <p>(2002)</p>
	MEDICAL ACADEMIC STAFF
1077.	<p>That this meeting commends the clinical academics who stepped up their clinical duties to help support the fight against Covid19. In particular, it commends and supports the committee's efforts to:-</p> <ul style="list-style-type: none"> i) recognises the additional mental health strain experienced by clinical academics during the pandemic; ii) ensure that clinical academics are fully supported by their institutions; iii) highlight additional research support and time requirements for clinical academics resuming PhD studies; <p>ensure that clinical academics receive appropriate wellbeing support from their institutions.</p> <p>(2021)</p>
1078.	<p>That this meeting notes with concern the decrease in academic doctor numbers and asks for any workforce strategy to consider the positive contribution of academic medicine to the UK.</p> <p>(2019)</p>
1079.	<p>That this meeting recognises the particular challenges of medical academic work and calls on employers to:-</p> <ul style="list-style-type: none"> i) ensure that all medical academics should have Follet compliant annual appraisal; ii) ensure all medical academics have a minimum of 1.5 SPAs. <p>(2018)</p>
1080.	<p>That this meeting notes the planned expansion of UK medical student numbers and calls upon both the BMA and GMC to ensure, as prerequisites for this expansion, the concomitant essential increase in the number of medical academic posts, SPAs for consultants and also funding for general practice which reflects the costs practices incur by providing teaching sessions.</p> <p>(2018)</p>
1081.	<p>That this meeting calls on the BMA to lobby HEE in order to recognise that academic research, whether it be undertaking an MD or a PhD, is a valid reason and a right to defer the start of a training program either at core training or specialty training level.</p> <p>(2016)</p>
1082.	<p>That this meeting has serious concerns about the threat of redundancies being imposed on medical academics in the UK, and the negative consequences for the quality of teaching and</p>

	<p>research in medical schools. We call on all UK governments to provide a long-term and sustainable funding solution for all UK medical schools.</p> <p>(2015)</p>
1083.	<p>That this meeting notes with considerable regret the proposed changes to the USS pension scheme for the future of clinical academia, with its particularly negative impact on clinical academics' terms and conditions compared to the NHS. This meeting further notes the unintended consequence that the NHS will gain in the short-term as clinical academics leave academia to return to NHS service posts. This meeting asks that clinical academics should continue to be able to remain in the NHS pension scheme, and that staff should be able to transfer between the two scheme with no loss of benefits at any stage in their career and posts.</p> <p>(2015)</p>
1084.	<p>That this Meeting calls on the BMA to ensure a satisfactory resolution to the current issue of the organisation that should hold the honorary contracts of academic doctors working in public health. Future contracts whether held by Public Health England or another body should offer public health academics the same terms and conditions as currently prevail in the NHS.</p> <p>(2013)</p>
1085.	<p>That this Meeting welcomes the establishment of the Health Research Authority (HRA) as a special health authority on 1 December 2011 and expresses the hope that the HRA will act as a national facilitator for appropriate and ethical participation in research by volunteers, patients and doctors.</p> <p>(2012)</p>
1086.	<p>That this Meeting notes the hard work that continues to be done in representing academics on the front line by academic representatives on Local Negotiating Committees (LNCs), and calls on the BMA to build on the guidance issued by MASC by:-</p> <ul style="list-style-type: none"> (i) bringing together academic members of LNCs locally and nationally; and (ii) establishing a dedicated internet-based forum set up to support representatives; (iii) working towards establishing LNCs for every medical school in the UK; (iv) working closely with UCU and UNITE to ensure that all medical academics are supported by an LNC. <p>(2012)</p>
1087.	<p>That this Meeting notes that the number of medical students in the UK has increased significantly over the last 15 years whilst the number of clinical academics employed by medical schools has halved over the same period. This Meeting believes that this has deprived students of leadership and mentorship and of research and educational role models in many specialist areas of medicine. This Meeting calls upon the BMA to:-</p> <ul style="list-style-type: none"> i) work with the General Medical Council to ensure that medical students are fully supported by appropriate clinical academic staff numbers in their undergraduate education; and ii) commence a workforce planning exercise to define 'appropriate clinical academic staff numbers' for the current number of medical students. <p>(2011)</p>
1088.	<p>That this Meeting notes in the current financial situation there is pressure on the Health Departments to reduce funding for academic medicine posts. This Meeting calls on the BMA to lobby for funding to be maintained and ring-fenced for academic medicine posts.</p> <p>(2010)</p>

1089.	That this Meeting recognises the barriers for women academics in career progression as described in the Women in Academic Medicine Report. It calls on the BMA to: <ul style="list-style-type: none"> (i) support and take forwards the recommendations in the report; (ii) regularly monitor progress against European standards. (2008)
1090.	That this Meeting notes the rise to prominence of non-clinical educators within medical schools and believes that practising clinicians must remain at the heart of the planning and delivery of medical education. (2008)
1091.	That this Meeting believes that for the integrated academic training pathway to be a success and comply with Follett principles, joint working between medical schools, postgraduate deaneries and trusts must take place; and calls for the establishment of joint committees comprising representatives from university and NHS employers and postgraduate deaneries whose responsibility it is to jointly oversee academic training programmes in their locality. (2008)
1092.	That this Meeting: <ul style="list-style-type: none"> (i) notes that the BMA has identified pay differences between female and male academics after allowance has been made for age, skills and seniority; (ii) is aware that the proportion of women in medical academic posts is low and notes that fewer than 10% of medical professors are women; (iii) is concerned that there is a lack of opportunity for women doctors to return to university posts after a career break and therefore demands that the BMA corrects this insidious gender discrimination by lobbying the government to implement the recommendation of the European Commission's Science Committee that women should comprise at least 40% of clinical academic staff. (2007)
1093.	That this Meeting demands that clinical research is given equal status as compared to basic science research and this should be reflected in the RAE 2008 or its future equivalent. (2007)
1094.	That this Meeting requests the MASC to monitor carefully changes to the NHS and USS pension schemes to ensure that doctors transferring from either sector are not disadvantaged. (2007)
1095.	That this Meeting believes in the principle of formal BMA trade union recognition in medical schools and all other academic institutions employing medically-qualified staff and: <ul style="list-style-type: none"> (i) considers that where this is achievable, it should be implemented as soon as practicable; (ii) supports the position adopted by the MASC Executive, that where formal recognition cannot be achieved immediately, agreeing a memorandum of understanding with the employing organisation is a reasonable alternative in the first instance, until full recognition is achieved. (2006)
1096.	That this Meeting believes that any consultant job plan (new or review) for clinical academics should ensure that adequate supporting professional activities are allocated, and that external duties are acknowledged as being separate from study or professional leave. (2006)
1097.	That this Meeting deplores the lack of a defined career pathway and a proper remuneration structure for doctors in academic medicine, and calls upon the government to correct this imbalance.

	(2006)
1098.	That this Meeting supports a target of at least 40% of women in senior academic medical posts and Heads of Department in medical schools, as per the EU the Women in Science programme standards. (2005)
1099.	That this Meeting believes that the new shift system in junior doctors working times has taken no account of medical student's educational needs and that medical schools need to consider staff rotas when planning teaching sessions, assessments and organising tutor groups. (2004)
1100.	That this Meeting rejects attempts to separate teaching institutions from research institutions because the highest quality medical teaching involves contributions from medical researchers and scientists, clinicians, and medical educationists. (2003)
1101.	That this Meeting believes that any appraisal mechanism implemented for medical academic staff should be: (i) based on the agreed scheme for NHS consultants; (ii) an integrated university and NHS exercise involving appraisers from both sectors in a single process. (2001)
1102.	That the difficulties of the present state of academic recruitment is to the detriment of the provision of high quality education for the increased numbers of doctors in training. (2000)
1103.	That this Meeting believes that joint appraisal between university and NHS of clinical academic staff is the appropriate way for achieving balanced work programmes. (2000)
1104.	That this Meeting deplores the loss of benefits when medical staff move from NHS employment to universities or colleges, should ask the MASC to exert all pressures on the employers to honour NHS service (and other medical service) and thus overcome this disincentive to medical academic employment. (1999)
1105.	That this Meeting believes that all universities employing medically qualified staff should recognise the BMA and BDA as the most appropriate organisations to look after the interests of their members in the workplace, and should grant full recognition to both associations. (1999)
1106.	That this Meeting calls on the universities to recognise fully the role of teaching in the education of undergraduates and postgraduates and not to promote research at the expense of teaching. (1998)
1107.	That this Meeting condemns the replacement of clinical academic posts with non-clinical posts which is a serious threat to future medical education and research. (1995)

<p>1108.</p>	<p>That this Meeting believes that in order for the public to be cared for by well educated and trained professionals:</p> <ul style="list-style-type: none"> (i) initial training of health and community care professionals should receive enhanced funding to make up for the losses sustained in recent years; (ii) postgraduate and continuing education should be restructured on a more formal and organised basis, with adequate funds provided; (iii) undergraduate, postgraduate and continuing education should be funded centrally and remain independent of and separate from monies for service provision; (iv) both undergraduate and postgraduate educators and trainers should receive appropriate training for these tasks and remuneration consistent with achieving optimum motivation and morale. <p>(1992)</p>
<p>1109.</p>	<p>That medical training requires adequate resources:</p> <ul style="list-style-type: none"> (i) to ensure a priority for postgraduate clinical education over management training; (ii) to recognise the training commitment of consultants and the consequent need for expansion of their numbers; (iii) to "train the trainers"; (iv) to allow protected time for study leave; (v) to guarantee adequate remuneration for GP tutors and course organisers; (vi) to enable GPs to pursue continuing medical education. <p>(1992)</p>
<p>1110.</p>	<p>That this Meeting believes that medical teachers should be taught to teach.</p> <p>(1984)</p>
<p>MEDICAL EDUCATION AND TRAINING</p>	
<p>1111.</p>	<p>That this meeting notes the unjust discrepancy in the title of certificate issued to two groups of doctors at the end of their training for them to enter the specialist register. While trainees are issued with CCT, self-directed trainees and SAS doctors who demonstrate all the competencies of the curriculum are issued with CESR. We believe that all doctors who successfully achieved all the competencies required for entry into the specialist register should be awarded the same certificate. Doctors who successfully achieved CESR would have already demonstrated their competency through meeting the training requirements in their specialty. Hence, they should be awarded the same certificate as their counterparts. We urge the BMA to campaign with the GMC, Health Education England and its devolved equivalents and the Royal Colleges to:-</p> <ul style="list-style-type: none"> i) abolish this two-tier system; ii) issue CCT for all doctors whose applications of entry into the specialist register are successful, regardless of their training pathway. <p>(2021)</p>
<p>1112.</p>	<p>That this meeting requires the BMA to lobby the Department for Education to develop in partnership with the BMA a self-care curriculum to be taught in state schools enabling the discovery of principles of care for oneself and others during periods of illness.</p> <p>(2018)</p>
<p>1113.</p>	<p>That this meeting is disappointed that surgical trainees find themselves struggling to gain their competencies due to service demands and asks the BMA to lobby appropriate bodies to create 'protected training time' which can be used at the trainees discretion as agreed with their educational supervisor to best benefit their training.</p> <p>(2018)</p>

1114.	That this meeting insists decisions regarding the allocation of study leave in hospitals should be made by clinicians and not non-clinical managers. (2018)
1115.	That this meeting recognises the value of high quality training. This meeting therefore calls upon the BMA to lobby relevant bodies:- i) to agree formal incentives and rewards for excellence in trainer practice and ; ii) for appropriate protected educational time in work plans for both trainers and trainees. (2018)
1116.	That this meeting is concerned about the funding cuts that HEE is being forced to make and demands:- i) the UK government address this immediately instead of passing the buck to arm's length bodies; ii) that HEE guarantees the support for trainees, trainers, educators and clinical/educational supervisors is increased in these testing times. (2017)
1117.	That this meeting insists that there should be nationwide protection for doctors undertaking the hospital component of GP training to ensure that all training posts provide the necessary training which will be required in general practice and are not simply used to fill gaps in secondary care rotas. (2017)
1118.	That this meeting calls on health organisations training physician associates or similar non-medical staff to:- i) make sure that learning outcomes are clear to trainers and supervisors; ii) make sure that patients do not mistake such students as doctors in training; iii) plan sufficiently to ensure that such clinical placements do not affect medical student teaching adversely. (2017)
1119.	That this meeting calls on all undergraduate Deans to ensure all medical students are trained in ways to assess pain in patients of all ages, including those with learning or communication difficulties. (2016)
1120.	That this meeting calls on medical schools to promote the value of diversity in training placements and experiences, and to encourage placements in the community and hospitals in both urban and rural settings. (2016)
1121.	That this meeting demands that the structure and politics of the NHS be included in undergraduate and postgraduate education. (2016)
1122.	That this meeting believes that trainees must be put at the heart of training, which must be of high standards, subjected to rigorous quality assurance, underpinned by academic values and promote leadership, flexible working and a healthy work-life balance. We support the following principles in any implementation of changes to medical training:- i) the fundamental aim is the delivery of patient care that is safe and of high quality; ii) the BMA should be included in the Shape of Training steering groups as the Representative Body of the medical profession; iii) the endpoint of training must remain at the current high standard of the UK CCT producing doctors capable of expert, unsupervised, independent practice in the NHS;

	<p>iv) there must be no introduction of a subconsultant grade either formally or by default;</p> <p>v) any moves to promote 'generalism' are not compatible with reduced length of training;</p> <p>vi) the current proposals to move full registration to the point of graduation are unacceptable;</p> <p>vii) graduate entry programmes must be explicitly protected;</p> <p>viii) Public Health Medicine must remain a medical specialty.</p> <p>(2015)</p>
1123.	<p>That this meeting recognises the increasing proportion of foundation year 2 doctors who are not progressing directly into specialty training in the UK. Whilst recognising the value of alternative career pathways for a proportion of trainees, this meeting highlights the problem this poses for workforce planning. We call on the BMA to work with appropriate bodies to:-</p> <p>i) investigate the underlying reasons for this rapidly accelerating trend, by surveying all foundation year 2 doctors who opt out of progressing directly into specialty training;</p> <p>ii) act on the findings of this investigation to better support the career decisions of foundation programme doctors, to ensure that those wishing to access specialty training posts are able to do so;</p> <p>iii) support those who pursue alternative career pathways after foundation training should they wish to return to specialty training.</p> <p>(2015)</p>
1124.	<p>That this meeting recognises the health inequalities faced by transgender patients and calls upon the BMA to:-</p> <p>i) lobby the Medical Schools Council and Royal Colleges to ensure that trans awareness is part of both undergraduate and postgraduate training;</p> <p>ii) organise Continuing Professional Development training events in collaboration with relevant external organisations such as trans health advocacy charities/NGOs.</p> <p>(2015)</p>
1125.	<p>That this meeting recognises that foundation programme oversubscription may prevent UK graduate international medical students from entering foundation programme training. We call on the BMA to:-</p> <p>i) lobby the UKFPO to ensure the fair treatment of all UK medical graduates in applying to foundation programmes;</p> <p>ii) monitor the recruitment process and identify instances of unfair exclusion.</p> <p>(2015)</p>
1126.	<p>That this Meeting is concerned that there is a wide variation of academic foundation programmes across the UK, both in terms of content and time dedicated to academia and therefore proposes that:-</p> <p>i) academic foundation programmes should become more equal and comparable in terms of content and protected time for academic work whilst ensuring that clinical competencies are met by all trainees;</p> <p>ii) clarity should be provided by deaneries to potential academic foundation trainees as to how much protected time they will have within their proposed programmes;</p> <p>iii) if wide variation remains then the interview process should allow for recognition of what the candidate achieved in the protected time available to them;</p> <p>iv) programmes which offer no difference to non academic programmes should no longer be advertised as such.</p> <p>(2014)</p>

1127.	<p>That this Meeting believes that the proposals outlined in the Greenaway Shape of Training Report, with shortened training and a CST:-</p> <ul style="list-style-type: none"> i) will not produce consultants with the level of training required by patients, the profession or services; ii) are not fit for purpose. <p>(2014)</p>
1128.	<p>That this Meeting notes with concern the ever-increasing cost of training and professional development which may include fees for essential courses as well as examinations. We call upon the BMA:-</p> <ul style="list-style-type: none"> i) to continue to lobby faculties, Royal Colleges and education providers to reduce the costs of examination, assessment and essential courses; ii) to lobby employers to recognise the cost of essential courses when allocating study leave budgets; iii) to seek a consistent ruling from HMRC that the cost of essential educational courses, assessments and examinations will be considered for tax purposes as essential professional expenses. <p>(2014)</p>
1129.	<p>That this Meeting deplores the proposal by the Shape of Training Review to give full registration to junior doctors at completion of their medical school studies and before they have worked in a supervised capacity managing patients and believes:-</p> <ul style="list-style-type: none"> i) this may put the public at risk as such qualified doctors will not have the necessary supervised training which allows them to practice safely; ii) this will risk damaging the well-being and career of these young doctors; iii) this policy will prejudice the ability of home grown graduates to work in the NHS which has trained them, as they will be competing for posts with doctors from overseas. iv) the financial risk of possible non-entry to the foundation programme will reduce the socio-economic diversity of applicants to medical school. <p>(2014)</p>
1130.	<p>That this Meeting:-</p> <ul style="list-style-type: none"> i) is concerned that the implementation of Working Time Regulations 1998 has negatively impacted on surgical training and experience; ii) is concerned about the increasing number of surgical trainees undertaking post-CCT fellowship to prepare for consultant appointment; iii) urgently calls upon the GMC, BMA, Surgical Royal Colleges, Joint Committee on Surgical Training and Surgical Specialty Associations to determine whether the length of the current CCT training programme is fit for purpose in preparing a trainee for appointment as a NHS consultant surgeon. <p>(2014)</p>
1131.	<p>That this Meeting believes junior doctors should be involved in discussions that affect their future careers from the outset. We therefore call on the BMA to lobby relevant stakeholders:</p> <ul style="list-style-type: none"> i) for a meaningful seat on groups discussing implementation of the Shape of Training Review; ii) to ensure there is no implementation of any elements of the Shape of Training Review without full and open consultation; iii) to ensure explicit and robust transition arrangements for current trainees are specified should any part of the Shape of Training Review be implemented. <p>(2014)</p>
1132.	<p>That this Meeting believes generalist & specialist knowledge and skills can & should co-exist in the same doctor, and we:-</p>

	<ul style="list-style-type: none"> i) believe the solution to the problems of the acute take is not to create a new cadre of generalist-only doctors, but to better equip doctors in specialty training with more generalist training; ii) call on the Shape of Training review to avoid recommending a separation of generalist & specialist training; iii) call on the Royal Colleges to consider extending training programmes to allow more generalist experience to be gained in the setting of a regulated, funded training programme rather than outside training. <p>(2013)</p>
1133.	<p>That this Meeting is deeply concerned over the direction being taken by the Shape of Training Review and calls on the BMA to continue to:-</p> <ul style="list-style-type: none"> i) uphold the CCT as the internationally recognised end point of training and a CCT/CESR/CEGPR remaining as the only requirement for a consultant or GP post; ii) vigorously oppose any move to introduce a CCT-level (or equivalent) sub-consultant grade. <p>(2013)</p>
1134.	<p>That this Meeting recognises that less than full time (LTFT) training is becoming increasingly important for growing numbers of doctors and graduate medical students in the profession. LTFT trainees may need additional support to be able to represent themselves and engage with BMA activities. This Meeting therefore calls on the BMA to:-</p> <ul style="list-style-type: none"> i) lobby deaneries to uphold agreements to fund flexible trainees for the duration of their training, and not to withdraw or threaten to withdraw funding part way through. <p>(2013)</p>
1135.	<p>That this Meeting notes the differential pass rates of black and minority ethnic candidates when undertaking postgraduate exams and:-</p> <ul style="list-style-type: none"> i) calls upon all organisations and bodies offering postgraduate exams to publish an analysis of their examination rates based on characteristics protected under the Equalities Act 2010 and any other relevant legislation; ii) calls upon the BMA to work with organisations and bodies offering postgraduate exams to develop solutions to ensure that these examinations do not unfairly discriminate between candidates; iii) congratulates those organisations that are already publishing such information. <p>(2013)</p>
1136.	<p>That this Meeting believes that the proposals within “Developing the Healthcare Workforce” threaten consistent high quality medical education and coherent workforce planning across the UK, and:-</p> <ul style="list-style-type: none"> i) notes that medical education is not organised in the same way as that of other healthcare professionals; ii) demands the retention of postgraduate deaneries in the absence of clear and acceptable provision for how and by whom their vital functions otherwise would be carried out; iii) believes that it is inappropriate for medical workforce planning to be undertaken at a local level; iv) believes specialty recruitment should remain led at a regional, national or UK level, depending on specialty size; v) calls on the government to rethink its proposals and to work with the profession to develop an effective, affordable and responsive system for educating and training the doctors that the UK needs. <p>(2011)</p>

<p>1137.</p>	<p>That this Meeting believes that the high standard of the CCT, CESR, CESR (CP), and CEGPR is worth protecting and:-</p> <ul style="list-style-type: none"> i) the standard should recognise the level of experience needed to undertake the duties of a consultant or GP; ii) assertions made that changes to junior doctors' training and working hours are leading to a fall in the standard of the CCT are currently unsubstantiated; iii) if training is deficient, then this must be addressed before specialist registration is awarded, which may require an extension to training; iv) instructs the BMA to work with the GMC, Royal Colleges and Deans to ensure that there is adequate evidence for the duration and quality of those curricula of programmes which lead to specialist registration. <p>NOTE: CCT – Certificate of Completion of training; CESR - Certificate of Equivalence for Specialist Registration; CEGPR - Certificate of Equivalence for General Practice Registration; CESR (CP) - Certificate of Equivalence for Specialist Registration (Combined Programme). (2011)</p>
<p>1138.</p>	<p>That this Meeting notes with concern the 'any qualified provider' proposals and the possible negative impact these may have on medical education and research and:-</p> <ul style="list-style-type: none"> i) calls on the UK government to require new providers of NHS services to at least match the facilities available in the current providers of NHS services for medical education and research; ii) calls for a consistent programme of postgraduate medical education to maintain high standards of training nationally. <p>(2011)</p>
<p>1139.</p>	<p>That this Meeting:-</p> <ul style="list-style-type: none"> i) notes the current problems with the UK Foundation Programme Office (UKFPO) application system, and the proposed changes – which are set to include an Educational Performance Measure and Situational Judgement Tests; ii) is unsettled by the lack of research and discussion of how valid these tools are with respect to performance as a junior doctor; for instance, as assessed by metrics such as Royal College membership exam scores or '360 degree' feedback from team members; iii) therefore mandates the Medical Students Committee to work with the UKFPO to ensure that such research is thoroughly performed based on the post-qualification performance of those who sit pilot tests, so that medical students and the UKFPO alike can take an evidence-based position on the value of these proposed changes; iv) recognises the importance of pilots running at medical schools in 2011 and 2012 and urges the BMA MSC to actively encourage all medical students to partake in these pilots. <p>(2011)</p>
<p>1140.</p>	<p>That this Meeting recognises that Directors of Medical Education are key players in ensuring the quality of delivery of medical education and calls upon the BMA, Colleges, and the Department of Health to do more to forge links with them and to support them in this work. (2011)</p>
<p>1141.</p>	<p>That this Meeting believes that education and training of doctors must be configured to reflect new patterns of care. (2011)</p>
<p>1142.</p>	<p>That this Meeting believes that every new graduate from a UK medical school should be guaranteed access to F1 posts that ensure their full medical registration can be achieved and the public investment in their medical training is protected and calls on the BMA to work with</p>

	<p>the relevant stakeholders on the required workforce planning and recognises that this may necessitate a reduction in medical student numbers. (2011)</p>
1143.	<p>That this Meeting is dismayed that the lack of communication between the UKFPO and foundation schools resulting in delays between the official results and foundation schools job allocations. Furthermore, the official results were released at a time of night when students were unable to seek guidance. This Meeting therefore calls on the MSC to lobby the UKFPO to:-</p> <ul style="list-style-type: none"> i) ensure job allocation information is released at 9am on a weekday, enabling all students immediate access to support if required; ii) ensure that students are unable to determine the outcome of their application prior to official release of results. <p>(2011)</p>
1144.	<p>That this Meeting calls on the government to retain control of workforce planning and development centrally to prevent unacceptable regional variations in training quality, the output of training and workforce availability. (2011 Special Representative Meeting)</p>
1145.	<p>That this Meeting believes that foundation training is not delivering the broad based experience originally planned, and that the historic imbalances in the distribution of posts must be corrected to ensure the quality of future doctors. (2010)</p>
1146.	<p>That this Meeting condemns the actions of some employers to cut all study leave funding for all of their doctors in a futile attempt to save money, and believes that this places the future quality of care of those employers' patients in jeopardy and calls for all approved study leave to be funded as per terms of service. (2010)</p>
1147.	<p>That this Meeting requests that the Royal Colleges remove any barriers which make it difficult for those who wish to change direction during specialist training. (2009)</p>
1148.	<p>That this Meeting believes that market pressures in the NHS are threatening the clinical and financial resources required for postgraduate medical training and continuing professional development. This will impact on the quality of care for patients and we call:</p> <ul style="list-style-type: none"> (i) on Health Departments to take action to ensure that these resources are made available; (ii) for an analysis of training and continuing professional development between foundation and non-foundation trusts. <p>(2009)</p>
1149.	<p>That this Meeting believes that less than full time (LTFT) training offers opportunities to reach a better work-life balance and:</p> <ul style="list-style-type: none"> (i) calls for the Royal Colleges actively to promote the option of LTFT training to trainees; (ii) demands that deaneries improve their published information on LTFT training; (iii) insists that employers include details of access to LTFT training in all job adverts. <p>(2009)</p>
1150.	<p>That this Meeting would welcome a major review and simplification of the e-portfolio to ensure it better meets the needs of trainees, trainers and patients. (2009)</p>

1151.	That this Meeting believes trainees should be able, in conjunction with educational supervisors, to best determine their training needs. We call for the BMA to lobby the postgraduate deaneries to provide FY1 and FY2 doctors with time and funding to address their individual and educational needs, in addition to any mandatory in-house training. (2009)
1152.	That this Meeting believes that advanced communication skills training must be made available for all doctors. (2009)
1153.	That this Meeting believes that any changes to the Foundation Programme should be made only where these can be demonstrated to improve the quality of training and that any changes should be implemented only after full research, consultation, piloting and agreement between the key stakeholders. (2009)
1154.	That this Meeting: (i) recognises the importance of broad based training and the necessity to have an adaptable workforce for the future and therefore supports the principles behind a two year generic foundation programme as the first stage of postgraduate medical training; (ii) believes that every foundation programme should include experience of working in the hospital at night, and out of hours experience; (iii) rejects the recommendations in the report by Professor Sir John Tooke to dismantle the Foundation Programme, and mandates the BMA to oppose any moves to do so. (2008)
1155.	That this Meeting believes that the BMA should resist a national knowledge-based assessment either during medical school or at the end of F1/PRHO to be used for exit into full registration or for selection into specialist training. (2008)
1156.	That this Meeting: (i) welcomes the recommendations in the Tooke Report highlighting the importance of flexibility in training; (ii) calls upon the BMA to work with Deaneries, Postgraduate Medical Education and Training Board, and the Royal Colleges to develop recognised training programmes such as the VSO/Royal College of Paediatrics and Child Health to ensure that flexibility is available to doctors in training; (iii) believes that the value of this overseas work should be appropriately recognised by individual Deaneries and PMETB; (iv) believes that doctors in training posts who wish to work abroad should be able to re-enter their training programme on return without losing their continuity of service; (v) calls for trusts to recognise education and training projects undertaken by UK doctors in developing countries as an important contribution to international colleagues. (2008)
1157.	That this Meeting believes that the current career structure, with its selection methods and inflexibility, is unfit for the purpose of providing suitably trained doctors for the NHS. We call on the BMA to: (i) explore the issues of single points of entry to training in view of potential detriment to doctors in training and patient care; (ii) explore methods to make entry to training fair and flexible; (iii) press for a structure that allows sufficient time for trainees to gain experience working in different specialties to inform career choice; (iv) lobby for a career structure which supports less than full time working; (v) press for the efficient use of education and training monies.

	(2008)
1158.	<p>That this Meeting believes the understanding of management systems and structures within education and training systems are not well enough promoted or supported, and we demand that:</p> <ul style="list-style-type: none"> (i) education within medical schools should include increased healthcare management experience and education including examples of how and where this can change systems; (ii) opportunities to work within healthcare management be offered within foundation training posts; (iii) management commitments are given appropriate encouragement and emphasis within hospital training posts (eg trust management committees or BMA commitments). <p>(2008)</p>
1159.	<p>That this Meeting believes that the introduction of non-medically trained healthcare practitioners should not adversely impact on undergraduate and postgraduate medical training. We call upon the BMA to:</p> <ul style="list-style-type: none"> (i) ask the government for clarification on the need for these new positions, and how practitioners such as physician assistants will interact with the multi-disciplinary team; (ii) survey urgently the impact of these practitioners on the quality and quantity of medical education and training; (iii) lobby the Royal Colleges and PMETB to review urgently the impact these posts are having on the training of junior doctors; (iv) lobby the government to provide information and reassurance that medical students' and junior doctors' education, training, job description and job prospects will not be adversely affected by the introduction of these posts; (v) oppose the introduction of these practitioners in UK medical schools and hospitals until such reassurance can be provided. <p>(2008)</p>
1160.	<p>That this Meeting believes that funding of undergraduate education, postgraduate training posts and study leave is essential to allow medical students and doctors in training to gain a full range of experience. We call on the BMA to lobby the Health Departments to:</p> <ul style="list-style-type: none"> (i) restore and maintain Medical and Dental Education Levy (MADEL) and Service Increment for Teaching (SIFT) funding to at least the equivalent of original 2006-07 funding levels; (ii) ring-fence MADEL and SIFT funding within SHA budgets; (iii) commit to a three year funding plan for MADEL; (iv) standardise study leave arrangements across the UK; (v) investigate any funding cuts to undergraduate education in medical schools and to evaluate their effect on medical undergraduate education; (vi) ensure that health service employers report in detail on such spending and for the BMA to invoke the Freedom of Information Act to establish how these funds have been spent. <p>(2007)</p>
1161.	<p>That this Meeting asserts that maintaining and improving clinical standards of patient care depends on the commitment to continual medical education and training and insists:</p> <ul style="list-style-type: none"> (i) that all fully registered doctors employed by NHS providers or private contractors providing NHS services must have a binding contract to allow study leave; (ii) that course fees and expenses must be reimbursed; (iii) that failure to honour the commitment to training should result in sanctions being taken against the relevant employing body. <p>(2007)</p>
1162.	<p>That the BMA believes that a taster week in a specialty of the applicant's choice should be available to all foundation year one doctors and calls on:</p>

	<ul style="list-style-type: none"> (i) all healthcare providers to make these easily available; (ii) employers not to withhold paid leave for this purpose unreasonably. <p>(2007)</p>
1163.	<p>That this Meeting calls upon the DH to provide universal training to all medical professionals with regards to the implementation of the new Mental Capacity Act.</p> <p>(2007)</p>
1164.	<p>That all clinicians undertaking undergraduate teaching responsibilities:</p> <ul style="list-style-type: none"> (i) should be appropriately trained, accredited and remunerated; (ii) should have protected time to carry out their teaching duties; (iii) should have their teaching performance assessed regularly to agreed standards. <p>(2007)</p>
1165.	<p>That this Meeting, whilst pleased that GPs are becoming more involved with the education of doctors in training:</p> <ul style="list-style-type: none"> (i) welcomes the increase in time spent in general practice during GP training to 18 months, but notes that payment to trainers for this activity is unacceptably low; (ii) insists that the Health Department recognises the workload impact on practices of having doctors in training; (iii) instructs Council to fight for adequate resources for the proper training of GPs; (iv) instructs Council to lobby the Health Departments to guarantee that future increases are at or above percentage increases in the retail price index, are ring-fenced solely for GP education; (v) instructs the GPC to continue to ensure that out of hours work continues as a core part of GP training and should be funded appropriately. <p>(2007)</p>
1166.	<p>That this Meeting:</p> <ul style="list-style-type: none"> (i) notes a reluctance of some medical and nursing staff to teach medical students within dedicated teaching hospitals; (ii) calls upon NHS employers and the GMC to emphasise the importance of doctors teaching students, as part of their roles as doctors; (iii) calls upon the Royal College of Nursing and the Royal College of Midwifery to stress the importance of providing a positive teaching environment to medical students to foster respect and a positive attitude of future doctors towards them and vice versa. <p>(2007)</p>
1167.	<p>That this Meeting is concerned that the standards of training for medical students and juniors will be compromised because of:</p> <ul style="list-style-type: none"> (i) a reduction of teaching resources in medical schools; (ii) an inability of hospital consultants to shoulder the burden of teaching junior doctors because of service needs; (iii) a large increase in the numbers of students; (iv) the scandalously poor resourcing by GP training; <p>and urges the BMA to draw the government's attention to this potential crisis.</p> <p>(2006)</p>
1168.	<p>That this Meeting condemns the recent withdrawal of job offers to prospective GP registrars in the London deanery and:</p> <ul style="list-style-type: none"> (i) insists that every possible support is given to these doctors; (ii) notes that Good Medical Practice advises that it is not acceptable for doctors to withdraw from jobs at short notice and believes that employers should work to similar standards; (iii) believes any employer offering a job to a medical practitioner must, subject to any statutory restrictions, provide that job as promised;

	<p>(iv) demands that the government ensures that funding is made available for these doctors to train as planned;</p> <p>(v) recognises with dismay the high percentage of training practices without a current trainee in some deaneries.</p> <p>(2006)</p>
1169.	<p>That this Meeting insists that effective systems to ensure the proper quality control of postgraduate medical education are essential and must include:</p> <p>(i) adequate levels of visiting to trusts, practices and deaneries;</p> <p>(ii) the ability to apply sanctions to improve standards where necessary.</p> <p>(2005)</p>
1170.	<p>That this Meeting considers that all postgraduate specialist training must include a period in general practice.</p> <p>(2003)</p>
1171.	<p>That this Meeting believes that, along with the much welcomed advances in flexible training posts, the NHS, medical schools and government must look to the future and encourage a higher number of male students to apply to medicine undergraduate courses to help with the staffing shortages in the foreseeable future.</p> <p>(2002)</p>
1172.	<p>That the British Medical Association should promote greater openness, accountability and revalidation of each of the royal colleges, with particular reference to:</p> <p>(i) teaching and training for membership examinations;</p> <p>(ii) the explicit tackling of institutional discrimination.</p> <p>(2000)</p>
1173.	<p>That this Meeting believes that all doctors should have training in teaching skills.</p> <p>(2000)</p>
1174.	<p>That this Meeting believes that more effective training should be given in communication skills.</p> <p>(1996)</p>
1175.	<p>That the BMA work with the Royal Colleges to develop recognition of time spent abroad with the major aid agencies as accreditable postgraduate training.</p> <p>(1995)</p>
1176.	<p><u>Continuing professional development</u></p> <p>That this meeting calls for recognition of SAS doctors from Employers, Deaneries and the GMC by:-</p> <p>i) creating career pathways for SAS doctors including an option of returning to training if so desired, and with full recognition of previous experience and seniority;</p> <p>ii) safeguarding the opportunity and time for training within service for SAS doctors, in line with that afforded to doctors in training, to ensure continued excellence in delivery of patient care;</p> <p>iii) recognising those pathways and banishing the use of pseudonyms such as 'others'.</p> <p>(2019)</p>
1177.	<p>That this Meeting is concerned that, when NHS employers, including primary care trusts and foundation trusts, decide that training is mandatory for clinical staff, then that training should occur within existing job plans or in clinical time, and should be funded by the NHS.</p> <p>(2010)</p>

1178.	That this Meeting believes that there should be adequate funds for CPD. (2006)
1179.	That part-time doctors and clinical assistants should be assisted financially to fulfil their CPD requirements. (2004)
1180.	That this Meeting believes that all NHS contracts, in primary and secondary care and in all crafts, should include specified and remunerated time for education and continuing professional development. (2003)
1181.	That this Meeting calls upon the JDC and consultant negotiators urgently to reopen negotiations with the Departments of Health with regard to study leave. (2003)
1182.	That this Meeting: (i) demands that time and money should be allocated to doctors by employing authorities to ensure their educational and skill development; (ii) supports the recommendation of the interim Wanless report that doctors should double the amount of time spent on professional development. (2002)
1183.	That this Meeting affirms the fact that professional education is a lifelong activity, and demands that the BMA support the concept of a continuum of education from undergraduate to postgraduate years. (2001)
1184.	That the BMA should try to get general acceptance of the principle that fees for postgraduate training courses should relate to the relative incomes of those attending, with reductions for those doctors who are starting in practice or have retired but wish to maintain their skills. (1999)
1185.	That this Meeting should seek to ensure that appropriate continuing medical education is available and accessible to all medical graduates regardless of employment status, without financial impediment or disincentive. (1998)
1186.	That continuing medical education should be fully and centrally funded. (1997)
1187.	That this Meeting believes the acquisition of qualifications and skills in medical teaching should be given greater recognition in determining career advancement in medicine. (1993)
1188.	<u>Financing medical education and professional development</u> That this meeting recognises that there are mandatory professional development requirements for trainees which they are expected to fund themselves. These vary between specialties and access to funding differs across the country. We call on the BMA to lobby relevant bodies to secure funding for courses, first exam attempts, subscriptions and online portfolios that are mandatory requirements for completion of the training programme. (2015)

1189.	<p>That this Meeting:</p> <ul style="list-style-type: none"> (i) supports the principle of a review of the Multi Professional Education and Training Levy (MPET) to ensure quality student training is funded; (ii) has serious concerns about how the current review is being taken forward; (iii) calls on relevant governmental departments to fully consult key stakeholders throughout the review; (iv) mandates the BMA to reject any proposals that jeopardise the world class medical training offered throughout the UK. <p>(2010)</p>
1190.	<p>That this Meeting:</p> <ul style="list-style-type: none"> (i) believes that junior doctors should be allowed to decide their learning priorities and how to best spend their study leave funding, following discussion with their educational supervisor; (ii) demands study leave funding should not be dependent upon where a trainee is based; (iii) calls for the BMA to lobby the relevant bodies to improve study leave arrangements; (iv) calls upon hospital doctors not to accept arbitrary limits on their study leave budgets and calls on the BMA to inform them of their rights. <p>(2008)</p>
1191.	<p>That this Meeting calls on the Health Departments, Deaneries and NHS organisations to stop using cuts in training budgets to balance finances in the short-term, and calls on them to reverse the cuts currently jeopardising the whole future of medicine in this country.</p> <p>(2006)</p>
1192.	<p>That this Meeting demands that adequate funding of pre- and postgraduate medical education must be protected.</p> <p>(2006)</p>
1193.	<p>That this Meeting:</p> <ul style="list-style-type: none"> (i) believes that lobbying for concessions for the clinical years of medical student training would have been more effective and achievable than the BMA's 'all or nothing' approach lobbying for complete abolishment of tuition fee charges for medical students; (ii) acknowledges the past efforts of the BMA in opposing tuition fees and calls on the BMA to refocus efforts on combating debt aversion and lobbying for improved financial support. <p>(2006)</p>
1194.	<p><u>Modernising medical careers</u></p> <p>That this meeting believes that undergraduate medical training should include knowledge of the structure and framework, funding and resource prioritisation of the NHS. We therefore call upon the BMA medical students committee to work with the education subcommittee of the Medical Schools Council and other relevant bodies, including the Health Foundation and the GMC, to ensure that this training is compulsory in the core curriculum of all medical schools in the UK.</p> <p>(2017)</p>
1195.	<p>That this Meeting:</p> <ul style="list-style-type: none"> (i) supports the formation of a new oversight body called "NHS Medical Education England" (NHS:MEE) as recommended by the Tooke Report; (ii) believes that the budget for medical education and training should be ring-fenced; (iii) believes that the budget for medical education should be managed by NHS:MEE; (iv) calls for an immediate appointment of a Director of Medical Education for England. <p>(2008)</p>

<p>1196.</p>	<p>That this Meeting has grave concerns about Modernising Medical Careers and:</p> <ul style="list-style-type: none"> (i) believes that there should be a fundamental review of the principles of Modernising Medical Careers; (ii) believes that any move to create a sub-consultant grade as a consequence of MMC must be opposed; (iii) calls on PMETB and others to amend curricula and structures to facilitate transfer of trainees between specialties (including general practice); (iv) calls on the Royal Colleges urgently to collaborate to agree transferable competencies; (v) calls on the BMA to lobby for improved careers guidance for junior doctors; (vi) recognises the good work done by the BMA in setting up careers guidance sessions for juniors and calls for this to be expanded as a membership benefit; (vii) believes that there should be competitive entry to specialties above ST1 level with recognition of relevant transferable competencies; (viii) believes that the length of specialty training may need, in the future, to vary to maintain a standard equivalent to that of current CCT holders; (ix) believes that future proposals should be carefully developed before implementation. <p>(2007)</p>
<p>1197.</p>	<p>That this Meeting is deeply concerned at the state of plans for the future of postgraduate medical education and calls on the Chief Medical Officers to make immediate arrangements to:</p> <ul style="list-style-type: none"> (i) put flexible training at the centre of the MMC process; (ii) ensure transitional arrangements that give fair opportunities to progress for those already in SHO posts; (iii) ensure fair application and selection processes for specialty training that avoid the ad hoc arrangements which have bedevilled the Foundation programme; (iv) analyse the readiness for the run-through specialist training; (v) reinstate medical workforce planning advisory structures; (vi) ensure adequate funding for the extra time need by trainers; (vii) investigate the implications of MMC for consultant, SAS and GP workload and for NHS clinical activity and patient care. <p>(2006)</p>
<p>1198.</p>	<p>That this Meeting calls on the medical Royal Colleges to:</p> <ul style="list-style-type: none"> (i) compile a database of the competencies required for each specialty and publish these either on the internet or in one simple document by August 2006; (ii) recognise and allow the transfer of shared competencies in the run-through grade training. <p>(2006)</p>
<p>1199.</p>	<p>That this Meeting believes that the BMA should be explicit in its views on the foundation programme and calls on the BMA to represent the following statements to the relevant agencies and organisations:</p> <ul style="list-style-type: none"> (i) there is sound educational value in being able to continue foundation training in the same foundation school as ones medical school as recommended by the GMC; (ii) students wishing to work in a foundation school different from their medical should be allowed to; (iii) all UK graduates of good standing should be guaranteed a foundation programme; (iv) the foundation programme should consist of a two year seamless training programme as outlined in the operational guide to foundation programmes; (v) competitive entry into a foundation programme should occur during the final year of medical school. <p>(2006)</p>
<p>1200.</p>	<p>That this Meeting believes that:</p>

	<p>(i) the increase in medical student numbers generally (and in Scotland in particular) should be supported by an increase in graduate places available in the Foundation years;</p> <p>(ii) the increase in medical student numbers must be reflected in a comparable increase in the numbers of teaching staff so that the quality of training is maintained.</p> <p>(2006)</p>
1201.	<p>That this Meeting believes that sudden shifts in emphasis between academic achievements and all-round development for application to F1/F2 posts are unfair, potentially discriminatory and hence should be avoided. With this in mind, we ask the BMA to campaign for a phased – in approach over several years for any changes in application and scoring criteria for F1 posts.</p> <p>(2006)</p>
1202.	<p>That this Meeting believes that following MMC initiatives for earlier entry into specialist training and in light of selection possibly being commitment based, students should have evolving careers advice and guidance throughout medical school.</p> <p>(2005)</p>
1203.	<p>That this Meeting recognises the benefits of acute out of hours and daytime experience for PRHOs and foundation year 1 doctors. It directs the British Medical Association to demand that Postgraduate Deaneries and Medical Schools ensure that PRHOs and foundation year 1 doctors will not be removed from acute out of hours experience which forms a valuable part of training.</p> <p>(2005)</p>
1204.	<p>That this Meeting believes that the inclusion of a general practice placement for every postgraduate doctor in foundation year two should be compulsory in order to improve overall postgraduate medical education and also improve communication between primary and secondary care and calls upon the BMA to lobby the relevant body to ensure adequate resourcing for this to occur.</p> <p>(2005)</p>
1205.	<p>That regarding “Modernising Medical Careers” this Meeting:</p> <p>(i) condemns the assumption by the MMC Delivery Board that further sub-specialty training will be required after attaining CCT;</p> <p>(ii) believes that the introduction of a “generalist” CCT is the same as the introduction of a sub-consultant/junior consultant grade and deplors this;</p> <p>(iii) is concerned by the proposed drastic reductions in the duration of training;</p> <p>(iv) insists that generalists require at least as much training as specialists;</p> <p>(v) insists that all consultants should be trained to at least the current high standards;</p> <p>(vi) believes that the proposals would produce ill-equipped consultants and GPs, endangering clinical practice and patient care.</p> <p>(2004)</p>
1206.	<p>That this Meeting:</p> <p>(i) welcomes foundation programmes as a potential improvement in the structure of training;</p> <p>(ii) is deeply concerned that applications are expected in the absence of explicit information at the time of application and calls on the health departments and medical royal colleges to provide the necessary information as a matter of urgency;</p> <p>(iii) calls for greater clarity in the selection criteria and application process;</p> <p>(iv) calls upon the health departments to provide clear and forceful guidelines for trusts to enable effective and flexible implementation of the foundation programme nationwide;</p> <p>(v) urges all parties in implementing foundation programmes to maintain flexibility and choice in terms of geographical location, part-time training and career planning.</p> <p>(2004)</p>

1207.	That this Meeting condemns any plans to extend the pre-registration year. (1992)
1208.	That this Meeting supports the GMC in its moves to emphasise the educational component of the pre-registration year and urges that this year complements the basic medical education of the undergraduate curriculum. (1992)
1209.	<p><u>Postgraduate Medical Education and Training Board</u></p> <p>That this Meeting:</p> <ul style="list-style-type: none"> (i) believes that the PMETB fees structure does not reflect their stated principle that “beneficiary pays”; (ii) insists that political independence does not require financial independence; (iii) calls on PMETB to make substantial reductions in its fees to doctors for CCT and Article 11/14; (iv) calls on PMETB to adhere strictly to their stipulated three month deadline for completing Article 14 assessment. <p>(2007)</p>
1210.	<p>That this Meeting believes that PMETB has chosen the easiest route to ongoing financing by proposing to charge trainees for the full cost of its operation and believes that:</p> <ul style="list-style-type: none"> (i) the proposed rises in their charges for certificates of completion of training are to be condemned; (ii) trainees, as only one of the beneficiaries, should only pay the costs directly attributed to the issuing of a certificate; (iii) PMETB does not need to maintain financial independence to ensure functional independence as this is governed by statute; (iv) trainees must be given the option of paying fees by installments over the period of their training; (v) PMETB's principal source of funding should be the NHS and national governments, with only a minor contribution from doctors in training. <p>We call on the BMA, working with the Royal Colleges, to continue to lobby PMETB, the Health Departments and the government on this issue. (2006)</p>
1211.	<p>That the BMA demands the membership of staff and associate specialist doctors on the main board of PMETB and on its Assessment and Training Statutory Committees and demands that the NHS Appointments Commission and health departments rectify this at the earliest opportunity. (2005)</p>
1212.	<p>That with regard to PMETB, the Meeting strongly feels that:</p> <ul style="list-style-type: none"> (i) the training time for junior doctors should not be shortened merely to achieve the government target of an increase in consultant numbers; (ii) training should be based on competency as defined by specialist training bodies in the appropriate fields; (iii) trainees should not be charged for certificates of completion of training. <p>(2003)</p>
1213.	<u>Study leave</u>

	That this Meeting recognises that there are wide variations in funding for study leave for trainees, consultants and SAS doctors and instructs Council to press for agreed national levels of funding. (2008)
1214.	That study leave for the purpose of developing a medical portfolio career should be protected and must not be unreasonably withheld, even if it does not relate specifically to the specialty that you are currently working in. (2006)
1215.	That this Meeting believes that opportunities for taking study leave should not be limited by commitments to service delivery and it therefore directs the BMA to negotiate with appropriate bodies: <ul style="list-style-type: none"> (i) to ensure that rota design does not limit ability to take study leave; (ii) to ensure that locum cover is provided by employers as appropriate to cover study leave; (iii) to ensure that service delivery is cancelled, when appropriate, to facilitate study leave for junior doctors; (iv) to ensure that employers are responsible for finding cover for study leave, rather than junior doctors. (2005)
1216.	That this Meeting calls for the Department of Health to establish a clear and unambiguous study leave entitlement for all trainees including: <ul style="list-style-type: none"> (i) the same study leave allowance, including private study leave, to be granted to all trainees regardless of whether full-time or part-time; (ii) time off in lieu to be granted for study leave taken on non-working days; (iii) the same method of applying for study leave funding regardless of full or part-time; (iv) adequate funding should be available to all trainees in all specialties. (2004)
1217.	That this Meeting believes that training in the skills of advanced life support, including trauma, neonatal and paediatric skills (as appropriate to specialty) is a clinical risk management concern, and thus should be delivered by means other than via trainees' study leave allowance. (2004)
1218.	That this Meeting believes that study leave funding throughout the UK is grossly inadequate and that: <ul style="list-style-type: none"> (i) there should be an immediate increase in funding; (ii) if a study leave course is effectively a compulsory requirement of training it should be funded in full, irrespective of study leave budgets; (iii) travel and subsistence expenses should automatically be met from a separate funding stream from course/conference fees; (iv) junior doctors, public health trainees and GP registrars should have individual study leave accounts for use throughout their post-registration medical training; (v) doctors should not be discriminated against by virtue of their geographical distance from courses or conferences. (2001)
1219.	That this Meeting: <ul style="list-style-type: none"> (i) requests that postgraduate deans should develop guidelines for trusts to ensure that no junior doctor incurs debt as a result of approved study leave within that doctors' assigned budget; (ii) believes that, where study leave funding is approved for a course, the approving trust should pay the course organisers directly;

	<p>(iii) believes that any arrangements for funding should recognise the needs of doctors moving to future posts within a rotation.</p> <p>(2001)</p>
1220.	<p>That this Meeting calls on the Government to ensure that study leave for junior doctors is centrally funded and covers all expenditure incurred.</p> <p>(1998)</p>
1221.	<p>That this Meeting believes that an agreed minimum period of study leave:</p> <ul style="list-style-type: none"> (i) should be a mandatory part of all junior doctors' contracts and training agreements; (ii) that trainees' study leave should be documented by the postgraduate deans; (iii) that failure to meet minimum targets should lead to a critical appraisal of the post, trainer and trainee; (iv) that study leave must be fully funded by regional deans and not by individual trainees; (v) that all junior doctors should be equitably funded for study leave. <p>(1997)</p>
1222.	<p>That this Meeting believes that study leave entitlement for all grades of medical staff should be made mandatory (as opposed to discretionary) and that there should be full reimbursement of expenses, further this Meeting believes that monies should be made available for the employment of locums to enable study leave to be taken.</p> <p>(1985)</p>
1223.	<p><u>Undergraduate curriculum</u></p> <p>That this meeting is deeply concerned by proposals to establish a Medical Apprenticeship Scheme that will lead to a two-tier system for medical professionals. This meeting calls on the BMA to:-</p> <ul style="list-style-type: none"> i) lobby for increased accessibility for financial support by way of bursaries, grants and subsidised tuition fees instead of apprenticeships; ii) propose the inclusion of extracurricular roles such as healthcare assistant (HCA) which are remunerated to financially support undergraduates; <p>recognise the impact on training of current medical students, doctors in training and educational supervisors.</p> <p>(2021)</p>
1224.	<p>That this meeting acknowledges the traumatic impact that clinical events encountered in their training and working environment, such as patient loss of life or patient life-threatening events, can have on junior doctors. This meeting recognizes that this trauma can have lasting negative consequences on trainee wellbeing. It calls upon the BMA to:-</p> <ul style="list-style-type: none"> i) lobby education bodies and employers to train all doctors in how to undertake an effective debrief; ii) lobby education providers to include information on the importance of debriefing after a traumatic event in all postgraduate teaching programmes; iii) lobby education bodies to promote the use of debriefs to all involved in training junior doctors; iv) work with the UK Resuscitation Council and other life support course designers to ensure that all life support courses have a mandatory debrief built into the end of the scenario training. <p>(2019)</p>
1225.	<p>That this meeting believes that the RCGP updated curriculum has failed to make the case for a 4 year training program. We call upon the BMA to lobby relevant bodies to:-</p> <ul style="list-style-type: none"> i) maintain the current 3 year training length;

	<p>ii) overhaul training to be based entirely in general practice with short integrated secondary care placements designed to directly address trainees learning needs;</p> <p>iii) adequately incorporate training in management and business skills to better equip trainees as future leaders and practice partners.</p> <p>(2019)</p>
1226.	<p>That this Meeting values the role of doctors as teachers and:</p> <p>(i) would like to see "how to teach" incorporated into the undergraduate medical curriculum to prepare students for their role as teachers in F1 posts and subsequent careers;</p> <p>(ii) calls on the BMA to lobby the Medical Schools Council to integrate "how to teach" into the core undergraduate curriculum;</p> <p>(iii) calls on the BMA to lobby the GMC to include the training of medical students as teachers in the review of "Tomorrows' Doctors" due to be published in 2009;</p> <p>(iv) would welcome greater recognition of good teachers.</p> <p>(2008)</p>
1227.	<p>That this Meeting believes that pharmacology is a vital part of the medical undergraduate curriculum and:</p> <p>(i) calls on the BMA, CHMS and the GMC to ensure that this is maintained;</p> <p>(ii) believes that the BNF is an essential educational resource and should be provided free of charge to all medical students who request one and mandates the BMA to lobby the Health Departments to fund this;</p> <p>(iii) calls on the BMA to lobby the Health Departments to ensure that the full allocation of BNFs is maintained in all UK hospitals.</p> <p>(2007)</p>
1228.	<p>That this Meeting proposes that all medical schools in this country provide basic first aid training for their medical students.</p> <p>(2006)</p>
1229.	<p>That a degree of flexibility be incorporated into undergraduate courses for students with special circumstances.</p> <p>(2005)</p>
1230.	<p>That this Meeting believes that the medical curriculum should include teaching of forensic medicine and legal issues such as presentation of self in court, due to the increasing legal cases.</p> <p>(2004)</p>
1231.	<p>That the core teaching of religious traditions and world views, particularly in respect of treatment, death and dying, needs to be strengthened in the curriculum, and that, in a multi-cultural environment, medical schools have a duty to provide this information.</p> <p>(2002)</p>
1232.	<p>That this Meeting believes that the minimum length of an undergraduate course in medicine for school leavers should be five years.</p> <p>(2001)</p>
1233.	<p>That this Meeting believes that, given the numerous ethical dilemmas posed by the recent advances in medicine, ethics teaching should take a more prominent role in current undergraduate training.</p> <p>(2000)</p>
1234.	<p>That this Meeting believes that:</p>

	<p>(i) basic life support training should be given before students begin clinical attachments; and</p> <p>(ii) advanced life support training should be given prior to graduation.</p> <p>(1999)</p>
1235.	<p>That this Meeting affirms its conviction that medical ethics should be an integral part of the undergraduate curriculum and postgraduate education.</p> <p>(1995)</p>
1236.	<p>That this Meeting requests the GMC to instruct medical schools to have an identifiable, substantial, part of the undergraduate medical curriculum devoted to the ethical and legal aspects of medical practice and that such teaching should be introduced in a non-dogmatic manner.</p> <p>(1986)</p>
1237.	<p>That in order to increase the emphasis on general practice in the medical curriculum all undergraduates should have a substantial period of observation and instruction in general practice during their clinical training.</p> <p>(1969)</p>
1238.	<p><u>Undergraduate education</u></p> <p>That this Meeting believes that the Bologna Declaration has the potential to change the face of medical education as it currently stands, and consequently the education and training of the medical profession and patient experience in the NHS. This Meeting notes that discussions regarding the Bologna Declaration have been predominantly based in countries outside of the UK which has led to a lack of UK representation and influence on discussion. Therefore, in order to protect the interests of the profession and patients, this Meeting:</p> <p>(i) calls on the BMA to discuss and develop policy on the Bologna Process to determine the effects, implications and desired outcomes of the implementation of the Declaration;</p> <p>(ii) calls on the BMA to take forward discussion with relevant stakeholders including CHMS and the GMC regarding the implementation of the Bologna Process in medical education;</p> <p>(iii) mandates the BMA to seek representation on European-wide committees discussing and developing initiatives related to the implementation of the Bologna Process in Medical Education.</p> <p>(2007)</p>
1239.	<p>That this Meeting believes that medical schools should time their re-sit examinations for final year medical students so that those who fail their finals but pass their re-sits are able to start their Foundation Programmes in August with the rest of their cohort.</p> <p>(2006)</p>
1240.	<p>That this Meeting, considering the roles and responsibilities of a Foundation Year One doctor, calls for integration and inclusion of medical students in the multidisciplinary health care team, in line with other allied health care professional students, to ease the transition from student to junior doctor.</p> <p>(2006)</p>
1241.	<p>That addressing the stigma of alcohol and drug dependence within the medical profession should begin at medical school. The BMA should therefore:</p> <p>(i) encourage all medical schools to include teaching on these issues in their curricula;</p> <p>(ii) ensure all medical schools have support mechanisms in place for students with substance misuse problems and that students are made aware of how to access these services.</p> <p>(2006)</p>

1242.	That this Meeting believes that every medical school should publish the cost per student of each of its medical degree programmes. (2005)
	MEDICAL ETHICS
1243.	That this meeting finds the practice of LGBTQ+ conversion therapy to be unethical and damaging. We call on the BMA to:- i) lobby the UK government to ensure this damaging practice is banned; ii) lobby the GMC to introduce sanctions up to and including erasure of medical practitioners performing LGBTQ+ conversion therapy. (2021)
1244.	That this meeting:- i) believes that the moral and ethical integrity of doctors is an essential component of wellbeing and morale in the medical workforce; ii) holds that reasonable and proportionate provision for the exercise of individual conscience should be provided for within medicine; iii) is concerned that inadequate conscience provision within medicine may on occasion be a cause of significant moral injury for clinicians; (2021)
1245.	That this meeting:- i) deplores the inhumane conditions which migrants suffer while imprisoned in detention centres; ii) calls on the BMA to call for an end to indefinite detention; iii) calls on the BMA to call for closure of detention centres. (2018)
1246.	That this meeting applauds the government's commitment to review the law on organ donation and its recent consultation on donor opt out, and welcomes such a change. (2018)
1247.	That this meeting welcomes the English government's announcement of a consultation on organ donation opt-out system and supports strategies to increase organ donation across the UK. (2018)
1248.	That this meeting believes that whilst doctors may not have the right to object to patients making personal recordings of consultations, and recognising that there may be benefits to doing so, condemns the practice of patients posting recordings online and calls on the BMA to lobby for sanctions against patients who breach their doctors' privacy in this manner. (2018)
1249.	That this meeting calls on the BMA to lobby the government to change the law so that doctors can treat patients regardless of immigration status without the threat of being prosecuted for fraud. (2018)
1250.	That this meeting recognises that the advent of new technologies can bring new ethical challenges to light and; i) believes that given the advent of Non-Invasive Prenatal Testing (NIPT) and the potential for whole Genome Sequencing the time is right for consultation to determine the views of the public and the profession on the need for limits to the scope of NIPT in practice. (2018)

<p>1251.</p>	<p>That this meeting notes that the BMA safeguarding vulnerable adults toolkit was last reviewed in 2011 and recognises that the Care Act 2014 placed adult safeguarding on a statutory footing and makes certain requirements of local authorities as the lead agency. We therefore call for:-</p> <ul style="list-style-type: none"> i) the BMA safeguarding vulnerable adults toolkit to be updated to reflect new legislation, case law, and standardised processes as required by the Care Act 2014; ii) the BMA to be a participant in any update of the national framework for adult safeguarding (Association of Directors of Social Services 2005). <p>(2017)</p>
<p>1252.</p>	<p>That this meeting:-</p> <ul style="list-style-type: none"> i) believes that the Human Rights Act is fundamental to the primary role of doctors in advocating and caring for patients; ii) urges the UK government not to repeal the Human Rights Act. <p>(2017)</p>
<p>1253.</p>	<p>That this Meeting recognises the value of good research, but is concerned that negative results are not always published and calls upon the government to:-</p> <ul style="list-style-type: none"> i) establish a mandatory open register of all clinical trials relating to drugs and other therapeutic interventions for NHS use; ii) make it compulsory that all results of registered clinical trials are published, whether negative or positive; iii) make it compulsory that all results of registered clinical trials are openly available within a year of each trial being completed. <p>(2013)</p>
<p>1254.</p>	<p>That this Meeting is concerned by the personal views expressed by senior politicians on reducing the time limit of abortion. This Meeting believes that in view of the technical limitations of screening at earlier gestational stages it would be unacceptable to change the time limit of abortion.</p> <p>(2013)</p>
<p>1255.</p>	<p>That this Meeting notes the 'opt out with safeguards' policy of organ donation and calls upon the BMA to:-</p> <ul style="list-style-type: none"> i) discuss in more detail what those safeguards will be; ii) ensure that the public are aware of the proposed policy and those safeguards; iii) explore whether those safeguards will work in practice to prevent the unwitting removal of organs without consent. <p>(2013)</p>
<p>1256.</p>	<p>That this Meeting states that:-</p> <ul style="list-style-type: none"> i) selective non-publication of unflattering trial data is research misconduct; ii) registered medical practitioners who give grounds to believe they have been involved in such conduct should have their fitness to practice assessed by the GMC. <p>(2013)</p>
<p>1257.</p>	<p>That this Meeting believes that there should be a unified form in each nation which could be the same across the UK for the expression of the wishes of a patient or where appropriate, their representatives views regarding resuscitation.</p> <p>(2012)</p>
<p>1258.</p>	<p>That this Meeting:-</p> <ul style="list-style-type: none"> (i) recalls the important role the BMA played in the abolition of capital punishment in the UK;

	<ul style="list-style-type: none"> (ii) condemns the use of capital punishment, wherever in the world it takes place; (iii) believes that it is unethical for doctors to be involved in the process of execution; (iv) notes that many executions are carried out using pharmaceuticals produced by multi-national pharmaceutical companies; (v) commends the decision by the UK Government to halt export of pharmaceuticals from the UK for use in executions abroad; (vi) calls on the BMA International Committee, Ethics Committee and other relevant bodies to work with relevant international organisations (including the WMA and WHO) to prevent the export and use of pharmaceuticals for the purpose of execution. <p>(2012)</p>
1259.	<p>That this Meeting:</p> <ul style="list-style-type: none"> (i) notes that a significant minority of mental health workers are offering conversion therapy for homosexuality, which is discredited and harmful to those 'treated'; (ii) notes that some of this conversion therapy is paid for by the NHS; (iii) calls on the Royal College of Psychiatrists and other bodies setting standards for mental health workers to publicly repudiate conversion therapies and explicitly include stipulations in their codes of practice against these attempts to alter sexual orientation; (iv) calls on the Health Departments to investigate cases where it seems conversion therapy has been funded with NHS money and to prevent this from happening in future. <p>(2010)</p>
1260.	<p>That this Meeting:</p> <ul style="list-style-type: none"> (i) recognises that the NHS is committed to providing spiritual care for patients; (ii) notes the position on inappropriate discussion of faith matters in GMC Guidance on Personal Beliefs and Medical Practice. <p>(2009)</p>
1261.	<p>That this Meeting:</p> <ul style="list-style-type: none"> (i) supports the rights of doctors and other healthcare professionals to conscientiously object to carrying out certain non-emergency lawful procedures, where: <ul style="list-style-type: none"> (a) such conscientious objection is recognised in statute, as in abortion and IVF, and in cases of withdrawal and withholding of life-supporting medical treatment in patients without capacity; and (b) in the event of seeing a patient seeking advice on such a procedure, the doctor should tell them immediately of the existence of a conscientious objection and of their right to see another doctor, although the consultation may continue if the patient and doctor both agree; and (c) in the event of seeing a patient seeking such a procedure, the doctor must, in line with GMC guidance, tell them of their right to see another doctor and ensure that the patient has sufficient information to exercise their right; but if the patient cannot readily make their own arrangements to see another doctor, the doctor must ensure that arrangements are made, without delay, for another doctor to take over their care; (ii) calls on the GMC to ensure its guidance on personal beliefs and medical practice reflects this view; (iii) calls on Parliament to retain the statutory right of doctors and other health care professionals to conscientiously object within the above limits. <p>(2008)</p>
1262.	<p>That this Meeting recognises the need for more donated organs and reiterates its support for an "opt-out" system of organ donation.</p> <p>(2008)</p>

1263.	<p>That this Meeting believes any decision to provide medical or surgical treatment to a child, or any decision to withhold medical or surgical treatment from a child, should:</p> <ul style="list-style-type: none"> (i) always be determined by assessing the best interests of the child; (ii) consider the ethical, cultural and religious views of the child's parents and/or carers but without allowing these views to override the rights of the child to have his/her best interests protected; (iii) be endorsed by an impartial court of law when disputes arise as to what constitutes the best interests of the child. <p>(2007)</p>
1264.	<p>That this Meeting is deeply concerned at conditions in which surgical instruments (of a high quality) are manufactured in Pakistan, which involves the employment of children, deficient health and safety measures and low wages. The NHS is a major purchaser of these instruments, at prices very much higher than the producers earn. We call upon the government to institute a fair trade policy for the purchase of these instruments which would be to the health and socio-economic benefit of the workers and their families.</p> <p>(2007)</p>
1265.	<p>That this Meeting is against the removal of anonymity from sperm donors.</p> <p>(2002)</p>
1266.	<p>That in difficult ethical situations, junior doctors should not be expected to make critical decisions without the formal and comprehensive input of the consultant.</p> <p>(2000)</p>
1267.	<p><u>Organ donation</u></p> <p>That this meeting believes that following the adoption of an opt-out system for organ donation in Wales in 2015, the BMA should actively lobby the governments in England, Scotland and Northern Ireland to implement an opt-out system.</p> <p>(2016)</p>
	<p>MEDICAL STUDENTS</p>
1268.	<p>That this meeting recognises medical student sex workers, that a large proportion of student sex workers are from marginalised backgrounds, and that the pandemic has forced student sex workers into more risky situations. It mandates the BMA to:-</p> <ul style="list-style-type: none"> i) lobby the GMC and Medical Schools Council to ensure medical students engaging with sex work, of whatever form, to support their studies are not penalised for this, and are safe from expulsion and professionalism proceedings; ii) work with medical schools to develop specialised support for students involved in sex work, ensuring an environment free from judgement and completely confidential. <p>(2021)</p>
1269.	<p>That this meeting acknowledges that women are still the minority in surgical specialties, holding only 11% of surgical consultant posts in 2016, and calls upon the BMA to lobby the Medical Schools Council to take more action in promoting the interest and involvement of female medical students in surgery via:-</p> <ul style="list-style-type: none"> i) lobbying medical schools to apply for places on behalf of their students at the Royal College of Surgeons Women in Surgery conferences and events; ii) lobbying medical schools to host lecture series with local female surgical consultants; <p>(2018)</p>

1270.	<p>That this meeting recognises that there is a lack of guidance on reporting incidents of racism directed at medical students from other medical students, senior medical professionals or patients. This conference calls on the BMA to:-</p> <ul style="list-style-type: none"> i) review current GMC policies and guidance on acts of racism; ii) lobby through appropriate groups to ensure all medical schools have a clear and accessible mechanism in place to report acts of racism; iii) create a method in which such reported incidents can be escalated to higher bodies such as the GMC or BMA. <p>(2018)</p>
1271.	<p>That this meeting notes the coming increase in medical school places by 1500 students per year, and calls upon the BMA JDC to lobby the government to:-</p> <ul style="list-style-type: none"> i) confirm that all medical graduates will have a guaranteed place for the Foundation Programme upon graduation; ii) commit to the necessary increase in investment to the Education and Training Tariff to safeguard the ongoing quality and access to postgraduate medical education. <p>(2018)</p>
1272.	<p>That this meeting calls on the BMA to improve awareness of student mental health in medical schools. The BMA should do this by:-</p> <ul style="list-style-type: none"> i) utilising its growing local networks to host mental health talks and events for local medical students; ii) calling upon medical schools to improve support for students with symptoms of mental health illness. iii) reporting back on progress and responses from medical schools. <p>(2017)</p>
1273.	<p>That this meeting, in light of the NHS medical recruitment crisis, is appalled by the decrease in medical student applications and calls for:-</p> <ul style="list-style-type: none"> i) places to be given on merit without financial barriers; ii) the government to increase medical student numbers and resource universities appropriately. <p>(2017)</p>
1274.	<p>That this meeting is encouraged by the wide variety of Widening Participation to Medicine initiatives in the UK but would like to see the following advancements:-</p> <ul style="list-style-type: none"> i) each medical school has a dedicated WP team and lead; ii) each medical school have programmes that help pupils with the application; iii) each medical school helps to organise work experience. <p>(2016)</p>
1275.	<p>That this Meeting is dismayed by the mistakes made by the United Kingdom Foundation Programme (UKFPO) and the Medical Schools' Council (tMSC) in the recruitment of Foundation doctors and:-</p> <ul style="list-style-type: none"> i) believes the UKFPO and tMSC should be held accountable for any mental and financial stresses that they may have caused to current final year medical students; ii) insists that the UKFPO seeks avoidance of such a situation in future years by carrying out rigorous and extensive testing of the system in advance; iii) demands that the agreed "thorough and independent review" of this year's situation actually happens. <p>(2013)</p>
1276.	<p>That this Meeting believes it is unacceptable for any candidate applying to the foundation programme to be removed from the application process on the basis of achieving a low</p>

	<p>Situational Judgement Test (SJT) score and calls on the UK Foundation Programme Office to ensure no student is excluded on this basis alone. (2013)</p>
1277.	<p>That this Meeting notes the report on fair access to professional careers published in 2012, which criticises the medical profession for taking too little interest in fair access to medicine and becoming more socially exclusive. Therefore this Meeting mandates the BMA to:-</p> <ul style="list-style-type: none"> i) prioritise fair access to medicine as a policy requiring action from all branches of practice; ii) request that the BMA's Medical Workforce Group develop and implement practical ways in which the Association can improve access to medicine for students from all backgrounds; iii) endorse the recommendations that the profession as a whole should work together to widen access to medicine and publish its intention for so doing; iv) explore the options to increase access to work experience for prospective medical students and promote successful schemes; v) lobby medical schools and the Medical Schools Council for greater transparency on how fair access and contextual data are incorporated into application procedures; <p>(2013)</p>
1278.	<p>That this Meeting supports the BMA in calling for medical schools to provide more information on how they spend student tuition fees. (2013)</p>
1279.	<p>That this Meeting:-</p> <ul style="list-style-type: none"> (i) acknowledges and praises the contribution that international medical students and doctors have made to the NHS for decades; (ii) notes that the percentage of international students at UK medical schools should not exceed 7.5%; (iii) is dismayed that this percentage is being exceeded by multiple medical schools across the UK to the detriment of local applicants; (iv) suspects that the high proportion of international medical students at UK medical schools is due primarily to revenue generation through often very high, occasionally extortionate, fees. <p>(2012)</p>
1280.	<p>That this Meeting is appalled at the errors made by the Student Loans Company and Student Finance England in mistakenly awarding tuition fee loans to students doing medicine as a second degree, and then later deducting the payment from universities. We call for:-</p> <ul style="list-style-type: none"> (i) Council to lobby for Parliamentary investigation into the errors; and (ii) Universities to give students more time to settle their fees in the event of such error coming to light <p>(2012)</p>
1281.	<p>That this Meeting:-</p> <ul style="list-style-type: none"> (i) notes that the increase in tuition fees from 2012 will place significant strain on medical students through increased debt; (ii) believes the majority of graduate students who wish to undertake a 5 or 6 year medical degree will be unable to afford to do so, as they will have to pay £9000 of fees upfront in years 1-4; (iii) mandates the MSC to lobby for an affordable fee arrangement that allows graduates access to 5 or 6 year medical courses. <p>(2012)</p>
1282.	<p>That this Meeting:-</p>

	<ul style="list-style-type: none"> (i) believes that there is a need for greater clarity regarding the actual number of medical students in each year group across each of the medical schools, set against the intake targets agreed by ministers; (ii) believes that, as funding provided to the NHS organisations to support the additional costs of teaching medical undergraduate students is linked to the target intake number, any places filled over and above agreed targets will place increased pressure on Additional Cost of Teaching (ACT) /Service Increment For Teaching (SIFT) funding, which could have damaging implications for the quality of teaching; (iii) calls on medical schools to publish up to date data showing the number of medical students in each year group, accounting for any discrepancy with intake targets set by ministers, and detailing how additional places will be funded. <p>(2012)</p>
1283.	<p>That this Meeting is concerned about the limited experience of some medical students, especially male medical students, on Obstetrics placement and believes that medical and midwifery students should have equal access to experience in Obstetrics while on placement. This Meeting therefore calls upon the BMA to:-</p> <ul style="list-style-type: none"> (i) lobby the Royal College of Obstetrics and Gynaecology (RCOG) in recognising this as a problem and work together in addressing it; (ii) identify current barriers to accessing adequate experience, and suggest potential solutions; (iii) lobby the Medical Schools Council and other relevant bodies to implement these changes. <p>(2012)</p>
1284.	<p>That this Meeting:</p> <ul style="list-style-type: none"> (i) congratulates the GMC on their inclusion and provision for disabilities within medical education and the medical profession's Doctors and Gateways to the Professions; (ii) recognises a lack of evidence surrounding the provision of support and reasonable adjustments for disabled students in medical education; (iii) calls for further investigation into the benefits and disadvantages to providing reasonable adjustments in medical education; (iv) recommends more funding be provided for such research. <p>(2010)</p>
1285.	<p>That this Meeting:</p> <ul style="list-style-type: none"> (i) believes that it is vital for medical students to receive regular feedback on their performance; (ii) encourages students to approach healthcare professionals they are working with for constructive feedback; (iii) calls on the MSC to work with the Medical Schools Council to encourage all students to feel comfortable and able to ask the relevant people for feedback; (iv) calls on the MSC to work with the Junior Doctors Committee to highlight the benefits of junior doctors to be involved in medical education; (v) calls on the MSC to work with the relevant stakeholders in the NHS to remind and encourage all doctors of their duty to teach students and give constructive feedback, regardless of whether they are in a formal teaching role; (vi) calls on the MSC to ensure students are not charged for detailed examination feedback. <p>(2010)</p>
1286.	<p>That this Meeting calls for the removal of car parking fees for medical students on placements within NHS hospital sites. Medical students are required to attend placements often a significant distance from their place of residence with no provision of accommodation. This Meeting calls on the BMA to lobby government to ensure free parking at NHS hospital sites for medical students.</p> <p>(2008)</p>

1287.	That this Meeting notes the variable standard of educational resources available for medical students on clinical attachments away from a main campus. It calls upon medical schools to ensure that students studying under the auspices of a single university have equal access to library, computing and educational resources. (2008)
1288.	That this Meeting recognises the difficulties many potential medical students have in organising clinical work experience. It therefore calls on the MSC to work with the GPC and CCSC to establish a national work experience scheme available to all UK school pupils interested in medicine. (2007)
1289.	That this Meeting believes that medical schools should provide HIV "post exposure prophylaxis kits" (to include drugs and comprehensive guidance as to when and how to take them) for their students who are undertaking medical electives on placements where HIV/AIDS is endemic and no such medication will be immediately available locally. (2007)
1290.	That this Meeting: <ul style="list-style-type: none"> (i) notes the close relationship between the medical profession and the pharmaceutical industry; (ii) notes that pharmaceutical marketing may influence prescribing habits such that they are not based on the principles of evidence based medicine; (iii) believes that medical schools should ensure that students are made aware of the implications of this on prescribing habits by teaching the subject in the undergraduate medical curriculum; (iv) calls on all medical schools to develop and make publicly available policy on student interactions with pharmaceutical representatives regarding their involvement in teaching activities; (v) mandates the MSC to produce guidance for medical students on interactions with pharmaceutical representatives; (vi) mandates the MSC to lobby the GMC and Council Heads of Medical Schools to implement these demands. (2007)
1291.	That this Meeting abhors the treatment of students being tested for HIV without adequate provision of information regarding the necessity of the test and its consequences. This Meeting believes that where medical students are to be offered tests for HIV they are offered pre-test counselling and made aware the test is not a mandatory requirement. The MSC should work with the BMA occupational health branch of practice committee and medical schools to produce clear guidelines to ensure this occurs. (2007)
1292.	That this Meeting calls on the BMA to campaign for the implementation of a maternity and paternity policy at every UK medical school. (2006)
1293.	That this Meeting: <ul style="list-style-type: none"> (i) believes that medical students are as much a part of the multidisciplinary health care team as nursing students and other health care profession students; (ii) believes that, in the spirit of working as a team, medical students should not have to compete with different health care profession students in order to complete their curriculum's practical objectives. (2006)

1294.	That this Meeting has observed the welcome increase in medical student numbers; however, it requests that the BMA should seek reassurance from the government that continued increases in numbers will not detriment students or doctors by either exceeding workforce requirements or negatively impacting on student teaching and access to learning resources, especially patients. (2006)
1295.	That the jointly agreed BMA/CHMS Medical Schools Charter clearly outlines the responsibilities of medical students and medical schools and believes that all medical schools should adopt this charter in its entirety. The BMA should therefore work with the CHMS to ensure that each UK medical school either participates fully in the Charter, using it to replace any current agreements or contracts, or provides detailed justification for any decision not to do so. (2006)
1296.	That this Meeting believes that medical students have limited control over where they are assigned to undertake their clinical attachments, therefore, it is unreasonable to expect them to meet the cost of travel to and from such placements. (2006)
1297.	That this Meeting believes that for students entering newly established medical courses, there should be adequate funding, resources, academics, clinical capacity and placements available to ensure these students are not disadvantaged compared to those on more established courses. (2006)
1298.	That this Meeting notes that discrimination is faced by both medical students with disabilities and those with disabilities applying to medical schools and: (i) believes that disability should not necessarily be a barrier to medical school entry; (ii) calls upon the BMA medical students committee to collect case studies of medical students with disabilities; (iii) calls upon medical schools to provide adequate support for medical students with disabilities; (iv) believes that assessment of medical students should be based positively upon competencies and not negatively upon conditions; (v) calls upon the GMC to work with the BMA medical students committee and CHMS to issue specific guidelines regarding the assessment of fitness to practice with respect to disabilities including mental illness, physical impairment and specific learning disabilities. (2005)
1299.	That this Meeting deplores the use of harassment and bullying in medical education and therefore resolves; (i) medical schools should have clear anti-harassment/bullying policies similar to those in the NHS; (ii) the MSC welfare subcommittee should produce and circulate a document to students detailing their rights with regard to harassment; (iii) the way medical schools handle complaints must allow for both anonymous and mediated mechanisms that must report back and act upon findings accordingly; (iv) the MSC, in conjunction with MASC and CCSC should develop a strategy plan considering mechanisms to tackle harassment and bullying of medical students which is to be presented to the ARM 2006; (v) the practice of consultants "signing off" students can be subjective, open to abuse and prevent many students from complaining about incidents of harassments and bullying for fear of hindering progress through their course. (2005)

1300.	That medical schools and teaching hospitals should provide for the needs of students of all faiths, particularly with regards to prayer room facilities and chaplaincy services. (2005)
1301.	That this Meeting calls for the MSC and BMA to work with medical schools to ensure that the right to study part time (at down to 50 % of full time rates) should be given to: (i) any medical student whose request to do so is supported by the university's or another appropriate occupational health physician; (ii) all medical students who are parents or carers. (2004)
1302.	That the Government's education policy has actually resulted in a future of medical schools for the rich. All medical schools should have a clear, publicly available widening participation agendas. (2004)
1303.	That this Meeting recognises that: (i) any "student agreements", or their corollary, that impose duties on individual students, must also impose duties on the medical school offering the agreements; (ii) if such agreements are to be recognised legally then they should be centrally formulated by CHMS and the GMC in negotiation with the BMA. (2004)
1304.	That this Meeting believes that there are benefits to students of a voluntary mentoring system from junior doctors and it demands that the BMA: (i) supports the MSC in setting up such schemes; (ii) sets up a mentoring support unit to recruit, train and support mentors; (iii) publishes guidelines on what students would like to gain from a mentoring process as well as what support mentors would be expected to provide; (iv) conducts market research to clarify what medical students want in this respect. (2004)
1305.	That this Meeting believes that measures to widen participation in medicine must be targeted specifically at medicine and not just for the whole university to which the medical school belongs. (2003)
1306.	That this Meeting believes that, given the difficulties in recruiting to rural practice and the importance of this sector of the workforce in our communities, there should be a greater promotion and funding of rural placements for medical students. (2003)
1307.	That this Meeting believes that: (i) medical students should not be expected to perform intimate examinations on patients who are anaesthetised or unconscious if appropriate consent has not been obtained; and (ii) that an optional clause for consent to such examination should be added to standard hospital consent forms with the explicit option of refusal of that clause. (2003)
1308.	That this Meeting believes that given the need for doctors to be increasingly involved in provision of care to patients with HIV and AIDS, students must not be prevented by medical schools from undertaking medical electives in countries with high incidence of HIV infection. (2001)
1309.	That this Meeting believes that attempts to exclude students from medical school on the basis of risk of acquiring HIV or viral hepatitis are discriminatory, unethical and unacceptable and therefore:

	<p>(i) calls upon the GMC to amend its guidelines to enable students with blood-borne infections to begin and complete degree courses in medicine in specific circumstances;</p> <p>(ii) calls upon deans of medical schools to show flexibility in modifying courses where necessary to accommodate such students.</p> <p>(1998)</p>
1310.	<p>That this Meeting believes that hospitals in receipt of SIFT/ACT/STAR should provide adequate library, computer and accommodation facilities for medical students.</p> <p>(1996)</p>
1311.	<p>That this Meeting believes that all graduating medical students should affirm an updated version of the Hippocratic oath.</p> <p>(1995)</p>
1312.	<p>That this Meeting believes that medical schools have a responsibility for their students and that they should provide clear guidance on health, safety and security for students undertaking community attachments and electives, both at home and abroad.</p> <p>(1995)</p>
1313.	<p>That this Meeting supports the awarding of ordinary degrees to individuals who complete three or more years of the undergraduate medical course with a good academic record but who wish to make an "honourable exit" from medicine.</p> <p>(1995)</p>
1314.	<p>That this Meeting believes that medical students should be taught practical procedures which would be relevant to their house jobs; these skills should be taught in an informed, systematic way and formally tested.</p> <p>(1995)</p>
1315.	<p>That this Meeting feels that medical students should be given training to deal with complaints from patients in order to recognise that this ability is part of a doctor's job.</p> <p>(1994)</p>
1316.	<p><u>Career guidance</u></p> <p>That this meeting believes that Looked After Children wanting to apply to medicine have equal value to the profession as other applicants and:-</p> <p>i) calls that children from care should not be discouraged from applying due to their personal background or lack of family support;</p> <p>ii) calls that children from care should receive additional support and information from universities during the application/interview process if requested;</p> <p>iii) calls that children from care should be allocated a contact from the university responsible for all students from care once a student at the university;</p> <p>iv) calls that children from care should be provided help in finding summer time accommodation for students with no out-of-term time base;</p> <p>v) the BMA should lobby each medical school to produce a 'looked after children' policy to increase participation by people who were looked after children.</p> <p>(2019)</p>
1317.	<p>That medical students should not be selected solely on academic criteria. Personality attributes must also be considered.</p> <p>(1980)</p>
1318.	<p><u>Medical students' finances</u></p> <p>That this meeting condemns the proposed increase in tuition fees and calls on the BMA to:-</p> <p>i) support other organisations campaigning against the proposals;</p>

	<p>ii) oppose excessive rates of interest charged on student loans and lobby for any interest charges to be in line with the governments' long-term borrowing costs. (2017)</p>
1319.	<p>That this meeting, with regard to the subject of student financing:-</p> <p>i) is appalled at the abuse of parliamentary processes by UK government to avoid debate on the removal of maintenance grants for students, including medical students from disadvantaged backgrounds;</p> <p>ii) calls for the retention of the NHS Bursary for medical and other healthcare students in its current form;</p> <p>iii) calls on council to investigate ways of increasing financial support to students from poorer backgrounds, to widen participation in medicine. (2016)</p>
1320.	<p>That this meeting calls upon the BMA to lobby for sufficient and equitable travel expenses to be provided for medical students on placements across the UK. (2016)</p>
1321.	<p>That this meeting is concerned that the massive debt that medical students will have accumulated by the end of their training will have a detrimental effect on the makeup of the medical workforce and requests:-</p> <p>i) the BMA to investigate the effect that this cumulated debt may have on the diversity of the future medical profession;</p> <p>ii) extension of the option of tuition fee loans to students doing a second degree;</p> <p>iii) increased direct funding to universities by government;</p> <p>iv) abolition of tuition fees. (2015)</p>
1322.	<p>That this Meeting is deeply concerned by the recent increase in university tuition fees, and fears that this will further restrict access to the medical profession to the most affluent rather than the most able and will reduce the socio-economic and ethnic diversity of future doctors, and therefore: -</p> <p>i) calls on the government to ensure that the proportion of students from disadvantaged backgrounds entering university is separately measured for medicine;</p> <p>ii) calls on the government to ensure that access agreements for those HE Institutions wishing to charge above £6,000 a year specifically address access to medical degrees and that these access agreements are properly monitored and enforced;</p> <p>iii) calls on the government to increase support for those studying medicine to ensure people are not disadvantaged by the longer course;</p> <p>iv) calls on the BMA to request that all medical schools detail their spending to show where the £9,000 medical students will be paying per year will go and how this will contribute to further improve the standard of teaching. (2011)</p>
1323.	<p>That this Meeting:</p> <p>i) welcomes the government announcement on 28 June 2011 regarding tuition fee support for medical students for 2012/13, but is dismayed that this policy has been confirmed for one year only;</p> <p>ii) calls on the government to improve tuition fee support for both undergraduate and graduate medical students beyond 2012, and mandates the BMA to lobby to ensure this is achieved. (2011)</p>
1324.	<p>That this Meeting believes that embarking on a medical career is increasingly dependent on parental financial resources not on aspirations of the student. This is detrimental to diversity</p>

	<p>among medical applicants, especially in attracting applicants from lower socio-economic backgrounds. This Meeting calls for:</p> <ul style="list-style-type: none"> (i) full funding to be available for all students sitting UKCAT; (ii) the BMA to campaign against lifting the cap off top-up fees; (iii) the restoration of free F1 accommodation or the provision of adequate financial compensation; (iv) the BMA to raise these matters with the relevant government departments. <p>(2009)</p>
1325.	<p>That this Meeting recognises the need for medical students to sometimes study at hospitals distant from their medical school base, and that reimbursement of travel expenses differs between medical schools.</p> <p>We call upon the BMA to:</p> <ul style="list-style-type: none"> (i) bring this matter to the attention of the Medical Schools Council, and to highlight the financial consequences on medical students; (ii) develop a guidance paper for medical schools concerning reimbursement of travel expenses; (iii) discuss with the Medical Schools Council possible methods to equalise the situation between medical schools. <p>(2009)</p>
1326.	<p>That this Meeting:</p> <ul style="list-style-type: none"> (i) abhors the decision of the Students Loans Company to use the retail price index as its preferred inflation index, which means interest payable on student loans has doubled from 2.4% in 2006 to 4.8% in 2007; (ii) recognises that this extra financial burden will be a key factor against widening participation and access to medicine; (iii) urges the BMA to lobby all medical schools to raise awareness among their students about the current situation; (i) supports the Early Day Motion (EDM) 263 tabled in Westminster Parliament which expresses concern on this matter, and suggests that interest charged on student loans should either be abolished, or pegged at a maximum of one percent to ensure a fairer deal for students and maximise recruitment to higher education; (v) supports the MSC's campaign to encourage all students to email their MPs to sign EDM 263 motion about widening access. <p>(2008)</p>
1327.	<p>That this Meeting:</p> <ul style="list-style-type: none"> (i) believes that rises in the fees that universities charge to students have a detrimental effect on the recruitment of students from disadvantaged backgrounds; (ii) condemns the UK government and the Scottish Executive for allowing English, Northern Irish and Welsh students studying in Scotland to be charged more tuition fees than their Scottish and EU colleagues; (iii) condemns the UK government and Welsh Assembly for allowing English, Northern Irish and Scottish students studying in Wales to be charged more tuition fees than their Welsh and EU colleagues; (iv) condemns the UK government and Welsh Assembly for allowing Northern Irish and Scottish graduate entry students studying in England and Wales to be charged more tuition fees than their English, Welsh and EU colleagues; (v) believes that fees charged by universities to students should not vary according to whether the student has been domiciled in England, Northern Ireland, Scotland or Wales and calls for the BMA Council to lobby the relevant authorities against such discrimination. <p>(2007)</p>

1328.	That this Meeting calls on the BMA and the Health Departments to continuously review the current NHS bursary allocation system with the aim of meeting the following targets: (i) funding to be made available to all medical students for the duration of their degree; (ii) bursary payments to be made on time; (iii) the establishment of similar scheme rules for all Northern Irish medical students. (2007)
1329.	That this Meeting deplores the costs of transport for medical students by car, bus or hospital conveyance to hospitals where parking fees are not waived and parking places not guaranteed. (2007)
1330.	That this Meeting deplores the huge amount of debt that medical students have by the time they qualify study and working conditions for medical students should be improved. (2007)
1331.	That this Meeting would like to see an increase in the amount of student loan for 3rd year and onward students. (2006)
1332.	That this Meeting has deep concerns about "top-up" fees as they might be expected to deter students from wider social backgrounds from participating in medical education. (2005)
1333.	That this Meeting believes that the current student loans system does not adequately reflect the needs of students on courses of professional study, and that: (i) a higher value of student loan should be available to medical students that adequately reflects the number of weeks and hours of required study, preventing the option of taking a part-time job; (ii) the amount of loan available to medical students should reflect the higher costs of participating in the course (materials, electives, travel costs, etc); (iii) the amount of loan available in the final year should not be reduced on the grounds of employment being able to be sought following completion of exams, as house officer posts do not commence until August. (2005)
1334.	That this Meeting: (i) notes that a notable proportion of medical students cease to receive financial support from their families before the age of 25; (ii) notes that a number of families do not contribute to the maintenance and essential course expenses of their offspring; (iii) believes many medical students are financially independent before the age of 25; (iv) believes the current system which deems only those students who are 25 years or older as independent is a fallacy; (v) resolves to mandate the MSC and BMA to campaign for a lowering of the age at which a student is deemed financially independent from 25 to a more appropriate age. (2005)
1335.	That this Meeting believes that the introduction of the Higher Education Bill 2004 will herald a time where access to medical school is dependent on one's willingness to commit to considerable levels of debt rather than one's aptitude. To this end, the BMA resolves to lobby the Government for the concessions for medical students that: (i) provides separate access agreements for medicine; (ii) expand the existing student support arrangements for medical students to ensure that essential maintenance and course costs are met; (iii) ensure that medical students are not in more debt than those studying three-year honours courses;

	<p>(iv) recognise the contribution medical students will make as doctors in repayment of debt accumulated at medical school;</p> <p>(v) treat graduate students in a fair, consistent and equitable manner.</p> <p>(2004)</p>
1336.	<p>That this Meeting believes that the deregulation of university fees will be detrimental to the future of medical education as the cost of a medical degree will become a deterrent for those from lower income families, depriving the medical profession of candidates of great potential and diversity that will enhance the provision of health care in the future.</p> <p>(2003)</p>
1337.	<p>That this Meeting believes that the anomaly whereby final year medical students receive a reduced student loan entitlement is unacceptable. It calls upon the BMA to:</p> <p>(i) launch a campaign to publicise this issue;</p> <p>(ii) undertake negotiations with the relevant government department to rectify this situation.</p> <p>(2003)</p>
1338.	<p>That this Meeting accepts that escalating student debt is discouraging people from studying medicine and calls upon the BMA to lobby for NHS bursaries to cover the realistic cost of living attached to studying medicine.</p> <p>(2003)</p>
1339.	<p>That the BMA should strongly pursue the expansion of the NHS bursary scheme to cover all the years of a medical degree in line with the provisions of other healthcare professional training programmes.</p> <p>(2002)</p>
1340.	<p>That this Meeting is concerned at the increasing levels of student debt and hardship and urges the BMA to continue to lobby the government for adequate funding for students.</p> <p>(2002)</p>
1341.	<p>That this Meeting believes that all final year medical students should be entitled to a full student loan.</p> <p>(2002)</p>
1342.	<p>That this Meeting calls for the abolition of tuition fees and the introduction of a graduate endowment system across the UK, to prevent discrimination by post-code and to enable students to enter higher education without the increased fear of financial burden generated by tuition fee payments and debt.</p> <p>(2001)</p>
1343.	<p>That this Meeting:</p> <p>(i) believes that parental means testing is flawed and has no place in a system of funding aspiring to equality of access; and</p> <p>(ii) urges the Government to replace parental contributions with grants or loans.</p> <p>(1998)</p>
1344.	<p>That this Meeting opposes the Government's plan to allow provision of the student loan scheme by private financial institutions.</p> <p>(1996)</p>
1345.	<p>That, whilst deploring the need to have student loans, medical students should be entitled to increased amounts.</p> <p>(1994)</p>

1346.	That this Meeting recognises the inadequate reimbursement of medical students' travel expenses by grant awarding bodies and calls for a review of travel expense awards. (1991)
1347.	That this Meeting insists that medical schools provide adequate transport for teaching attachments away from the local teaching base. (1991)
1348.	<u>Selection</u> That this Meeting deplores those financial obstacles that discourage potential applicants from a diversity of backgrounds from entering medical school, (in particular calls to raise tuition top-up fees); and instructs the BMA to explore a scheme where student debt arising from undergraduate medical degrees could be written off pro-rata by subsequent years worked in the NHS. (2010)
1349.	That this Meeting calls for the BMA to: (i) review the new medical school entry examination (UKCAT) with a view to effectiveness and the implications of the cost to candidates; (ii) investigate the causes of any under-representation of minority ethnic groups and those from poorer socio-economic groups within medical schools; (iii) lobby relevant bodies to acknowledge and address discrepancies in the representation of ethnic and socio-economic groups in medical schools. (2008)
1350.	That this Meeting: (i) welcomes the introduction of criteria other than just academic achievement for entry to medical school; (ii) urges that any such criteria or testing must be evidence-based, open to audit and long-term evaluation. This audit should include a comprehensive impact assessment process on the grounds of race, disability, gender, sexual orientation, religion or belief, age and socio-economic backgrounds; (iii) believes that there are currently significant barriers to entry to medical school for students from lower socioeconomic backgrounds and the cost of additional testing should not be a barrier to medical school entry; (iv) calls on medical schools and the Council of Heads of Medical Schools to investigate and implement methods to ensure that costs are not incurred by potential medical students. (2006)
1351.	That this Meeting believes that an upper age limit on entry to medical school is likely to be imposed by medical schools at some point and requests that the MSC and BMA explore the issues of embarking upon a medical career at an advanced age. This work should be undertaken as a matter of urgency. (2006)
1352.	That this Meeting believes: (i) that dyslexia is not a barrier to becoming a doctor; (ii) that students who are dyslexic should receive additional support during their undergraduate medical training; and (iii) resolves that medical schools should adopt the BMA MSC Dyslexia Guidance as best practice and widely promote the availability of this guidance to medical students. (2006)

1353.	<p>That this Meeting:</p> <ul style="list-style-type: none"> (i) notes the white, western world-view implicit in parts of the GAMSAT entrance exam; (ii) notes the under-representation of minority ethnic individuals on UK graduate entry courses; (iii) mandates the MSC Education Subcommittee to examine, or cause an external body to examine, the GAMSAT examination for ethnic bias and institutional racism, and other examinations as it sees fit; (iv) calls upon the BMA to lobby government and medical schools for an independent review of medical school entrance examinations for ethnic bias and institutional racism. <p>(2004)</p>
1354.	<p>That this Meeting calls for medical schools to have open and transparent applications procedures and measures for medical student selection, in order for candidates to understand on what criteria they are being assessed.</p> <p>(2004)</p>
1355.	<p>That this Meeting notes the shortfall in applicants to medical schools from non-traditional backgrounds and so supports medical school recruitment outreach projects but recommends:</p> <ul style="list-style-type: none"> (i) that such teams interact with school pupils before they choose their GCSEs; (ii) that such work should be carried out in conjunction with other healthcare profession groups. <p>(2004)</p>
1356.	<p>That this Meeting believes work experience:</p> <ul style="list-style-type: none"> (i) should not be a pre-requisite to medical school entry as it is not always a useful experience and is difficult to obtain by applicants from lower socio-economic classes; (ii) guidelines should be produced by the Department of Health on what students can and should be able to do during work experience; (iii) should be facilitated regionally by hospitals and medical schools to help students gain placements. <p>(2003)</p>
1357.	<p>That personality testing is currently not sensitive enough to establish what makes a safe or good doctor. It should hold no place in:</p> <ul style="list-style-type: none"> (i) medical school selection; (ii) assessment of qualified doctors referred to the National Clinical Assessment Authority. <p>(2002)</p>
1358.	<p>That for NHS medical appointments and for selection for medical school written information to be considered by shortlisting panels must not include the applicant's name, sex, date of birth, marital status, nationality, place of birth, place of qualification or address.</p> <p>(1997)</p>
1359.	<p><u>Student health</u></p> <p>That this meeting is dismayed at university inaction regarding the depression and suicide epidemics which permeate our profession and calls upon the BMA to:-</p> <ul style="list-style-type: none"> i) lobby all medical schools to provide all students with a tutor with a purely pastoral role for the duration of their degree. Formal suicide awareness and mental awareness training should be mandatory for these tutors; ii) identify medical schools at which wellbeing and professionalism staff do not operate in separate departments, and lobby these departments to separate; iii) lobby all medical schools produce annual reports on their actions to improve mental wellbeing provision for medical students; iv) conduct a national survey of wellbeing interventions medical schools have put in place and how complaints from medical students about wellbeing support services are handled.

	(2020)
1360.	<p>That this meeting recognises that medical student support services, especially in relation to mental health, can be involved in both fitness to practice and academic progression processes. We therefore call for the BMA to lobby relevant bodies to: -</p> <ul style="list-style-type: none"> i) establish clear separation between student support and academic progression services; ii) be transparent about how medical student support services data is used and the limits of confidentiality; iii) provide examples of best practice solutions of confidential student support services. <p>(2019)</p>
1361.	<p>That this meeting notes there is a need for increased recognition, publicity and support for the mental health needs of medical students. This meeting calls for the BMA to:-</p> <ul style="list-style-type: none"> i) continue to research the types of mental health issues being experienced by students so support can be provided to meet the students' needs; ii) review current mental health support provided by medical schools, particularly noting any disparities in support offered between medical schools; iii) campaign to make mental health awareness and promotion of self-care practices a core part of the medical education curriculum; iv) campaign for clinical facilitators to receive basic training in order to support medical students with mental health difficulties; v) campaign for increased access to personal tutoring and high quality psychological support at medical schools and in hospitals; vi) lobby student health services to provide extended opening hours for medical students that are not able to comply with a 9 to 5 timetable. <p>(2018)</p>
1362.	<p>That this meeting calls on medical schools and NHS trust / health boards to provide free influenza vaccinations for all medical students on placement and calls on the BMA to publicise the entitlement to medical students and NHS providers.</p> <p>(2015)</p>
1363.	<p>That this Meeting calls on the BMA to campaign for improved mental health provision for medical students by:</p> <ul style="list-style-type: none"> i) lobbying the medical schools council (or other relevant bodies) to separate mental health/welfare services within medical schools from professionalism/fitness to practise panels; ii) lobbying medical schools to provide appropriate training in mental health for medical student support staff that work with medical students; iii) working with medical schools to ensure students with mental health difficulties are provided the same level of support that is given to students with other disabilities or illnesses; iv) encouraging medical schools to make all students aware of the support services available to them at their medical school, e.g. disability support office, counselling service and the disability support allowance; v) supporting medical students in coming forward with any mental health concerns without prejudice. <p>(2014)</p>
1364.	<p>That this Meeting regrets that the reform in student health and conduct has not led to trusts relaxing their rules on students who are infected with Hepatitis B, and calls upon the BMA to ensure that this untenable position is reversed immediately in line with current legislation.</p> <p>(2004)</p>
1365.	<p>That this Meeting believes that a past diagnosis of mental illness is not in itself a sufficient reason to prevent qualified and suitably recovered students from embarking on a medical undergraduate course.</p>

	(2001)
1366.	<p><u>Student numbers</u></p> <p>That this Meeting believes that increasing medical student numbers has caused some oversubscription to the foundation programme;</p> <p>i) that there should be a Foundation Post for all graduating UK medical students.</p> <p>(2014)</p>
1367.	<p>That this Meeting:</p> <p>(i) acknowledges that NHS workforce planning has resulted in the creation of 2,150 more medical school places than in 1997, increasing the number of students at many medical schools;</p> <p>(ii) recognises that the increase in medical school places has resulted, in some medical schools, in unacceptable student numbers to each clinical teacher increasing the pressure on clinical staff to provide quality teaching whilst continuing to provide quality care for patients;</p> <p>(iii) believes that the increasing ratio of medical students to patients also reduces the amount of clinical experience possible per student which ultimately has negative effects on medical education;</p> <p>(iv) calls on the BMA to survey medical students and medical academics across the country regarding students to clinical teacher ratios;</p> <p>(v) calls on the BMA to lobby the Medical Schools Council, the General Medical Council and other key stakeholders to ensure that increasing student numbers does not come at the detriment of student education.</p> <p>(2009)</p>
1368.	<p>That this Meeting believes given the current job climate, that there should be stricter controls on the number of places at medical school to avoid the overproduction of doctors with limited career opportunities and that there should be a complete embargo on the opening of any new medical schools.</p> <p>(2008)</p>
1369.	<p>That this Meeting believes that expansion in student numbers in medical school has been mismanaged by the government, and medical schools that were already too large have got bigger. Expansion has had a detrimental effect on the delivery of education in some schools. We call for an urgent re-assessment of medical school numbers by an independent body, a re-allocation where necessary, and a sustained increase in the number of medical educators.</p> <p>(2005)</p>
	MEDICAL WORKFORCE
1370.	<p>That this meeting is appalled at reports that doctors have been encouraged to discharge patients early or not to admit patients despite the risk and calls on the BMA to:-</p> <p>i) develop a clear plan to support doctors to deal with performance issues resulting from system pressures;</p> <p>ii) continue and escalate lobbying to the Departments of Health to urgently increase front line capacity;</p> <p>iii) campaign for the introduction of safe staffing legislation across the UK;</p> <p>iv) create a toolkit for trusts and health boards to enable and assist them to set and adhere to safe minimum staffing levels.</p> <p>(2021)</p>
1371.	<p>That this meeting welcomes the Health and Safety Executive requirements on employers for facilities for pregnant and breastfeeding employees, believes no pregnant person should be forced to take any risks to their baby's life or wellbeing, and:-</p>

	<ul style="list-style-type: none"> i) calls for clear guidance for pregnant doctors on prolonged standing, shift work and night shifts; ii) calls on the BMA to negotiate the right to opt out of long shifts and night shifts for pregnant doctors without any negative repercussions on the individual; iii) calls on Trusts to ensure that adequate facilities are provided for staff to breastfeed. <p>(2021)</p>
1372.	<p>That this meeting condemns successive governments' failures to retain the medical workforce, and calls upon the current governments to ensure appropriate financial recognition of long serving clinicians and also ensure there are no financial disincentives to work more hours or more years.</p> <p>(2021)</p>
1373.	<ul style="list-style-type: none"> i) That this Meeting believes that wholly owned subsidiaries undermine the terms and conditions of health workers and lead to a two tier workforce. ii) This Meeting calls on the BMA to oppose wholly owned subsidiaries and to call for existing wholly owned subsidiaries to be abolished and all workers to be brought back into NHS terms and conditions. <p>(2019)</p>
1374.	<p>That this meeting welcomes the increasing role of non-medical members of the clinical workforce, with the following provisos: -</p> <ul style="list-style-type: none"> i) they must be fully trained for the role by a national certified body, preferably linked to a royal college; ii) they must belong to a regulatory body; iii) appropriate indemnity must be agreed with the employing body; iv) they must be seen to be part of a multidisciplinary team; v) they must have a title which makes it clear that they are not medically qualified. <p>(2019)</p>
1375.	<p>That this meeting is concerned by the increasing numbers of doctors that are suffering from burnout and demands that HM Government: -</p> <ul style="list-style-type: none"> i) reduces the bureaucratic burden of assessments during training; ii) reduces the bureaucracy created by appraisal and revalidation; iii) reduces the CQC inspection system which is causing stress to medical and other healthcare staff; iv) recognises that constant inspection does not produce improvement unless funding, staffing and appropriate resources are also improved. <p>(2019)</p>
1376.	<p>That this meeting recognises the research carried out by the Cavell Nurses Trust that has shown that nurses experience a higher risk of violent attack and domestic abuse in the home than that experienced by the general population, and believes that this risk may also apply to the medical profession due to the inherent personality of those that work in healthcare. This meeting therefore calls upon the BMA to follow the example of UNISON and:-</p> <ul style="list-style-type: none"> i) carry out a research study of members to assess if this risk exists; ii) offer specialised support for members affected by domestic abuse, including mental health support and emergency legal and financial assistance; iii) publicly increase awareness of these risks affecting health professionals; iv) formulate resources for doctors and medical students to improve the ability of the profession to recognise domestic abuse in patients and colleagues. <p>(2018)</p>
1377.	<p>That this meeting, with respect to the development of medical associate professionals, asks the government to:-</p> <ul style="list-style-type: none"> i) ensure appropriate regulation of the role; ii) ensure there are clear lines of accountability;

	<p>iii) ensure that there is clarity between the role and that of nurses;</p> <p>iv) address any unfair disparity of salary scales between the role and medical trainee posts. (2018)</p>
1378.	<p>That this meeting notes that the NHS has a drastic shortage of doctors and:-</p> <p>i) insists that the government address the central issue of workforce planning instead of attempting to populate the workplace with alternatives to trained doctors;</p> <p>ii) believes this drastic shortage is dangerous to patients, as non-doctors are put in the position of taking decisions they are not qualified to make;</p> <p>iii) instructs the BMA to seek comprehensive data annually on workforce planning for junior doctors and Extended Role Practitioners in the UK;</p> <p>iv) calls on the BMA to urgently insist that government end the scandal of rota gaps and shortages of doctors by employing more doctors in the NHS. (2018)</p>
1379.	<p>That this meeting believes the current system of funding for equipment and support for doctors with disabilities and health needs is confusing, inefficient and unfair to the doctors affected. This meeting therefore:-</p> <p>i) calls on the BMA to lobby relevant stakeholders to implement a fair and efficient system to provide funds for equipment and support for doctors with disabilities and health conditions;</p> <p>ii) believes that health education bodies should urgently tackle this issue by mandating training providers have a rapidly accessible fund from which Access to Work Equipment can be paid;</p> <p>iii) believes that equipment provided should be held by a doctor for the duration of their training irrespective of their employer;</p> <p>iv) believes that specialised or personalised equipment such as a wheelchair or adapted hearing aid should be transferred with the doctor even if they move to another region or nation of the UK;</p> <p>v) believes that funding should cover the costs of all equipment required by Access to Work. (2018)</p>
1380.	<p>That this meeting recognises that there is a chronic understaffing problem in the NHS and:-</p> <p>i) demands the detailed scoping of staffing levels of doctors is carried out individually across all the disciplines of healthcare in the UK to highlight the shortage;</p> <p>ii) proposes the introduction of enforced and published safe staffing levels applicable to doctors in primary and secondary care;</p> <p>iii) demands a universal, robust system by which doctors can immediately alert senior management to unsafe staffing and working conditions prior to, at the commencement of, or during any given shift. (2018)</p>
1381.	<p>That this meeting mandates the BMA to work with relevant bodies to ensure that where extended role practitioners (ERPs) and doctors share clinical duties:-</p> <p>i) there is an evidenced need to recruit an ERP;</p> <p>ii) the training needs of both groups are fully considered and clearly defined;</p> <p>iii) both groups have appropriate supervision, responsibility and safeguards in their roles. (2017)</p>
1382.	<p>That this meeting demands that the UK government act to avert future crises in workforce availability including reviewing the Shortage Occupation List and investments into specialties at particular risk including:- emergency medicine, general practice and paediatrics. (2017)</p>

1383.	That this meeting is concerned about the health and wellbeing of our medical colleagues particularly; stress, fatigue, burnout, substance abuse and low morale. This meeting:- i) congratulates the BMA and the Royal Medical Benevolent Fund on establishing the pilot DocHealth programme and supports an extension, following successful evaluation of the pilot; ii) calls for the establishment of a comprehensive workplace policy and code of conduct, within the framework of health and wellbeing, to help prevent and reduce the risk of harm caused by alcohol and substance misuse amongst employees; iii) calls for a fully functional and resourced occupational health service for all NHS staff; iv) calls on the government to raise morale amongst NHS staff. (2017)
1384.	That this meeting notes that the UK has fewer doctors per head of population than nearly all other European nations and believes that there must be a concerted effort, and appropriate incentives, to encourage medical recruitment and retention with the aim of increasing the number of doctors to at least the European average. (2016)
1385.	That this meeting, with regard to the training of physician associates, calls for:- i) an impact analysis on the training of doctors and medical students; ii) the introduction of their professional regulation. (2016)
1386.	That this meeting believes that government do not recognise the special difficulties of medical recruitment in rural areas and must create incentives to improve recruitment and retention in these areas. (2016)
1387.	That this meeting believes that the BMA should regularly survey medical students and junior doctors to ascertain the proportion intending to continue with or leave a career in medicine in this country. (2016)
1388.	That this meeting believes that the time commitment for newly appointed Guardians of safe working is being underestimated by Trusts and demands that:- i) the BMA advises LNCs that for most Trusts one Professional Activity (PA) session will be inadequate to fulfil this role effectively; ii) specific funding is given to Trusts to support this role. (2016)
1389.	That this meeting supports better working relationships between clinicians and managers to improve morale, gain better understanding of roles and improve patient care. We ask that the BMA lobby the relevant bodies to incorporate ways of collaborative working between clinicians and managers throughout the postgraduate curriculum, eg joint service improvement projects. (2016)
1390.	That this meeting insists that all managers must be accountable to a professional body, such as health professional registration. (2016)
1391.	That this meeting notes the contribution of emigration to NHS medical recruitment problems and:- i) asks the BMA to work with NHS Employers and governments to develop incentives promoting the retention of doctors in the NHS;

	<p>ii) calls for a national financial resettlement programme to incentivise and support doctors to return to work in the UK;</p> <p>(2015)</p>
1392.	<p>That this Meeting believes that every effort should be made to support doctors in training who may be experiencing difficulties in providing out of hours child care and ask the government, CoPMeD and NHS Employers to provide additional resources to meet the needs of out of hours childcare for doctors in training who are obliged to provide out of hours cover and who are or who become single parents where no other unpaid childcare options are available to them.</p> <p>(2014)</p>
1393.	<p>That this Meeting recognises that many doctors taking career breaks are being lost to the NHS due to the unreasonable demands made of them to enable them to return to work. Therefore we ask that:-</p> <ul style="list-style-type: none"> i) doctors on return to work programs to be appropriately remunerated for their work; ii) programmes to be structured such that the amount of time on the programme is proportionate to the time away from work and educational needs of the doctor; iii) clinician to be forced to pay for a period of supervision or mentorship as part of their return; iv) when training programme places remain unfilled funds should be ring fenced to support doctors returning to work in these specialties. <p>(2014)</p>
1394.	<p>That this Meeting is profoundly concerned by the significant and growing health burden on our profession. As doctors, our hours of work and the stresses of our working role result in atypically high rates of drug abuse, divorce and suicide and we believe:-</p> <ul style="list-style-type: none"> i) shift patterns, and night working contribute to worsened long term cardiovascular outcomes, and an increased rate of breast and colon cancers; ii) this a tragic loss to our profession, and to society as a whole; iii) the profession must refuse to let its health and wellbeing continue to suffer the collateral damage of a health system under stress; iv) the BMA should establish a working party to collate current research and address this important issue. <p>(2014)</p>
1395.	<p>That this Meeting recognises the increasing potential for stress and burnout in doctors and medical students, and that those affected do not always come forward to ask for help. It therefore calls upon the BMA to:-</p> <ul style="list-style-type: none"> i) identify how widespread stress and burnout is among doctors and medical students; ii) undertake an assessment of factors leading to stress and burnout in doctors and medical students; iii) ensure that comprehensive guidance is produced to help recognise and provide support to doctors and medical students affected; <p>(Lapsed 2019)</p> <ul style="list-style-type: none"> iv) work with the Medical Schools Council to ensure that effective pastoral support is available in every medical school. <p>(2013)</p>
1396.	<p>That this Meeting is outraged at suggestions that training female doctors or part-time doctors is a tremendous burden and a strain on the NHS or an excuse for the crisis in attendances in Emergency departments. We demand this is refuted by the MPs who reportedly made such statements and retracted by the Prime Minister or Secretary of State for Health, to set the record straight.</p> <p>(2013)</p>

1397.	<p>That this Meeting views with great concern the recent Royal College of Physicians report that found that 37% of trainee physicians describe the workload of the medical registrar as unmanageable, and calls upon the BMA to:-</p> <ul style="list-style-type: none"> i) lobby for implementation of recommendation 23 of the Francis Report to develop standards for minimum staffing levels; ii) work with relevant bodies to develop evidence-based tools for appropriate minimum medical staffing levels for different services; iii) lobby deaneries, LETBs and other relevant bodies to ensure that training is protected in the face of high workloads. <p>(2013)</p>
1398.	<p>That this Meeting urges the medical community to recognise the vital importance of rehabilitating doctors who are forced to have a career break due to illness or personal circumstances and suggests:-</p> <ul style="list-style-type: none"> i) enabling the implementation of a streamlined pathway in order to facilitate their smooth re-integration into the system, supporting them at all stages, from treatment to eventual recovery and re-employment; ii) the Practitioners Health Programme, which has shown commendable results in the London area, be rolled out to the rest of the country to benefit doctors all over Great Britain <p>(2013)</p>
1399.	<p>That this Meeting:-</p> <ul style="list-style-type: none"> i) notes a divergence of opinion within the profession regarding the impact of the European Working Time Directive and Working Time Regulations 1998 on postgraduate medical education and training; ii) notes that this polarisation only serves to divide the profession, and plays into the hands of politicians seeking to circumvent a key piece of legislation promoting employee welfare and patient safety; iii) calls upon the BMA and the Royal Colleges to develop joint policy that focuses on effective delivery of training within the European Working Time Directive framework, rather than seeking to undermine the Directive. <p>(2013)</p>
1400.	<p>That this Meeting remains concerned at reports of UK medical graduates being unable to secure places on foundation programmes on graduation, and repeats its call for better matching of numbers of foundation places to expected demand for posts.</p> <p>(2013)</p>
1401.	<p>That this Meeting believes that every eligible medical graduate from a UK medical school should have the opportunity to obtain full GMC registration, and:-</p> <ul style="list-style-type: none"> (i) believes it to be unacceptable for a UK medical graduate not to have the chance of an FY1 place and therefore not be able to obtain full GMC registration; (ii) calls on the Department of Health and devolved governments, the UKFPO and the Medical Schools Council to ensure sufficient foundation training programmes for all eligible UK graduates; (iii) calls for consideration of a coupling of the first year of the Foundation Programme with the undergraduate medical course. <p>(2012)</p>
1402.	<p>That this Meeting notes with concern the predicted oversupply of CCT holders expected over the coming decade, but recognises that this provides opportunities in addition to challenges. This Meeting calls on the BMA to:-</p> <ul style="list-style-type: none"> (i) support the conclusion of the Academy of Medical Royal Colleges' report 'The Benefits of Consultant-Delivered Care' that there is evidence across a wide range of

	<p>specialist medical fields that consultants deliver better patient outcomes and improved efficiency of care;</p> <p>(ii) develop and promote an appropriate description of consultant presence, for patient and service needs over the next decade;</p> <p>(iii) lobby the Department of Health and devolved administrations to fully consider this evidence and recognise that a move to a consultant present service would significantly improve the quality of care.</p> <p>(2012)</p>
1403.	<p>That this Meeting acknowledges that doctors are not always safe to drive home after night shifts. Therefore the BMA is strongly urged to campaign for free access to hospital accommodation / transport for doctors, upon completing a night shift.</p> <p>(2012)</p>
1404.	<p>That this Meeting:-</p> <p>(i) recognises that there are misconceptions about working when pregnant, particularly out-of-hours and emergency hospital work;</p> <p>(ii) is concerned that there are limited guidelines or recommendations for doctors on safe working practice while pregnant;</p> <p>(iii) calls on the BMA to develop guidelines for doctors on working while pregnant and share this with NHS employers in order to raise awareness among all involved of the available evidence and to improve working conditions.</p> <p>(2012)</p>
1405.	<p>That this Meeting requests for more effective support for disabled doctors at all levels.</p> <p>(2011)</p>
1406.	<p>That this Meeting agrees that doctors in training who are allocated to peripheral rotations should not be financially disadvantaged as a consequence of travel expenses associated with such work.</p> <p>(2011)</p>
1407.	<p>That this Meeting, whilst continuing to oppose the proliferation of non standard posts designed to fill gaps in rotas, recognises the reality that these posts exist and that the doctors who are occupying these posts should be protected by national terms and conditions of service, and including protected time for professional development.</p> <p>(2010)</p>
1408.	<p>That this Meeting insists that staff working in community services, both currently and in the future, should be offered employment contracts consistent with national terms and conditions of service, including pension rights, and should not be disadvantaged if the service is transferred to a private provider.</p> <p>(2010)</p>
1409.	<p>That this Meeting calls upon the government to instruct all NHS trusts to observe nationally agreed terms and conditions of employment for medical staff in order to insure that patients are not disadvantaged by doctors choosing not to apply for posts with inferior conditions of employment.</p> <p>(2010)</p>
1410.	<p>That this Meeting:</p> <p>(i) deplores the current standard of workforce planning by the Health Departments;</p> <p>(ii) is concerned about the lack of information regarding doctors leaving the profession and calls upon the BMA to investigate the numbers, demographics and reasons for doctors leaving the profession;</p>

	<p>(iii) believes that the number of medical students must be aligned with the number of specialist trainees which in turn, must be aligned with the number of consultants and general practitioners;</p> <p>(iv) calls upon the BMA to work with all the relevant stakeholders to ensure that all trainees have access to both the projected and required numbers of trainees gaining CCT in the next five years, for all specialties.</p> <p>(2010)</p>
1411.	<p>That this Meeting calls on the BMA to lobby all NHS employers to recognise that induction to the workplace is not just a tick box exercise; it should be role specific, and that time be provided during working hours to undertake induction activities (including electronic modules).</p> <p>(2010)</p>
1412.	<p>That this Meeting feels that it should be mandatory for all NHS employers to prepare contracts for new staff by the day they start work at the latest.</p> <p>(2009)</p>
1413.	<p>That this Meeting believes that the NHS Confederation favours the appointment of subconsultant grades despite denials and it asks the BMA to condemn such actions.</p> <p>(2009)</p>
1414.	<p>That this Meeting believes that less than full time working should be available to any doctor who would prefer to work part time.</p> <p>(2009)</p>
1415.	<p>That this Meeting believes that in order to maintain high quality healthcare, clinical staff in all settings should have access to an adequately resourced and staffed audit department. Therefore we call upon the BMA to lobby the Health Departments to ensure these are provided.</p> <p>(2008)</p>
1416.	<p>That this Meeting:</p> <ul style="list-style-type: none"> (i) condemns the government's persistent attempts at eroding the role of doctors in delivering NHS services and substituting them with non-doctors to the detriment of patients and mostly leading to duplication of resources; (ii) calls on the BMA to carry out a survey of doctors to clarify and emphasise the role of the doctor at various career stages including the service contribution of trainees and to use this information in lobbying government departments. <p>(2008)</p>
1417.	<p>That this Meeting deplores the widespread variation in Agenda for Change banding, with consequent difficulties in recruitment and retention in affected areas.</p> <p>(2007)</p>
1418.	<p>That this Meeting condemns the unregulated increase in the numbers of non-medical staff taking on medical tasks and roles. We urge the BMA to:</p> <ul style="list-style-type: none"> (i) assess the impact on medical employment and training; (ii) insist on strict clinical governance arrangements. <p>(2007)</p>
1419.	<p>That this Meeting believes that repeated attempts by government to establish a sub-consultant grade, at times supported by some Royal Colleges, must continue to be absolutely opposed by the association.</p> <p>(2007)</p>
1420.	<p>That this Meeting deplores the apparent attempt to erode salary levels agreed in contract negotiations with below inflation pay rises to public sector workers. It also condemns attempts by government to demonise public sector workers and blame them for causing inflationary</p>

	pressures; and calls on government to support and reward public sector workers by resisting the temptation to use pay awards as easy targets for cost cutting. (2007)
1421.	That this Meeting: (i) notes concern over the potential for confusion that the title of medical or surgical care practitioner (MCP)/(SCP) conveys to patients and calls on the BMA to make strong representation to the Health Departments that the job title of this new position does not confuse or mislead patients into believing they are being attended to by a doctor; (ii) is concerned about the impact MCP/SCPs have on training and practice and seeks special reassurance that such posts will not be detrimental to medical student or junior doctor teaching and training by removing opportunities to learn basic, essential clinical practices; (iii) believes that the numbers of MCP/SCPs should be carefully controlled; (iv) insists that MCP/SCPs are clearly identifiable as non-medical staff to patients; (v) insists that MCP/SCPs and other such practitioners have a nationally applied title, agreed with the BMA. (2006)
1422.	That this Meeting is concerned that the medical and other health-care professional redundancies due to the NHS financial crisis will compromise patient care, and calls upon the BMA to pursue this issue vigorously with government. (2006)
1423.	That this Meeting believes that doctors should only be required to cross-cover specialties in which they have relevant competencies and calls on NHS Employers and/or postgraduate deans to ensure this. (2005)
1424.	That this Meeting deplores the misrepresentation by the Government of staff numbers within the NHS by the counting of individuals rather than whole time equivalents. (2005)
1425.	That this Meeting is alarmed at increasing government attempts to populate primary and secondary care with non medical staff in the provision of clinical duties and demands that the government pay due attention to issues of training, experience, clinical governance, degree of autonomy and supervision. The titles of allied health professionals should not imply that they are medically qualified. (2005)
1426.	That this Meeting: (i) welcomes the introduction of allied professionals in improving healthcare delivery; (ii) deplores any potential reduction of essential learning opportunities for trainees; (iii) calls upon the Departments of Health to ensure that this does not compromise training, and the UK's tradition of producing good quality competent doctors. (2005)
1427.	That the BMA demands all trust grade doctors who share rotas with training grade doctors are given equal training recognition to their training colleagues. (2005)
1428.	That this Meeting believes that all interviews for medical appointments should be objectively structured and externally audited. (2003)
1429.	That employers within the NHS family should take their responsibilities for employing disabled doctors seriously and this Meeting calls for the application of nationally agreed guidelines for this provision. (2002)

1430.	That this Meeting calls for appropriate induction programmes for all health staff, particularly if they are new to the NHS. (2002)
1431.	That this Meeting believes the grade and qualifications of all professionals involved in patient care must always be clearly apparent to patients and referring doctors. (1996)
1432.	That this Meeting asks the Association to explore ways to facilitate the release of career grade doctors for overseas development work. (1995)
1433.	That this Meeting, recognising that 50% of medical students are women, calls for further efforts to encourage the promotion of more women to senior posts. (1991)
1434.	That this Meeting, concerned at the findings of the Joint Working Party on "Women Doctors and their Careers", and recognising that 50% of medical students are now women, believes that: <ul style="list-style-type: none"> (i) since women are under-represented at consultant level proportional to the number of women graduating, the Council should further investigate this area focusing particularly on the problems and prejudices currently encountered by female junior doctors, to encourage the promotion of more women to senior posts; (ii) in view of the difficulties encountered by doctors wishing to pursue part-time training for "well founded individual reasons", the procedures for appointment to part-time training posts be revised to enable more doctors wishing to pursue these options to do so; (iii) further measures such as an increase in the number of training posts where the average week approximates to 40 hours and the provision of locum cover for doctors on maternity leave should be encouraged. (1991)
1435.	That the BMA and the Royal Colleges and their Faculties should take action to address the structural barriers to the career progress of women doctors as evidenced by Isobel Allan's report "Doctors and their Careers". (1989)
1436.	That this Meeting reiterates its call for the introduction without further delay of a competent data system for medical manpower planning. (1984)
1437.	<u>Non consultant career grades</u> That this meeting calls upon the BMA to ensure that NHS Employers include within all non-consultant grade doctors contracts the right to;- <ul style="list-style-type: none"> i) a minimum of six weeks' notice of rota schedules; ii) all study leave / annual leave / personal leave being honoured when requested with 6 weeks' notice; iii) full reimbursement of costs by the employer for any financial loss incurred as a consequence of leave being cancelled by the employer. (2015)
1438.	That this Meeting is alarmed by the emergence of non consultant post CCT posts and demands that the BMA:- <ul style="list-style-type: none"> i) warns potential applicants about this practice; ii) highlights the bad practice of employing authorities who continue to perpetrate this.

	(2011)
1439.	<p><u>Whistleblowing, discrimination and bullying</u></p> <p>That this meeting is seriously concerned about the extent of bullying and harassment in the NHS and: -</p> <ul style="list-style-type: none"> i) condemns bullying and salutes those who stand up to it; ii) congratulates the BMA on the stance adopted and the work undertaken thus far; iii) welcomes the Sturrock review and calls for the recommendations of that report to be implemented across the wider NHS; iv) calls for the annual reporting by all NHS bodies of bullying and harassment cases and their outcomes. <p>(2019)</p>
1440.	<p>That this meeting:-</p> <ul style="list-style-type: none"> i) is appalled by the continuing high levels of bullying and harassment suffered by the workforce of the NHS; ii) demands that all stakeholders should be lobbied to produce specific, practicable and innovative action to wipe out this huge problem which is destroying the health and morale of so many workers and thereby adversely impacting on the safety and quality of services offered to patients. <p>(2018)</p>
1441.	<p>That this meeting calls upon NHS bodies to take ownership of concerns raised by doctors about potential high profile system failures without exposing those doctors to career risk or other detriment.</p> <p>(2016)</p>
1442.	<p>That this meeting calls on all medical schools to protect students who whistle-blow about poor clinical practice they witness.</p> <p>(2016)</p>
1443.	<p>That this meeting exhorts the BMA to promote a zero tolerance to bullying and harassment and:-</p> <ul style="list-style-type: none"> i) is appalled that an unacceptable number of members have experienced bullying and harassment; ii) urges the BMA to promote development of support mechanisms such as resilience training and counselling for those members who are subjected to bullying and harassment; iii) insists that those who bully or harass others are held accountable and dealt with appropriately. <p>(2016)</p>
1444.	<p>That this Meeting fully supports the well-established policies to allow doctors to fulfil their ethical and moral obligations to raise concerns about poor standards of patient care or safety. We therefore call on the BMA to lobby:</p> <ul style="list-style-type: none"> (i) to safeguard the principle of whistleblowing in the NHS under the Public Interest Disclosure Act 1998; (ii) to ensure that whistleblowers are not penalised or victimised; (iii) for action to stop NHS organisations suspending or excluding doctors who have been whistleblowers, where no concern has been raised about the doctor's clinical care. <p>(2010)</p>
1445.	<p>That this Meeting:</p>

	<ul style="list-style-type: none"> (i) recognises the bravery and commitment to their patients that doctors and others show when they raise concerns about standards of care and training; (ii) condemns the bullying and harassment that can sometimes occur after concerns about standards of care and training have been raised; (iii) calls on the BMA to produce guidance for doctors about whistle-blowing; (iv) calls on the BMA to ensure that all staff of askBMA and Regional Services who provide advice to doctors are aware of whistle-blowing guidelines and protections, and know how to address these aspects of doctors' requests for help from the BMA; (v) calls on the GMC to make it clear to doctors who are managers that harassment of whistle-blowers is a breach of "Good Medical Practice" guidance; (vi) demands that the BMA campaigns for zero tolerance of bullying of medical staff by medical staff. <p>(2009)</p>
1446.	That this Meeting demands that the BMA create an awareness programme in order to assist all doctors to fully understand the subtleties of bullying and harassment in the workplace. (2005)
1447.	That this Meeting is dismayed at the climate of fear and use of overt bullying that has developed within the NHS and believes: <ul style="list-style-type: none"> (i) it is detrimental to quality patient care; (ii) it should be resisted at all levels; (iii) the BMA should publicise the damage this has done to doctor -manager relationship; (iv) that it fundamentally undermines the ethos of the NHS. <p>(2003)</p>
1448.	That this Meeting believes that: <ul style="list-style-type: none"> (i) racism expressed by doctors or medical students should be regarded as a matter of serious professional misconduct; (ii) medical schools should incorporate anti-racism education as part of under graduate medical teaching. <p>(2003)</p>
1449.	That this Meeting recognises that postgraduate professional exams are unintentionally discriminatory and calls on royal colleges to include more assessors from broader ethnic backgrounds in their courts of examiners. (2003)
1450.	<p><u>Flexible training and working</u></p> <p>That this meeting supports the work that has been done in efforts to widen access to Category 3 less than full time working in emergency medicine and calls upon the BMA to work with relevant stakeholders to ensure that this access is introduced to an equivalent standard across:-</p> <ul style="list-style-type: none"> i) all specialties and; ii) all grades. <p>(2018)</p>
1451.	That this meeting condemns the poor career structure for part time doctors in all branches of the profession, and calls on the government, in the interests of maintaining a comprehensive workforce, to find an urgent remedy for this problem. (2018)

<p>1452.</p>	<p>That this meeting notes the challenges associated with returning to clinical practice after periods of time out, either as a result of opportunities such as research periods or longer career breaks as a result of wider life experiences. We are aware of examples of excellent practice in supporting doctors in return to work, although individual experiences can be very variable. Given this, we believe:-</p> <ul style="list-style-type: none"> i) that "return to work" programmes should be available to all doctors after a period out of clinical practice, be formalised, appropriately accredited and tailored to the individual doctor's requirements; ii) the BMA should consult with relevant stakeholders on how return to work can be facilitated by the GMC, HEE and employers as appropriate, both for doctors who have had shorter and extended breaks from clinical work; iii) that the BMA should take forwards this work by establishing guidance for doctors on return to work. <p>(2016)</p>
<p>1453.</p>	<p>That this meeting recognises the value of Less than Full Time (LTFT) work for doctors, but notes that these doctors sometimes face challenges that are directly linked to their working pattern. We therefore call on the BMA to work with organisations that employ doctors to:-</p> <ul style="list-style-type: none"> i) ensure that LTFT doctors are not disadvantaged in job application and allocation processes; ii) improve career structures for LTFT doctors in the interests of maintaining a comprehensive workforce; iii) ensure that working patterns are developed, beyond restrictive "Job Share" arrangements, to allow access to appropriate training opportunities; iv) facilitate and support return to work after a career break. <p>(2015)</p>
<p>1454.</p>	<p>That this Meeting urges the BMA to negotiate a retainer/returner scheme, with appropriate central funding, across the whole UK for all branches of practice within the NHS.</p> <p>(2007)</p>
<p>1455.</p>	<p>That this Meeting recognises the recent decline of those undertaking flexible training (according to COPMEDs biannual survey), and calls for an urgent enquiry into the reasons for this. Where this is due to insufficient funding, this Meeting calls for adequate financial resources, which must be protected, to be dedicated to flexible training, so that the disappointing trend can be reversed, in order for the Department of Health target of 20% of the workforce training flexibly to be a realistic goal.</p> <p>(2007)</p>
<p>1456.</p>	<p>That geographical stability is key to family-friendly working, and calls on the BMA to insist that this is taken into account when planning run through training.</p> <p>(2006)</p>
<p>1457.</p>	<p>That this Meeting calls upon the Health Departments to reinstate and appropriately fund the flexible careers scheme to allow retention of trained and experienced clinicians.</p> <p>(2006)</p>
<p>1458.</p>	<p>That this Meeting believes that all trainees are entitled to train flexibly and that:</p> <ul style="list-style-type: none"> (i) they are able to compete for posts on equal grounds; (ii) the arbitrary differentiation of trainees based on inflexible lists relating to their reason to apply for flexible training is abandoned; (iii) the BMA hold a stakeholder event within one year to look at new and different ways of addressing this issue. <p>And calls on the BMA to continue to lobby for increased funding and access to flexible training for all.</p> <p>(2006)</p>

1459.	That the BMA must campaign for flexible training to be available for all doctors, not just parents and those who are ill, and calls on government and the NHS Employers to recognise this in future planning. (2005)
1460.	That this Meeting: (i) calls on the BMA, the Royal Colleges and Departments of Health to support doctors who wish to spend time working in developing countries for humanitarian purposes; (ii) recognises the value of such experience to the UK health service when these doctors return to the UK; (iii) calls on the BMA to work closely with the Medical Royal Colleges to develop guidelines and criteria for recognising such work for postgraduate training or CPD purposes. (2004)
1461.	That this Meeting condemns the illegal practice by some employers to coerce flexible trainees to increase their sessions due to the financial difficulties of the employing bodies. (2003)
1462.	That this Meeting believes that: (i) the criteria for eligibility to undertake flexible training should be less rigid and should not discriminate against men with children; (ii) pay for flexible trainees should be fully centrally funded to ensure that trainees are not lost to the medical workforce because of the action of certain trusts. (2001)
1463.	That the Government's failure adequately to fund flexible training demonstrates: (i) that it is paying lip service to family-friendly policies; (ii) that it has no intention of Improving Working Lives for junior doctors; (iii) that it is acting in bad faith with respect to the recent pay deal; (iv) that the NHS is a callous and insensitive employer; (v) that the BMA needs to continue lobbying the government on this issue, and that this Meeting directs the BMA to do this. (2001)
1464.	That this Meeting deplores flexible training contracts consisting of 9 months with no on call and 3 months of high frequency on-call which are detrimental to training, service delivery, family life and future pension benefits; and calls upon the BMA to: (i) report employers who use such contracts to the NHS equal opportunities unit; (ii) name and shame training locations using these contracts; (iii) censure individual members who as employers use these contracts. (2001)
1465.	That hospital retainer/returner schemes should be established as a matter of urgency and be made available to all hospital doctors. This returner should enable maintenance of skills and knowledge, facilitate revalidation, but not be a disadvantage in application for future substantive posts, or necessarily be considered as training. (2001)
1466.	That, if the Department of Health wishes to encourage retention of the junior doctor workforce, flexible training must be: (i) fully funded; (ii) sufficiently flexible to enable trainees to: (iii) change the proportion of full-time equivalent work; and (iv) opt out of an on-call commitment at appropriate times in their training programme. (1999)

1467.	That the BMA actively promote the opportunities and merits of flexible portfolio careers which should be widely available to the medical profession as a matter of personal freedom. (1997)
1468.	That this Meeting recognises that now at least half of medical graduates are female and insists that training in all specialties must make positive efforts to be attractive to these doctors. (1996)
1469.	That this Meeting recommends that the opportunity for flexible training should be freely available to all training grade doctors. (1995)
1470.	That this Meeting strongly supports the introduction of flexible or part-time working opportunities at the SHO level, but believes that these schemes must be within the current manpower limits, and should be centrally aided. (1992)
1471.	That this Meeting reaffirms its commitment to the availability of part-time training at all grades and in all specialties. (1984)
1472.	<p><u>Health and morale</u></p> <p>That this meeting recognises the need for mechanisms to allow doctors to raise and resolve concerns affecting their health and welfare and calls for: -</p> <ul style="list-style-type: none"> i) exception reporting to be made available for all grades of doctors; ii) negotiating of contractual safeguards to allow senior hospital doctors the ability to withdraw from long term second on-call in appropriate circumstances. <p>(2019)</p>
1473.	<p>That this meeting:-</p> <ul style="list-style-type: none"> i) calls upon the government to urgently address the low morale and burnout in all parts of the NHS; ii) asks the BMA through the Departments of Health and National Health Services to seek to better retain doctors. <p>(2018)</p>
1474.	That this meeting asks the Association to collect the evidence of high workload pressures leading to early burnout in doctors in all branches of medicine and request NHS England to reinvest in a fully functional Occupational Health Service for all doctors. (2018)
1475.	<p>That this meeting is seriously concerned at the number of doctors suffering from burnout and stress related to an unsafe workload burden and:-</p> <ul style="list-style-type: none"> i) believes that tired and overworked doctors have an adverse effect on patient safety; ii) calls for a shift by the NHS to a culture that looks after the physical and mental health of its workforce, with occupational health services fully funded by Departments of Health; iii) insists that the Departments of Health indemnify all doctors for the associated reduction in patient safety; iv) deeply regrets the recent increase in lives lost to suicide from our profession and calls on the BMA to work with training and employing bodies to improve support for doctors working in a system under pressure. <p>(2018)</p>
1476.	That this meeting believes that medical morale has never been lower and we demand that the government reveals its plans to correct this.

	(2016)
1477.	That a better health service is dependent on improved staff job satisfaction. (2002)
1478.	That this Meeting believes that increasing workload is a significant factor in low morale among general practitioners. (1999)
1479.	That this Meeting instructs Council to insist upon adequate consultation time in respect of NHS management reorganisation proposals. (1986)
1480.	<p><u>Working conditions</u></p> <p>That this meeting notes that the law provides for workplaces to have accredited safety representatives as well as safety committees, which employers are obliged to convene and consult in matters of health and safety and that the Covid-19 pandemic has demonstrated insufficient risk assessment and inadequate worker protection in many workplaces. Therefore, this meeting calls for the BMA to:-</p> <ul style="list-style-type: none"> i) take advantage of these legal provisions for worker representation (including time paid by employers for the safety representatives to undertake their duties); ii) publicise the purposes and legal provisions of Safety Representatives and Safety Committees amongst its members; iii) insist that employers provide Safety Representatives with paid leave to take up the training required to undertake the responsibilities of their role; iv) insist that employers support the proper functioning of Safety Representatives as well as the regular convening of Safety Committees. <p>(2021)</p>
1481.	That this Meeting calls for the retention of sleeping and rest facilities for hospital doctors to achieve proper rest on duty when work-load allows and to reduce fatigue before travelling home. (2008)
1482.	That this Meeting calls for all health care workers and students to be provided with personal attack alarms, whilst in clinical areas, on community or domiciliary visits and on hospital grounds and that well-rehearsed, effective procedures must exist for aiding colleagues in the event of an alarm being raised. (2007)
1483.	That this Meeting calls for the BMA to negotiate terms and conditions of service to require that rotas are received at least 6 weeks prior to commencement of the post. (2007)
1484.	That this Meeting believes that in view of shift working patterns, handover briefings are increasingly important, but condemns departments where doctors are expected to arrive early or finish late in order for these to occur. It therefore calls for all NHS employers to ensure that rotas incorporate at least 30 minutes overlap between shifts to facilitate safe clinical care. (2007)
1485.	That this Meeting should examine and support the need for robust security arrangements for hospital staff working at night. (2006)

1486.	That all medical staff should have convenient access to office space, computers and secretarial support effectively to do their work. (2005)
1487.	That this Meeting firmly believes that a doctor's desire for safe and sensible working hours in no way implies a reduced commitment to: (i) their patients; (ii) the profession; (iii) the quality of their work; (iv) their career. (2003)
1488.	That this Meeting demands that the shift of work from secondary to primary care services or vice versa should be properly structured and appropriately resourced. (1997)
1489.	<u>Working time regulations</u> That this Meeting believes that the reduction in junior doctors' hours due to the full implementation and adherence with EWTD has had a detrimental effect on medical education and training, which could lead to increased risks for our patients. It calls upon all relevant stakeholders to: (i) work together to maintain the current standards for CCT which may necessitate an increase in the duration of training; (ii) urgently find sustainable solutions for the delivery of high quality clinical training, experience and patient care, whilst working within the envelope of hours available under the Working Time regulations. (2010)
1490.	That this meeting, in the light of motion 159, reaffirms this organisation's longstanding commitment to the appropriate implementation of the Working Time Regulations. (2010)
1491.	That this Meeting believes that doctors in training have the right to be trained and that the activities they undertake should be focused around appropriate education and clinical experience and not around rotas purely designed for employers to declare implementation of the European Working Time Directive. We call upon: (i) the BMA to provide guidance on designing suitable rotas that focus on education and clinical experience; (ii) employers to ensure that juniors are engaged in the design of their own rotas. (2010)
1492.	That this Meeting believes that senior doctors must benefit from health and safety legislation as much as any other group of doctors, and so they must not be expected to work outside the protections of the Working Time Regulations; rotas and job plans should therefore not be constructed so as to oblige senior doctors to breach the Regulations without their willing assent. (2009)
1493.	That with regard to Working Time Regulations this Meeting calls upon the BMA to work with appropriate stakeholders to: (i) ensure that high quality specialist training is possible with an average 48 hour working week; (ii) ensure that training programmes meet those standards required for appointment to a consultant post;

	<ul style="list-style-type: none"> (iii) ensure that the duration of programmes is sufficiently flexible to meet the standards for inclusion on the Specialist Register; (iv) ensure training opportunities are designed to make the best use of the time available; (v) develop assessment methods that are robust and support the trainee; (vi) ensure managed expansion of consultant posts. <p>(2009)</p>
1494.	<p>That this Meeting believes full compliance with the EWTD should be vital for a trust to hold foundation trust status.</p> <p>(2009)</p>
1495.	<p>That this Meeting insists that the quality of training of junior doctors in the UK must be maintained within the constraints of the European Working Time Directive and recognises that in some specialties (especially procedural specialties) this might necessitate increasing the total number of years spent training prior to the award of CCT.</p> <p>(2008)</p>
1496.	<p>That this Meeting believes that, with regard to the European Working Time Directive:</p> <ul style="list-style-type: none"> (i) it represents essential protection for doctors; (ii) patients may be put at risk by tired doctors who have not had appropriate breaks and rest during and between their shifts; (iii) the directive must be implemented in full for all employed doctors, including doctors in training no later than 1 August 2009; (iv) all time spent at a work place at the request of an employer must count as working time; (v) the only inactive time on call should be when one is available for work, but not required to be within the workplace, performing work or preparing for work; (vi) It is good practice to organise work so as to minimise excessive tiredness; work should not be planned deliberately to incur compensatory rest. If the need for compensatory rest should arise, it should be available as soon as possible after the interrupted rest period; (vii) Local Negotiating Committees should ensure that local agreements with employers recognise that compensatory rest as defined by the EWTD is taken as soon as possible after a disruption to rest and in place of planned work even if this means cancellation of planned patient care; (viii) the two judgements “SiMAP” and “Jaegar” of the European Court of Justice should be endorsed and calls on the Health Departments to maximise efforts to ensure readiness of the NHS for the impact of the provisions of the EWTD in August 2009; (ix) the BMA must publicise the widespread failure of implementation of the EWTD and use this to make the case for a large increase in consultant numbers; (x) the BMA must oppose the decision of the European Council of Ministers on 9 June 2008 that the inactive period of on-call time will not be classed as working time, by lobbying the European Parliament and seeking collective agreements as appropriate. <p>(2008)</p>
1497.	<p>That this Meeting believes that the reduction in junior doctors’ hours and implementation of the EWTD is adding to the already escalating clinical and administrative workload of other hospital doctors and that:</p> <ul style="list-style-type: none"> (i) as hours are reduced more medical work remains to be done in less time; (ii) the process can only proceed safely if adequate resources are put in place to absorb the additional workload; (iii) the EWTD can only be successfully implemented if also implemented for other hospital doctors. <p>(2003)</p>

1498.	<p>That this Meeting believes that, in order to deliver adequate health care within the framework of the EWTD, the government must consider radical service reconfiguration and:</p> <ul style="list-style-type: none"> (i) calls on the government to publicly acknowledge this need; (ii) calls on the BMA to educate the public accordingly; (iii) calls on the government to examine alternative models of care from other countries to help plan such reconfiguration. <p>(2002)</p>
1499.	<p>That this Meeting believes that implementation of the European Working Time Directive requires:</p> <ul style="list-style-type: none"> (i) fundamental change to the way healthcare is delivered in the UK; (ii) massive consultant expansion; (iii) innovative and flexible ways of working by consultants so that they can deliver high quality healthcare and high quality training; (iv) substantial financial investment from the Government; (v) improved postgraduate medical training to ensure sufficient adequately trained consultants; (vi) limiting medical work to tasks that require a doctor; (vii) expanding non-medical clinical staff numbers. <p>(2001)</p>
1500.	<p>That this Meeting is of the view that employing authorities should not be allowed to coerce medical staff into opting out of the limits set under the working time regulations.</p> <p>(1999)</p>
1501.	<p>That for patients' safety all doctors' workload should be subject to limitation in intensity and hours of work.</p> <p>(1994)</p>
1502.	<p><u>Work/life balance</u></p> <p>That this meeting calls for doctors to be provided with flexibility by their employer with regards to when they take their annual leave.</p> <p>(2021)</p>
1503.	<p>That this Meeting welcomes the advice of Professor Chambers that a satisfactory and tenable work-life balance relies upon long-term planning. It therefore:</p> <ul style="list-style-type: none"> (i) deplores the decision of those employing organisations which actively chose to make long-term planning near impossible by withholding information on posts, banding and rotas within rotation schemes; and (ii) calls upon the BMA to lobby the postgraduate deaneries to ensure that all rotations offered have full, up-front information on posts, banding and working patterns publicised at the time of advertising the rotation, and that posts which refuse to provide this information should have educational approval withdrawn. <p>(2006)</p>
1504.	<p>That this Meeting believes that freedom to take annual leave and study leave is a basic right of all doctors and deplores attempts to restrict or limit the taking of said leave by doctors, including the concept of 'fixed annual leave' and restricting the times at which such leave may be taken. It demands the BMA take urgent action to prevent such occurrences.</p> <p>(2004)</p>
1505.	<p>That this Meeting:</p> <ul style="list-style-type: none"> (i) believes that the "family friendly" NHS is a myth; (ii) believes that all doctors have a right to family friendly working hours; (iii) deplores the lack of readily available childcare in the NHS; and

	(iv) believes that if the Department of Health is serious about the family friendly NHS, they should make provision to support doctors taking time off when their children are sick. (2003)
	MEDICO-LEGAL AFFAIRS
1506.	That this meeting notes the concerns expressed by indemnity providers that the goodwill shown to clinicians in the pandemic will be lost under a deluge of litigations and demands the BMA seek:- i) a Repeal of S2(4) of the Law Reform (Personal Injuries) Act 1948; ii) the establishment of an independent body to define the NHS health and social care package which can give an appropriate standard of care for all patients irrespective of the cause of the patient's care requirements; iii) that we move to a New Zealand no fault compensation scheme. (2021)
1507.	That this meeting calls for a move in the NHS away from personal responsibility to corporate responsibility with regards to errors and mistakes. (2018)
1508.	That this meeting:- i) requires the BMA to robustly participate in any review of Gross Negligence Manslaughter (GNM); ii) calls for the law on GNM to take into account system pressures and failures when considering individual responsibility; iii) believes that an independent body should have a remit to provide confidential, professional, no-fault safety incident investigation on a par with the aviation industry. (2018)
1509.	That this meeting, in the light of increasing personal injury awards and rapidly increasing medical indemnity costs:- i) supports the introduction of a system of no-fault compensation for medical injuries; ii) supports the principle of annual care payments to the injured, rather than lump sum payments; iii) seeks the direct reimbursement by government of medical indemnity costs relating to NHS treatment. (2017)
1510.	That this meeting believes that the current situation with respect to rapidly rising indemnity costs for GPs in England is unsustainable and calls on the Department of Health in England to put in place a fully reimbursed system for all GPs on the national performers list, with equivalent arrangements for GPs elsewhere in the UK. (2016)
1511.	That this Meeting believes that the English libel laws are being used by commercial organisations to prevent scientific debate. That this Meeting supports reform of the libel laws so that:- i) there is a public interest defence; ii) costs of litigation should be proportional to damages awarded; iii) there should be a more rapid process to enable cases to be heard quickly; iv) commercial organisations should only be able to sue for libel if they can show financial damage in this jurisdiction; v) peer-reviewed academic publications be added to the list of public interest reports which benefit from the defence of statutory qualified privilege. (2011)

1512.	That this Meeting asserts that in order to demonstrate an up-to-date understanding of medicine and to maintain credibility with appellants and the profession, doctors working as medical members of Tribunals should be licensed as well as registered and subject to the revalidation process, and calls on the BMA to work with the appropriate bodies to achieve this position. (2011)
1513.	That this Meeting notes that the judgement in the "XYZ" case (High Court 11th May 2011) effectively abolishes the anonymity of expert witnesses in child protection proceedings, and calls on BMA Council and the Medico-Legal Committee to consider what subsequent actions need to be taken to protect both children and doctors. (2011)
1514.	That this Meeting believes that the exposure of the NHS to competition law will embroil commissioners in endless legal action at the hands of unsuccessful bidders for NHS services. Such legal action will either waste consortia resources if contested or result in capitulation to bidders supported by large legal resources. This Meeting therefore calls on the BMA to campaign against the application of competition law to the NHS. (2011)
1515.	That this Meeting believes that 'medical error' is a complex process in which allocation of individual culpability rarely advances justice or patient safety, and so criminalisation of medical error is inappropriate for all but a tiny minority of cases; greater understanding of individual incidents can only be achieved through early, non-adversarial review involving medical experts. (2009)
1516.	That this Meeting: (i) recognises that although they may be justified, medical negligence claims have a significant financial impact on the NHS to the detriment of patient care; (ii) mandates the BMA to consult with the government and relevant bodies to debate and set levels of compensation that are fair, not only to the injured patient, but also to the taxpayer and NHS patients. (2007)
1517.	That this Meeting recommends that it is essential for any practitioner asked to prepare a report on a patient for a third party to: (i) have access to all the relevant health records with the patient's consent; (ii) be suitably trained to prepare such a report; (iii) be reimbursed in an appropriate and timely manner. (2004)
1518.	That this Meeting requires a complete reappraisal and re-negotiation of the statutory rights for attendance by doctors at road traffic accidents in view of the considerable disincentives that exist. (1996)
	MENTAL HEALTH
1519.	That this meeting is concerned about the possible adverse impact that Covid 19 will have on the mental health of healthcare workers and carers:- i) with the potential for colleagues to experience anxiety, grief, unresolved anger, depression, moral injury and even PTSD as a result of their experiences; ii) and insists that Governments and NHS departments must without delay make resources widely and rapidly available for all health workers and carers who need

	mental health support. (2020)
1520.	That this meeting calls upon the Department of Health and Social Care to commit to: - i) increasing mental health funding incrementally over the period of the 10 Year Plan to reach a minimum of 25% of overall budget in line with mental health treatment need and activity levels; ii) parity of resource, access, and outcome for mental and physical health services rather than esteem; iii) requiring those commissioning local services to allocate adequate, ring fenced funds for mental health promotion and prevention in line with the 10 year plan. (2019)
1521.	That this meeting calls upon the government to urgently address mental health care for adolescents (CAMHS) and 16 to 18-year-olds and establish clearer national standards of care for commissioners. These standards should include effective care after the age of 18 years. (2018)
1522.	That this meeting calls on the Department of Health to ensure that the impending review of the Mental Health Act for England and Wales is underpinned by the following principles:- i) parity for mental and physical health; ii) the Responsible Clinician for any detained patient must be suitably experienced in treatment of both mental and physical disease; iii) the Act must seek to remove discriminatory elements for detained black and minority ethnic patients; iv) conditions for applying Community Treatment Orders must be strengthened to prevent overuse; v) appeals and Tribunals must be robust, protect patient's rights, and be appropriately funded with adequate time and resources for clinician involvement. (2018)
1523.	That this meeting believes that parity between physical and mental health will only be achieved if the stigma against mental health problems among medical professionals is addressed. We call on the BMA to create a national campaign to eliminate mental health stigma among medical professionals. (2017)
1524.	That this meeting believes that mental health is in crisis, and that there has to be a root and branch review by the UK government of commissioning arrangements, beds and community provision. (2017)
1525.	That this meeting calls on all undergraduate and postgraduate Deans to ensure that doctors at every stage of training understand the Mental Capacity Act, recognise that capacity can fluctuate, recognise reversible causes of impaired capacity and understand the requirement to involve those important to a patient in a meeting about a best interests' decision. (2016)
1526.	This meeting:- i) acknowledges the current underfunding of mental health care and; ii) urges UK governments and the NHS to increase the funding for mental health services to reflect parity of esteem with physical health care services. (2015)

1527.	<p>That this meeting deplores the discrimination and poor health outcomes faced by people with learning disabilities and urgently calls upon the BMA to:-</p> <ul style="list-style-type: none"> i) lobby all medical schools to implement mandatory training which must include personal contact with people with learning disabilities, for example training co-led by people with learning disabilities; ii) ensure all GP surgeries and hospital trusts put in place reasonable adjustments required under the Disability Discrimination Act to allow people with learning disabilities equal access to healthcare as is their human right;. <p>(2015)</p>
1528.	<p>That this meeting, regarding television programmes such as Channel 4's The UnDateables, believes that:-</p> <ul style="list-style-type: none"> i) they may be used by viewers as entertainment at the expense of vulnerable participants including people with autism, mental health conditions and learning difficulties such as Down's Syndrome; ii) certain vulnerable participants, such as people with autism, may not be able to perceive the potential for exploitation; iii) the BMA's concerns should be raised with the programmes' producers and with television regulators. <p>(2015)</p>
1529.	<p>That this meeting believes that current perinatal mental health services are inadequately resourced and there is an urgent shortage of beds in mother and baby units, and that no woman should be separated from her newborn baby because an appropriate service has not been commissioned in the area. Where NHS provision is not available and a mother has had her baby removed due to her mental health, appropriate support services should be available for this vulnerable group. We call on the BMA to facilitate a round table discussion with the RCOG, RCPsych and RCPCH to produce a joint statement on perinatal mental healthcare, and consider the need for parity of esteem between mental and physical health needs and reflect the importance of bonding in the neonatal period for both mothers and babies.</p> <p>(2015)</p>
1530.	<p>That this Meeting deplores the disproportionate additional financial cuts to mental health services and calls on governments to respect the principle of parity of esteem, and to cease stripping mental health services.</p> <p>(2014)</p>
1531.	<p>That this Meeting:-</p> <ul style="list-style-type: none"> i) notes that since April 2011 over 1700 acute mental health beds in England have been closed; ii) notes the 85% bed occupancy rate recommended by the Royal College of Psychiatrists for acute adult and general psychiatric wards and is concerned that average occupancy levels in England on acute adult and psychiatric beds are now running at 100%; iii) believes that any further reduction of bed numbers will result in an inefficient and unsafe system of mental healthcare provision; iv) calls for a national review of mental health inpatient bed numbers; v) deplores the closure of NHS inpatient beds within the NHS mental health sector, leading to increased cost because of enforced use of private health services, and calls on governments to stop further bed closures; vi) calls for further improvements of the provision of mental health services in the community. <p>(2014)</p>
1532.	<p>That this Meeting believes that despite the commitment in 2013 by the Secretary of State for Health to tackle the leading causes of early death, this government has failed in its duty of</p>

	care to reduce the levels of preventable premature mortality among patients with a mental health condition and/or intellectual disability. This Meeting calls on the government to make provisions for a national mortality review system for these vulnerable groups as a matter of urgency. (2014)
1533.	That this Meeting deplores the cuts in the legal aid system and:- i) believes that the cuts will be detrimental to justice and the right to a fair trial particularly to the most vulnerable such as those with mental disorders and; ii) supports the Barristers in their opposition to cuts in legal aid. (2014)
1534.	That this Meeting:- i) is concerned by the inappropriate admission of adolescent mental health patients to adult medical wards; ii) recognises that patients with dual psychiatric diagnoses often receive substandard care; iii) demands more integration of social and NHS care in mental health services; iv) calls on government and commissioners to rapidly rectify these issues. (2013)
1535.	That this Meeting insists that patients with mental health difficulties have the same rights with regard to choice as others, and deplores discrimination against them by independent sector treatment centres. (2010)
1536.	That this Meeting understands that community treatment orders are being implemented at rates far higher than expected. This is the first evidence that the revised Mental Health Act in England and Wales is infringing rights as the BMA predicted. We call on the government to open discussions aimed at correcting the faults in this legislation which they forced through against the advice of the combined voice of all concerned in providing and receiving mental health care. (2009)
1537.	That this Meeting believes that training for assessors for the elderly under the Mental Health Act 2007 should be obtainable by interested doctors in all areas of England and Wales. (2009)
1538.	That this Meeting deplores the cuts imposed upon psychiatric services as a result of acute trust deficits, and demands that this be reversed. (2007)
1539.	That this Meeting believes that there is a great shortage of specialist treatment for asylum seekers with mental health problems especially post traumatic stress disorders. Further finance and support is required in these areas. (2007)
1540.	That this Meeting believes that the evolution of the Mental Health Draft Bill has become so complicated that it has become an impenetrable and unwieldy piece of legislation. We welcome the findings and recommendations of the Parliamentary Scrutiny Committee, and call for the Mental Health Draft Bill to be completely re-written following the Committee's extensive criticisms. (2005)
1541.	That this Meeting deplores the stigmatising attitudes, widespread within the medical profession, towards patients and staff with mental health problems. This Meeting believes that such attitudes cause much damage to the individuals concerned and are a form of

	discrimination that is as unacceptable as racism. This Meeting, therefore, welcomes the proposals arising from the Daksha Emson report aimed at rooting out such attitudes and calls on senior members of the profession, including the chief medical officers, to ensure that the report's proposals are acted upon. (2004)
1542.	That this Meeting expresses its genuine concern over Home Office proposals to involve the psychiatric profession in the preventative detention of individuals who have not committed a serious offence but are described by the Government as "dangerous, severely personality disordered". (2000)
1543.	That this Meeting believes there should be closer co-operation between health and local authorities regarding psychiatric patients to ensure optimum delivery of services to the mentally ill. (1998)
1544.	That this Meeting expresses its considerable concern at the present underfunding of the mental illness services in the regional medium secure unit sector and the consequential effect this is having on: <ul style="list-style-type: none"> (i) the professional staff who have to cope with this demand from seriously mentally ill and dangerous patients; (ii) the community and carers who have to cope with these difficult, seriously disturbed patients; (iii) the prison service staff who are not trained to look after such patients within the prison sector; (iv) the inordinate delay in giving these patients the appropriate management and thus increasing the serious risks to both the patient and the community in which they reside. (1995)
1545.	That this Meeting, while welcoming care in the community for the mentally ill, requests Council to resist any move towards making the care of the chronic mentally ill unduly dependent upon private charitable and voluntary organisations, leading to diminution of proper medical and nursing supervision. (1992)
1546.	That this Meeting, in the interests of the public, considers that a general practitioner should be included as a member of each mental health tribunal. (1960)
	NATIONAL HEALTH SERVICE
1547.	That this meeting supports the demand of other health unions for a 15% pay rise for NHS workers. (2021)
1548.	That this meeting believes that honesty with the UK public is required with respect to the recovery from the pandemic and:- <ul style="list-style-type: none"> i) endorses the Royal College of Emergency Medicine's plan for the recovery of Unscheduled, Urgent, Emergency and Acute care; ii) believes that substantial new additional financial investment is required to increase and support the necessary workforce, equipment, facilities and support services to achieve recovery of physical, mental health and public health services; iii) believes that all unnecessary bureaucracy and targets distracting from patient care should be suspended until the recovery is complete. (2021)

<p>1549.</p>	<p>That this meeting, in respect of access to NHS services, the BMA should negotiate with NHS bodies to ensure: -</p> <ul style="list-style-type: none"> i) parity of access is equitable, clear and non-discriminatory for all patients; ii) decision-making is based on clinical assessment of need and potential for benefit to the individual patient; iii) services which alleviate pain, promote mobility and improve quality of life will remain within the NHS; iv) commissioning decisions will include equity impact assessment, and public and clinical consultation. <p>(2019)</p>
<p>1550.</p>	<p>That this meeting is concerned about the wide disparity in access to care experienced by UK patients. This meeting:-</p> <ul style="list-style-type: none"> i) calls for a review of the impact of centres of excellence and super-specialisation on patients living in the more remote parts of the United Kingdom; ii) insists that NHS funding allocation formulae recognise rurality as well as inner city deprivation. <p>(2018)</p>
<p>1551.</p>	<p>That this meeting calls on the UK governments to:-</p> <ul style="list-style-type: none"> i) confirm the NHS is based on the original principles of Bevan; ii) ensure the NHS meets the needs of its patients; iii) ensure the workforce and funding of services are commensurate with the demands made on them; iv) remove the strategy and administration of the NHS from direct political control. <p>(2018)</p>
<p>1552.</p>	<p>That this meeting believes that the recurrent and increasing winter crisis in the NHS is totally unacceptable and urgent steps must be taken to provide adequate and safe patient care.</p> <p>(2018)</p>
<p>1553.</p>	<p>That this meeting supports the national day of protest and celebration on 30th June 2018 in commemoration of the 70th Birthday of the NHS organised by Health Campaigns Together, the TUC, the health unions and the People's Assembly.</p> <p>(2018)</p>
<p>1554.</p>	<p>That this meeting:-</p> <ul style="list-style-type: none"> i) is opposed to the introduction and imposition of insurance-based healthcare systems in the UK; ii) commends the BMA's position of opposing accountable care organisations and integrated care systems operating within the current competitive framework in England; iii) calls for a collaborative universal healthcare system free from market forces and competition; iv) is concerned that healthcare systems are being created in the UK using non- statutory vehicles without appropriate parliamentary and public scrutiny; v) insists that there is full consultation with the medical profession, the public and parliamentary representatives on any new healthcare systems for the UK; vi) demands that any new UK healthcare systems in any nation of the UK are created only through primary legislation in parliament or national assembly. <p>(2018)</p>
<p>1555.</p>	<p>That this meeting expresses its heartfelt condolences to the families and friends affected by the recent events in Manchester and London. We would also like to applaud the swift and</p>

	<p>compassionate actions of the public, NHS and other emergency services in the face of these catastrophic events. (2017)</p>
1556.	<p>That this meeting applauds NHS England for the changes to the primary and secondary care interface within the standard hospital contract which came into effect on 1st of April 2016, with subsequent additional requirements in 2017. However it is dismayed to note that despite the national levers, there are trusts and CCGs that do not appear to acknowledge or enforce these changes. We call on the BMA to create a communications work stream which is focussed on reaching out to trusts, CCGs, different branches of practice to communicate the interface changes. (2017)</p>
1557.	<p>That this meeting does not support the existing practice of charging NHS employees to park at their place(s) of employment, especially as this payment typically does not guarantee space. It also demands that the NHS sites better monitor parking facilities to ensure they are adequately maintained, secure and safe for all staff at all hours of work. (2017)</p>
1558.	<p>That this meeting recognises the acknowledged links between poor medical engagement with risks to patient safety and poor outcomes for patients and:-</p> <ul style="list-style-type: none"> i) recognises that promoting greater medical involvement in the design and planning of healthcare is crucial in ensuring that improved patient services are properly designed and effectively implemented; ii) calls for radical change of the management culture in the NHS from the current hierarchical focus on narrowly based targets towards a clinically based system adapted to the needs of patients; iii) calls for all NHS organisations to agree and sign up to a new medical engagement charter that will facilitate the positive involvement and engagement of doctors who are willing to work in close cooperation with other clinical and non-clinical healthcare staff. <p>(2017)</p>
1559.	<p>That this meeting mandates council to lobby for the restoration of the duty of provision of universal health care to the secretary of state for health. (2017)</p>
1560.	<p>That this meeting reminds governments and healthcare organisations that they serve and are accountable to patients and the public. This meeting calls upon healthcare organisations to:-</p> <ul style="list-style-type: none"> i) conduct business in public, with open and free access to reports and papers so that appropriate scrutiny can be undertaken; ii) provide verifiable evidence for changes to practice and / or services before decisions are made; iii) stop extrapolating claims beyond evidence and applying hyperbole to justify their actions without appropriate evaluation. <p>(2017)</p>
1561.	<p>That this meeting notes that the NHS Bill 2015, a private members bill by Caroline Lucas MP, has fallen because of lack of parliamentary time. The NHS Bill 2015 was supported by the BMA. It is likely that a similar bill will be tabled again within this Parliament. This ARM calls on the BMA to support any legislation in Parliament that seeks to achieve the same aims, or substantially the same aims as the NHS Bill 2015. (2016)</p>
1562.	<p>That this meeting believes the current government plans for the NHS are unsustainable, are a danger to patient safety, and that in order to combat this all health workers should stand</p>

	<p>together to fight against a worsening of terms and conditions for all those working within the NHS. (2016)</p>
1563.	<p>That this meeting demands that the BMA lobby government to stop private companies using the NHS logo when they deliver NHS care. (2016)</p>
1564.	<p>That this meeting deplores the projected future reorganisation of the NHS into 44 Sustainability and Transformation areas (Transformation Footprints) linked to Local Authorities which:- i) will require each area to have a Five Year Plan in place by September 2016; ii) will develop new models of health care policy without reliable supporting evidence and; iii) must achieve financial balance with the threat of large penalties for failure and calls on the BMA to condemn this massive “top-down” reorganisation. (2016)</p>
1565.	<p>That this meeting believes that Health and Well Being Boards should include a proper balance between political, professional, NHS and patient representation and should not be subordinated to the political and corporate processes of the local authority. (2015)</p>
1566.	<p>That this meeting would support a successful implementation of the Five Year Forward View subject to it:- i) involving full consultation with the relevant stakeholders in both primary and secondary care; ii) being clinically led; iii) involving primary, community and secondary care clinicians working in collaboration and not one group dominating another; iv) supporting organisations working together and not focus on creating a new single organisation which would employ all staff involved; v) focussing on the provision of services within an area and not on competition to provide services outside their locality. (2015)</p>
1567.	<p>That this meeting accepts that devo-manc offers an opportunity to the public of Greater Manchester to integrate health and social care under one umbrella. However, we insist that this further reorganisation of the NHS has not been tested through a public consultation and therefore we have these major concerns:- i) that the budgetary constraints will increase and not decrease the health inequalities; ii) that without safeguards for the a rising demand on social care, the NHS will suffer disproportionate cuts; iii) the terms and conditions of NHS staff need to be protected; iv) the track record of the Local Authority to privatise public services will inevitably affect the local health services. We recommend that the BMA urgently seeks to meet with the government to ensure that our worst fears are allayed. (2015)</p>
1568.	<p>That this meeting is concerned that emergency medicine department overcrowding compromises patient safety. Instead of portraying emergency medicine departments as failing, this meeting calls upon governments to invest in:- i) training more emergency medicine doctors; ii) developing the infrastructure and systems to prevent delays in patient management in emergency medicine departments;</p>

	<p>iii) ensuring adequate provision for health and social care out with the acute setting.</p> <p>(2015)</p>
1569.	<p>That this meeting recognises the current constraints being faced by general practice and A&E units in terms of workload exceeding capacity, and demands that the government:-</p> <ul style="list-style-type: none"> i) prioritises public education strategies including self-care and using services appropriately; ii) stops misleading the public with unrealistic expectations like 7 day opening or 48 hour access; iii) has an honest dialogue with the public about what present day GP services can provide within current resources. <p>(2015)</p>
1570.	<p>That this Meeting:</p> <ul style="list-style-type: none"> i) deplores the actions of the Secretary of State for Health in trying to legislate so that future Trust Special Administrators can make binding recommendations for trusts outside that to which they were appointed; ii) urges the BMA to continue to lobby against non-clinically driven service reconfiguration plans. <p>(2014)</p>
1571.	<p>That this Meeting calls for the restoration of the statutory responsibilities of the Secretary of State for Health to secure and provide universal healthcare</p> <p>(2014)</p>
1572.	<p>That this Meeting recognises the need for safe, high quality emergency and in-patient care throughout the week and:-</p> <ul style="list-style-type: none"> i) notes that delivering emergency care is not the same as providing comprehensive non-urgent, elective and planned care on a seven day, 24 hour basis; <p>(2013)</p>
1573.	<p>That this Meeting requests the BMA to launch a debate with the public and the health professions about what type of health service they wish for in the future and how it could be delivered in a climate of shrinking resources.</p> <p>(2013)</p>
1574.	<p>That this Meeting, with regard to NHS 111:-</p> <ul style="list-style-type: none"> i) is alarmed that it worsens patient access to appropriate care; ii) is alarmed that it reduces efficient use of available resources; iii) is alarmed that it increases pressure on A&E and GP services; iv) demands that the project is re-designed; v) calls upon the government to commission an independent inquiry into the debacle which must specifically address the whole inappropriate application of triage by the least qualified, contrary to evidence based practice. <p>(2013)</p>
1575.	<p>That this Meeting:-</p> <ul style="list-style-type: none"> i) notes the Health Secretary, Jeremy Hunt's attack on the NHS and his comments about mediocrity and coasting; ii) has no confidence in the Secretary of State for Health, Jeremy Hunt. <p>(2013)</p>

1576.	That this Meeting believes that care, compassion and competence must be at the heart of the NHS. (2013)
1577.	That this Meeting demands that in future all private healthcare companies receiving a funding stream within the NHS be subject to freedom of information requests under the terms of the Freedom of Information Act 2000 in the same way as existing NHS public sector organisations. (2013)
1578.	That this Meeting expresses grave concern at the process and outcomes of the Special Administration measures imposed on some NHS trusts. (2013)
1579.	That this Meeting is alarmed that the government's direction of travel is towards further NHS bureaucracy and expense, and rejects this as being unacceptable in a time of financial restrictions. (2013)
1580.	This Meeting believes that the primary aim of the NHS and all UK healthcare providers should be the care of patients. (2013)
1581.	That this Meeting believes the term "bed blocker" should no longer be used as:- i) it implies that patients are to blame for any shortage of hospital beds; ii) it implies that patients are less important than hospital beds. (2012)
1582.	That this Meeting still believes in the NHS, universal, comprehensive and free at the point of delivery and demands that the government categorically states its agreement with this principle. (2011)
1583.	That this Meeting cherishes the NHS and wishes to see it remain as an equitable healthcare provider. (2011)
1584.	That this Meeting rejects all attempts to privatise the NHS. (2011)
1585.	That this Meeting calls the Secretary of State for Health to maintain the NHS publicly funded and condemns any attempt to privatise the NHS, directly or indirectly, wholly or in parts. (2011)
1586.	That this Meeting deplores the proposal to introduce personal health accounts and believes:- i) it risks disadvantaging patients with chronic health conditions; ii) it is likely to result in over-provision for some patients to the detriment of others; iii) it is against the fundamental principle of the NHS which is to provide care when and where it is needed; iv) that BMA Council must campaign against the concept of personal health accounts. (2011)
1587.	That this Meeting believes that BMA Council should continue to lobby the English Department of Health:- i) to provide a comprehensive high quality national health service free to all at the point of access; ii) to maintain opportunities for training for medical students and junior doctors. (2011)

1588.	That this Meeting believes that the financial pressure on the NHS to make unprecedented efficiency savings in the coming years is the strongest argument to abandon the wasteful costs of duplication, bureaucracy and competition inherent in an NHS market, and calls upon all major political parties to support an efficient alternative collaborative model of healthcare for pragmatic reasons, regardless of party political ideology. (2010)
1589.	That this Meeting reaffirms that the first duty of a doctor will always be the care of their patients, above political, ideological and financial pressures and targets. (2009)
1590.	That this Meeting notes the overwhelming support in both 2006 and 2008, for the aims and principles of the Keep our NHS Public campaign and calls on the BMA leadership to provide a report to Council within 3 months, demonstrating exactly how this support has been provided. (2009)
1591.	That this Meeting proposes that the management of the NHS should be run by an independent board with a long term strategy, free of party political interference. (2008)
1592.	That this Meeting calls upon the government to present NHS statistics appropriately, and insists that any published headlines acknowledge the date to which the statistics refer. (2008)
1593.	That this Meeting notes the divergence of UK national healthcare systems and asks for an annual report of differences between the UK healthcare systems in terms of costs, processes and outcomes. (2008)
1594.	That this Meeting calls on the BMA to return to the NHS core values of the ARM 2006 mission statement ie: <ul style="list-style-type: none"> • free at the point of delivery • ethically rationed by clinical priority without discriminatory values • equitably resourced • funded out of general taxation • these fundamental values cannot be maintained if the NHS is broken up and tendered to private corporations. (2008)
1595.	That this Meeting reaffirms that the first duty of doctors is to patients and: <ol style="list-style-type: none"> (i) re-states its commitment to the core values of an integrated health service based upon the health needs of patients and the public; (ii) deplores any withdrawal of services solely on the basis of non-profitability in a competitive market; (iii) calls for a new patient charter that also focuses on the individual's responsibility both in health and in illness; (iv) believes that National Clinical Standards for quality must underpin local management and provision of services; (v) that the NHS is best funded by general taxation. (2007)
1596.	That this Meeting notes the Secretary of State's commitment to patient choice for childbirth but insists that:

	<p>(i) whether delivered in a consultant unit, a midwifery led unit or at home, women must be cared for throughout labour and delivery by a fully qualified midwife on a one to one basis;</p> <p>(ii) the place of delivery must be a safe environment for mother and child, taking into account the medical history and local resources.</p> <p>(2007)</p>
1597.	<p>That this Meeting believes those contributors to media, statutory and other officially commissioned investigations into the state of the NHS should be allowed to exercise their rights to free speech without disciplinary action.</p> <p>(2007)</p>
1598.	<p>That this Meeting is concerned that recent pay rises for clinical staff are increasingly portrayed as the reason for financial deficits within NHS organisations, and asserts that:</p> <p>(i) staff within the NHS are entitled to good pay, working conditions and pensions;</p> <p>(ii) properly rewarded staff are part of the solution to NHS difficulties and not part of the problem.</p> <p>(2006)</p>
1599.	<p>That this Meeting believes that the National Health Service can and should be:</p> <p>(i) free at the point of access;</p> <p>(ii) ethically rationed by clinical priority without discriminatory values;</p> <p>(iii) equitably resourced;</p> <p>(iv) funded out of general taxation.</p> <p>These fundamental values cannot be maintained if the NHS is broken up and tendered to private corporations.</p> <p>(2006)</p>
1600.	<p>That the NHS is far too important to be left in the hands of the politicians.</p> <p>(2005)</p>
1601.	<p>That this Meeting:</p> <p>(i) recognises the overwhelming evidence that short-term political initiatives have caused significant damage to long-term patient care; and</p> <p>(ii) believes that ministers should set policy and not directly or indirectly control NHS operational matters.</p> <p>(2005)</p>
1602.	<p>That this Meeting calls upon the BMA vigorously to promote the general incorporation of hand hygiene into medical culture, so that it becomes socially, morally and ethically unacceptable for doctors not to wash their hands before touching each and every patient.</p> <p>(2004)</p>
1603.	<p>That in relation to instances where individual patient dissatisfaction with the National Health Service becomes publicised, this Meeting:</p> <p>(i) notes with dismay that politicians choose not to be bound by standards of confidentiality and conduct similar to those which apply to doctors and should not disclose details of individual patients unless express consent has been given;</p> <p>(ii) believes that ill-informed politicisation of such instances further undermines morale of hard pressed health service staff;</p> <p>(iii) insists that the Association continues to oppose such politicisation whenever it occurs.</p> <p>(2002)</p>

1604.	That this Meeting believes that increased consultation times would produce a significant improvement in the quality of patient care, and must be given high priority in both the primary and secondary sectors of the NHS. (2001)
1605.	That now the NHS is 50 years old this Meeting: (i) calls for Government to recognise that the NHS is for the benefit of the UK population as a whole and should be adequately and fairly resourced for patient care and all those working in the service; (ii) implores all doctors always to act in the best interests of the NHS through professional consensus and unity. (1998)
1606.	That this Meeting believes that if traditional secondary care functions are to be devolved to primary care, then enough remuneration and funding must accompany these extra clinical responsibilities. (1998)
1607.	That this Meeting demands that the National Health Service must provide equity of access and treatment for all patients irrespective of the GP with whom they are registered or their geographical location within the United Kingdom. (1997)
1608.	That the attention of the Government be drawn to the need for continuous education of the public, both in youth and adult life, in the constructive and responsible use of the National Health Service. (1956)
1609.	<u>Care pathways</u> That this meeting calls on the BMA to promote the named clinician concept with NHS employers as recommended by the Academy of Medical Royal Colleges and the GMC for all patient admissions. (2015)
1610.	That this Meeting recognises fragmented care is not in the best interests of patients and contributes to unnecessary pressure on front line services and:- i) believes the BMA should proactively define and develop proposals for integrated models of care and resourcing systems; ii) believes any definition of integrated care should include in its scope both primary and secondary care; iii) believes any definition of integrated care should include social care within its scope. (2014)
1611.	That this Meeting believes it is a flawed concept to separate the planning of primary, secondary and tertiary care. (2011)
1612.	That this Meeting believes that doctors from primary and secondary care must combine to develop patient care pathways to maximise the efficiency and effectiveness of its delivery. (2011)

1613.	That this Meeting believes that the patient experience is enhanced by the development of clinical pathways through collaboration between primary, secondary and tertiary medical care and calls on the profession and the NHS to initiate and facilitate this process as a matter of urgency. (2008)
1614.	That this Meeting believes that 'Care closer to home' should not reduce access to specialist medical opinion. (2007)
1615.	That this Meeting believes that the care of every patient should be driven by: (i) evidence of best outcomes; (ii) robust clinical governance pathways. (2007)
1616.	<u>Commercialisation- use of independent sector</u> That this meeting is concerned about multiple reports of problems with private providers of NHS services and demands: - i) rigorous evaluation of outcomes compared with NHS services; ii) that contracts must enable the provision of integrated, multidisciplinary care; iii) private providers undertaking NHS contract work are required to treat a representative population case mix rather than excluding all but the lowest risk patients; iv) that contracts should be withdrawn from private providers which fail to provide services of the required standard; v) private providers which fail to provide services of the required standard are not eligible to bid for future NHS work. (2019)
1617.	That this meeting:- i) is opposed to a UK-US trade deal, which would facilitate US corporations running healthcare in England; ii) calls on the BMA to lobby government against such deals. (2018)
1618.	That this meeting is opposed to a UK-US trade deal facilitating US corporations getting NHS public sector contracts in England. (2018)
1619.	That this meeting would like private providers to sign up to the recommendations of privatisation and independent sector provision in the NHS outlined in the BMA report in 2018. (2018)
1620.	That this meeting:- i) is critical of the lamentable performance of Capita plc, now being investigated by the Public Accounts Committee in parliament; ii) notes that this outsourcing company, holding £1 billion of NHS contracts, which includes Primary Care Support Services, issued a profit warning on 31 January 2018, raising the possibility of another Carillion crash; iii) urges the BMA to lobby the government to avoid such massive private NHS outsourcing, which not only risks jeopardising multiple NHS services, but when foundering can cause massive disruption of jobs and services, and lead to an inevitable bail-out from public funds. This meeting calls on the BMA to press for the taking back of outsourced NHS workers into direct NHS Employment.

	(2018)
1621.	<p>That this meeting is concerned that Accountable Care Organisations will make it easier for large private companies to take over and profit from huge areas of English healthcare and demands:-</p> <ul style="list-style-type: none"> i) full consultation from the very onset with healthcare professionals and patients; ii) that all proposals must be evidence based and properly funded; iii) that any change must be clinically led with patient care and not financial savings being the prime driver; iv) assurances from the Department of Health and Social Care and NHS England that all doctors working within ACOs will be employed on national terms and conditions. <p>(2018)</p>
1622.	<p>That this meeting deplores the continual privatisation of the NHS and:-</p> <ul style="list-style-type: none"> (i) instructs council to bring our concerns to the government and public; (ii) demands an evidence base on the effect of tendering and outsourcing of contracts; (iii) insists that the government ensures that Freedom of Information Requests apply to all private organisations who are commissioned to provide NHS services. <p>(2016)</p>
1623.	<p>That this meeting believes that to enhance integration of care government must:-</p> <ul style="list-style-type: none"> i) abolish the pro competitive duties of such bodies as Monitor, foundation trusts and clinical commissioning groups (CCGs) which are extremely costly and divert money away from patient care; ii) legislate to prevent competition law operating in the NHS. <p>(2015)</p>
1624.	<p>That this meeting believes that the use of franchising and contracting with private providers to manage hospital services is destabilising, has significant risks and has adverse consequences with unacceptable costs to the tax payer, giving no benefit to patients; and:-</p> <ul style="list-style-type: none"> i) believes that private companies should not be permitted to walk away without consequence from contracts and that safeguards must exist to protect patients if contracts are terminated early; ii) insists that the NHS is the preferred provider of services for the NHS; iii) demands that government introduce mechanisms to bring services delivered by private providers back into NHS provision. <p>(2015)</p>
1625.	<p>That this meeting believes that as long as the private sector is still delivering NHS care they should be subject to the same standards as the NHS, in particular around transparency, ethical behaviour and financial probity. To that end the BMA should lobby to ensure that:-</p> <ul style="list-style-type: none"> i) they are subject to FoI requests, in particular regarding costs, profits and outcomes, and not hide behind 'commercial confidentiality'; ii) they pay UK taxes, in particular corporation tax; iii) they offer NHS national terms and conditions to employees. <p>(2015)</p>
1626.	<p>This meeting notes our ARM record of opposing the privatisation of the NHS.</p> <p>(2015)</p>
1627.	<p>That this Meeting is dismayed that private providers have won so many tenders for clinical services in the English NHS since the Health and Social Care Act came into force, and:-</p> <ul style="list-style-type: none"> i) believes the market in healthcare has led to fragmentation and waste with adverse implications for patient safety, quality assurance and training; ii) calls for the repeal of competitive tendering legislation;

	<p>iii) calls for a patient-focussed healthcare system based on collaboration, cooperation, transparency and accountability. (2014)</p>
1628.	<p>That this Meeting notes that negotiations continue regarding the Transatlantic Trade and Investment Partnership and:-</p> <p>i) believes that the signing of such a treaty will tip the balance of power further towards private corporations and away from the public sector;</p> <p>ii) demands that the NHS is exempted from any such treaty. (2014)</p>
1629.	<p>That this Meeting:-</p> <p>i) demands that all providers of medical services, including private and third sector providers, are subject to the Freedom of Information Act (2014)</p>
1630.	<p>That this Meeting notes it is BMA policy to oppose privatisation of the NHS and to monitor whether NHS clinical contracts go to private companies. We call on the BMA to publish and publicise this information. (2014)</p>
1631.	<p>That this Meeting believes that commercial health care providers have profit as an overriding aim and:-</p> <p>i) opposes any further moves towards privatisation of the National Health Service;</p> <p>ii) asks that the BMA consider how best to ensure consistent quality of patient care in a market driven system;</p> <p>iii) calls for the NHS to be the preferred provider, with proper integration and collaboration between primary and secondary care;</p> <p>iv) applauds those administrations which have chosen to avoid competition driving their health care systems;</p> <p>v) calls on the BMA to work with the public and other stakeholders to defend the NHS. (2013)</p>
1632.	<p>That this Meeting notes the plethora of ex ministers in the pay of private health organisations, pharmaceutical companies and dispensing chemists and insists the government ensures that 'insider' knowledge and contacts do not influence Department of Health decisions. (2012)</p>
1633.	<p>That this Meeting believes that increasing competition in a market that cannot expand can be short sighted and potentially more expensive in the long run. (2012)</p>
1634.	<p>That this Meeting recognises that the private sector cherry picking local services will compromise the future viability of local hospital trusts. (2012)</p>
1635.	<p>That this Meeting believes that market-based policies in NHS healthcare provision:-</p> <p>i) are not based on sufficient evidence that they will improve quality of care;</p> <p>ii) are ideologically driven rather than evidence-based;</p> <p>iii) are potentially detrimental to medical training and professionalism;</p> <p>iv) may undermine the social contract between doctors and patients and reduce public trust in doctors;</p> <p>v) should be abandoned. (2011)</p>

1636.	That this Meeting believes that when secondary care services are provided by private companies the tariff paid must never exceed the tariff paid to NHS trusts for the same type of care. (2011)
1637.	That this Meeting requires that the government legislates to enable NHS providers to become preferred providers in the NHS, with the use of non-NHS providers only when a service is of inadequate quality, insufficient capacity, or not available on the NHS. (2011)
1638.	That this Meeting believes that the insistence on enforced competition ('Any Willing Provider' or tendering methods) for the provision of health services:- i) will undermine the ability of local GPs ,consultants and public health doctors to work together to create an efficient local service for the benefit of patient; ii) will inflate the cost of contracting at a time of financial constraint; iii) increases fragmentation of the care pathway for patients; iv) could severely damage the overall financial stability of local NHS hospitals, with the risk of departments or hospitals closing v) favours large commercial companies who currently are allowed to cherry pick the profitable services and who will have the financial power to undercut NHS providers. (2011 Special Representative Meeting)
1639.	That this Meeting deplores the continued commitment of all major parties to further commercialisation and competition in the NHS in England and is seriously concerned that: (i) this unproven, non evidence-based agenda will fail to produce better quality of care for patients; (ii) there is the very real danger that personalised, continuing and holistic care will be lost and this will prove very costly in the long term. (2010)
1640.	That, in respect of the franchising of the management of Hinchingbrooke Hospital in Huntingdon, this Meeting: (i) notes with concern the impending franchising of the management of the hospital to a private company; (ii) notes with concern that only private sector organisations progressed their bids; (iii) calls on the BMA to monitor the contracting process to ensure that no special funding arrangements are provided to the successful bidder; (iv) calls on the BMA to scrutinise this experiment in order to ensure that the private sector is not given preferential treatment and to ensure that patient care is not compromised. (2010)
1641.	That this Meeting commends the BMA for pursuing the 'preferred provider' status for the NHS and exhorts it to oppose vigorously privatisation of our NHS in any form. (2010)
1642.	That this Meeting believes that introducing private pathology networks will re-order priorities towards financial objectives at the expense of clinical priorities and we call upon Council to vigorously oppose such privatisation schemes. (2010)
1643.	That this Meeting: (i) remains seriously concerned that current NHS reforms in England continue to provide an increasing role for the commercial private sector and the development of a market in the NHS;

	<ul style="list-style-type: none"> (ii) calls upon politicians of all parties to enter into a constructive and meaningful dialogue with doctors, other NHS professionals and patients to enable a new approach which will safeguard the future of the NHS; (iii) believes that a market system for the NHS is an expensive waste of taxpayers' money; (iv) deplores the government's persistent and zealous pursuit in England of political dogma at the expense of patient care and without due regard of the views of clinicians and the public; (v) demands that further commercialisation is abandoned in favour of a true spirit of collaboration which is central to the ethos and success of the NHS. <p>(2009)</p>
1644.	<p>That this Meeting believes that the current global economic crisis is living proof of the dangers of devolving the commissioning and provision of the NHS to the vagaries of the market, and this meeting therefore demands that the government learns from this and jettisons its commercially driven NHS reforms, in order to rebuild a secure and sustainable future for the NHS in England.</p> <p>(2009)</p>
1645.	<p>That this Meeting rejects the commercialisation and break up of the NHS in England into competing businesses and:</p> <p>(Lapsed 2014)</p> <ul style="list-style-type: none"> (i) congratulates the BMA for launching a campaign against this; (ii) mandates Council to mount a public information campaign against this; (iii) calls for the retention and proper public funding of NHS GP surgeries, district general hospitals and publicly provided community care; (iv) demands that Council campaign to maintain training opportunities for medical students and junior doctors. <p>(2009)</p>
1646.	<p>That this Meeting believes that this government's healthcare reforms have undermined and fragmented core NHS services in England by reconfiguring the NHS as a collection of profit-driven competing enterprises and by diverting increasing levels of funding out of the public sector. This meeting calls on the BMA to work with other organisations to keep NHS services within the public sector, and to ensure that the public are informed of the detrimental effects to patient care.</p> <p>(2008)</p>
1647.	<p>That this Meeting insists that:</p> <ul style="list-style-type: none"> (i) NHS providers should be supported and developed and have "preferred provider" status in delivering NHS care to NHS patients; (ii) the private sector should be used to treat NHS patients only in the interim where there is insufficient capacity in the NHS. <p>(2008)</p>
1648.	<p>That this Meeting believes that the internal market has failed the public and instructs the BMA to campaign against further commercialisation of the NHS as this would further:</p> <ul style="list-style-type: none"> (i) destabilise services; (ii) increase costs; (iii) reduce public trust; (iv) limit the capacity to reduce health inequalities; (v) compromise continuity of care; (vi) disrupt and disintegrate training and career pathways. <p>(2008)</p>
1649.	<p>That this Meeting affirms that all providers of specialist services to NHS patients should be subject to the same standards of clinical governance.</p> <p>(2008)</p>

1650.	That this Meeting calls on the BMA to lobby the government to prevent alternative providers of health care from “cherry picking” patients and targeting only the most profitable areas of healthcare. (2008)
1651.	That this Meeting demands that NHS care should only be purchased from for-profit organisations if: (i) the NHS cannot provide the service; (ii) other important local services will not be destabilised and lost; (iii) the for-profit organisation is required to provide training, education, research and development at least to the level provided by NHS organisations; (iv) the for-profit organisation makes adequate provision to deal with ongoing complications resulting from the services provided by them; (v) doctors employed by them have terms and conditions (including pensions) which are nationally agreed and ratified by the BMA; (vi) they are subject to the same regime of transparency and openness as NHS providers; (vii) they are subject to a realistic training levy; (viii) their involvement is time-limited, until NHS services can expand and replace them there is an identified need; (ix) medical staff working for the organisation have contracts which are superannuable within the NHS pension scheme. (2007)
1652.	That NHS patient care in CATS should only be delivered by doctors who are employed within a managed environment and clinical governance structures analogous or identical to those in NHS organisations. (2007)
1653.	That this Meeting has grave concerns about companies such as UnitedHealth being awarded contracts to provide primary care services as happened in Derbyshire. (2006)
1654.	That this Meeting recognises the potential offered by private involvement in the provision of health care only insofar as it does not contravene the fundamental principles of a comprehensive high quality national health service free to all at the point of access. (1996)
1655.	<u>Commissioning</u> That this meeting views the current meaning and use of “commissioning” as a misappropriation of its original intent and meaning within the NHS and believes:- i) it should be interpreted as a form of strategic planning led by clinicians; ii) the profession should refute the idea that commissioning necessitates purchasing powers; iii) the process of planning and provision must be led by the public sector; iv) there needs to be a genuine partnership approach between commissioners and providers. (2015)
1656.	That this meeting demands that all CCGs have a strong secondary care presence. (2015)
1657.	That this Meeting notes with concern the proposal for Commissioning Support Units to become separate entities in 2016 and call for any support functions for Clinical Commissioning Groups to remain in the NHS.

	(2014)
1658.	<p>That this Meeting recognises the NHS Act confers responsibilities on CCGs to promote patient involvement and choice and:-</p> <ul style="list-style-type: none"> i) believes these responsibilities take precedence over the NHS Procurement, Patient Choice and Competition (2) Regulations 2013; ii) Instructs the BMA to publicly and privately lobby for the requirement for competitive tendering to be withdrawn from Regulations applying to the NHS. <p>(2014)</p>
1659.	<p>That this Meeting notes with concern that commissioning for addictions services is moving under public health rather than CCGs. Addictions have widespread health implications and cannot be sidelined or separated away from medical services in primary and secondary care. This Meeting calls on the BMA to lobby for addictions services commissioning to come under the remit of CCGs.</p> <p>(2013)</p>
1660.	<p>That this Meeting deplores the lack of management funding available for Clinical Commissioning Groups (CCGs) and believes that:-</p> <ul style="list-style-type: none"> i) lack of high quality staff will hamper the effectiveness of CCGs; ii) effective commissioning requires adequate management funding; iii) smaller CCGs will fail if they are unable to recruit sufficient staff; iv) many good quality commissioners have been lost to the NHS as a result of reorganisation. <p>(2013)</p>
1661.	<p>That this Meeting, in respect of Commissioning by Clinical Commissioning Groups (CCGs) believes that:-</p> <ul style="list-style-type: none"> i) CCGs should be locally accountable not centrally directed; ii) CCGs should have freedom to commission services in ways that best meet the needs of their populations; iii) CCGs should have autonomy on the procurement of services for their patients; <p>(Lapsed 2018)</p> <ul style="list-style-type: none"> iv) CCGs should be entitled to review the commissioning decisions of their predecessor PCTs; v) the BMA should monitor interference with and challenges to CCG decision-making; vi) if CCGs are prevented from making decisions in the best interests of patients, the BMA should consider balloting GPs on withdrawal from engagement with CCGs. <p>(2013)</p>
1662.	<p>That this Meeting believes in developing good practice in the governance of Clinical Commissioning Groups (CCGs) and that:-</p> <ul style="list-style-type: none"> i) membership, meetings and policies should be transparent; ii) no individual with a significant conflict of interest such as a directorship or significant shareholding in a commercial health provider should be a member of a CCG board; iii) resources should be sufficient to allow participation by GPs and secondary care doctors; iv) a majority of CCG board members should be GPs; <p>(2013)</p>
1663.	<p>That this Meeting believes that doctors in practices, community organisations and local hospitals should be encouraged to work together and not be driven apart because such collaboration is deemed anti-competitive.</p> <p>(2013)</p>

<p>1664.</p>	<p>That this Meeting believes that in respect of commissioning and tendering for services, the following principles must apply:-</p> <ul style="list-style-type: none"> (i) quality should be at the heart of all NHS contracts; (ii) before transfer of services to primary care, commissioners should ensure that the necessary infrastructure, governance, capacity and resources are in place; (iii) imposed conditions of commercial confidentiality are unacceptable; (iv) local NHS organisations should be regarded as preferred providers and alternative providers should only be sought if local organisations are unable or unwilling to improve services to the required standard; (v) an impact assessment on local NHS services must be considered as part of any decision to tender for alternative providers; (vi) “cherry picking” must be prohibited. <p>(2012)</p>
<p>1665.</p>	<p>That this Meeting, in respect of clinical commissioning support services (CSS), believes:-</p> <ul style="list-style-type: none"> (i) that safeguards are needed to protect patients from vested interests; (ii) that CSS should be selected by commissioners without external pressure; (iii) that CSS should not be forced to become non-NHS organisations; (iv) that commissioners should not be forced to outsource commissioning support to private companies. <p>(2012)</p>
<p>1666.</p>	<p>That this Meeting believes that in respect of the proposals for performance management of Clinical Commissioning Groups (CCGs):-</p> <ul style="list-style-type: none"> (i) the proposed financial rewards are potentially unethical and undermine the trust between patients, doctors and society; (ii) CCGs will be pressured to ration care; (iii) CCGs should adopt an ethical code of conduct which ensures transparency and the prioritisation of patient interests over performance targets; (iv) the proposals increase bureaucracy and limit effective commissioning; (v) the proposals should be opposed. <p>(2012)</p>
<p>1667.</p>	<p>That this Meeting:-</p> <ul style="list-style-type: none"> i) believes that successful commissioning requires decisions to be based on population health needs and calls for public health support to be available to commissioning consortia; ii) is opposed to the privatisation and fragmentation of the NHS into a multitude of competing providers with the potential to destabilise pivotal hospital services and insists that commissioning bodies should be required to use local NHS services as their preferred provider, unless the local NHS services cannot provide the services or capacity required; iii) calls upon the BMA to ensure that there are appropriate safeguards to prevent local variations in care leading to a “postcode lottery” and that patients are treated equitably. <p>(2011)</p>
<p>1668.</p>	<p>That this Meeting believes that successful commissioning requires the close collaboration and support of doctors from across the profession.</p> <p>(2011)</p>
<p>1669.</p>	<p>That this Meeting deplores the inadequate managerial funding set aside to support effective GP commissioning, and calls for more realistic resources to be given to underpin commissioning.</p> <p>(2011)</p>

1670.	That this Meeting supports the principles of clinician-led commissioning with increased medical participation in the organisation and delivery of NHS care for the benefit of patients and believes that this could be achieved without the need for further legislation. (2011 Special Representative Meeting)
1671.	That this Meeting believes that successful and effective commissioning can only occur through close collaboration between general practitioners, hospital doctors and public health doctors. (2011 Special Representative Meeting)
1672.	That this Meeting believes that proposed GP Commissioning Consortia should: i) hold meetings in public and publish agendas, minutes and other papers; ii) include in the appointment of clinicians to commissioning roles an electoral process which is open to local GPs whatever their contractual arrangements; iii) not be entitled to remove the Primary Medical Services contract of a GP practice. iv) not be able to expel practices without reference to an independent external evaluation. (2011 Special Representative Meeting)
1673.	That this Meeting believes that the Health and Social Care bill should ensure that, in carrying out commissioning functions, GP Commissioning Consortia must: i) act in a transparent, fair, evidence-based manner; ii) take account of advice from all medical specialties, patients and the public; iii) take into account clinical need, equity, quality of care, cost-effectiveness and the effect of clinical pathways on research, education, training and the sustainability of the health economy; iv) be permitted to encourage collaboration between commissioners and current local providers to develop integrated services, without being accused of anticompetitive behaviour; v) commission, as a minimum, a national set of core services which ensure appropriate care for patients wherever they live. (2011 Special Representative Meeting)
1674.	That this Meeting believes the relationship between doctors and patients in NHS general practice:- i) is underpinned by the provision, via the GP contract, of Primary Medical Services [Care] by independent GP practices; ii) may be undermined by the introduction of commissioning as a requirement of the GP contract; iii) will be threatened if GP practice remuneration is dependent on rationing decisions, the requirement to balance commissioning budgets or the interests of a commissioning consortium; (2011 Special Representative Meeting)
1675.	That this Meeting calls on Parliament to amend clause 1 of the Health and Social Care Bill to ensure that the Secretary of State remains fully accountable for the provision of services, albeit with that function delegated to the National Commissioning Board and Commissioning Consortia. (2011 Special Representative Meeting)
1676.	That this Meeting believes that the awarding of annual contracts encourages short-termism in the NHS and should be avoided. (2009)
1677.	That this Meeting believes that: (i) the private sector should have no role in the commissioning of public services; (ii) commissioning bodies should be assessed, regulated, monitored and accountable;

	(iii) the Framework for External Support for Commissioners (FESC) will undermine PCT infrastructure, local accountability and a public health perspective. (2008)
1678.	That this Meeting believes that the private sector should have no role in the commissioning of public services. (2007)
1679.	That this Meeting believes that public health professionals should have a key role in commissioning services at both a national and regional level. (2007)
1680.	That this Meeting believes that Practice-based Commissioning will be successful only if it: <ul style="list-style-type: none"> (i) is clinician-led; (ii) involves patients at all stages of planning; (iii) is advised by a robust public health workforce; (iv) is guided by professionals from both primary and secondary care; (v) is allowed time to show return on investment; (vi) is adequately resourced by the Departments of Health. (2007)
1681.	<u>Competitive tendering</u> That this Meeting strongly That this Meeting exhorts the BMA to assert its pride in the NHS and promotes it as the preferred provider of healthcare services. (2014)
1682.	That this Meeting believes that the frequent retendering of services in the NHS leads to poorer quality standards particularly in the provision of Primary Care Out of Hours Services. (2011)
1683.	That this Meeting believes price competition is a hugely retrograde step and:- <ul style="list-style-type: none"> i) that price competition in healthcare is damaging; ii) that with scarce resources the prime focus will be on cost and not quality; iii) Acknowledges the BMA input into the lobbying, leading to the government amendment removing the provision for price competition in the bill. (2011 Special Representative Meeting)
1684.	That this Meeting:- <ul style="list-style-type: none"> i) believes that there is no place for commercial confidentiality in a publicly funded health service; ii) believes that the terms of all financial transactions between the NHS and external contractors should be made public; iii) asks the BMA to lobby for an appropriate amendment in the legislation to reflect this transparency. (2011 Special Representative Meeting)
1685.	That this Meeting believes that the competitive tendering of primary medical services contracts by PCOs: <ul style="list-style-type: none"> (i) is of questionable value to the NHS, particularly due to the resources consumed by the process; (ii) results in the awarding of short term contracts which will seriously undermine the ability of general practitioners to provide continuous high quality patient care needs greater transparency of the process, the costs and in feedback to bidders. (2009)

1686.	That this Meeting believes that competitive tendering has resulted in loss of standards and morale in the health boards/authorities where it has been implemented. (1990)
1687.	<u>Evidence based reform</u> That this Meeting believes that change should be cost effective and evidence-based. (2009)
1688.	That this Meeting deplores the waste of public money and resources due to multiple changing or unproven initiatives and the cost of contracts with private companies making profits for shareholders and thus instructs the BMA to campaign for a moratorium on these, until both clinical and cost effectiveness have been proven. (2008)
1689.	That this Meeting calls for the BMA Council to lobby for the establishment of a National Framework Advisory Board which would: (i) identify and resolve areas of deficiency in clinical evidence; (ii) define evidence based minimum clinical needs; (iii) establish a nationally accepted minimum provision of care and ensure this is met on a local basis. (2007)
1690.	That this Meeting condemns the precipitous implementation of health service initiatives without proper evaluation. (2007)
1691.	That this Meeting believes that any allocation of healthcare resources must take into account the true health needs of the population to ensure that appropriate capacity is available. (2007)
1692.	<u>Foundation hospitals</u> That this Meeting is concerned that up to 49% of Foundation Trust income will be allowed to come from private work and demands:- i) increasing private work does not interfere with the primary duty of providing NHS care; ii) robust safeguards put in place must be adhered to and audited with results made public; iii) a two-tier health service is not created with those with the ability to pay enabled to go to the front of the queue. (2012)
1693.	That this Meeting believes that new arrangements that allow NHS hospitals to increase their private patient ratio to as much as 49% will compromise NHS patient care, and is to be deplored. (2012)
1694.	That this Meeting insists that the provision of private care in Foundation Trusts must not be at the expense of NHS care to patients and requires that trusts explicitly and publically demonstrate that the running of private services will be resourced from additionality in terms of staffing and infrastructure. (2012)
1695.	That this Meeting believes:- i) that NHS Trusts need sufficient time to achieve foundation status;

	<p>ii) that forcing all NHS trusts to achieve foundation status before they are ready will impact negatively on patient care;</p> <p>iii) too great an emphasis placed on trusts' financial stability will be at the expense of patient care.</p> <p>(2011 Special Representative Meeting)</p>
1696.	<p>That this Meeting is concerned that the requirement for NHS Trusts to achieve NHS Foundation Trust status, with no clear alternative strategy, drives some of them to place this target above all others, including safe patient care.</p> <p>(2010)</p>
1697.	<p>That this Meeting insists that foundation trusts continue to offer contracts which adhere to national terms and conditions of service.</p> <p>(2010)</p>
1698.	<p>That this Meeting, in the light of the drive for more trusts to become foundation trusts, urges the BMA to continue to press for national contracts for terms and conditions of service to be followed as a minimum standard.</p> <p>(2010)</p>
1699.	<p>That this Meeting insists that foundation trusts should continue to offer contracts of employment that adhere to national terms and conditions of service, and tasks BMA Council to lobby the Foundation Trust Network on this issue.</p> <p>(2010)</p>
1700.	<p>That this Meeting remains concerned about the development of foundation hospital trusts, and demands that:</p> <ul style="list-style-type: none"> (i) independent evaluation of the performance of first wave trusts and their impact upon local health services (including neighbouring trusts) is carried out; (ii) continuation of foundation status, and further rollout, must not take place unless independent evaluation provides evidence of overall benefits to healthcare. <p>(2004)</p>
1701.	<p>That no hospital should be granted foundation status unless:</p> <ul style="list-style-type: none"> (i) it is fully compliant with the European Working Time Directive; (ii) it is fully compliant with the New Deal for junior doctors; (iii) protected time and funding for training of junior doctors are provided on the same basis as in non-foundation trusts. <p>(2004)</p>
1702.	<p>That this Meeting strongly opposes the creation of foundation hospitals and the development of a two-tier system in the NHS.</p> <p>(2003)</p>
1703.	<p><u>Funding and finance</u></p> <p>That this meeting affirms its belief in a publicly funded and provided NHS and calls on the BMA to: -</p> <ul style="list-style-type: none"> i) lobby relevant decision-makers to ensure the NHS is protected from future trade agreements which would threaten this status; ii) work with like-minded stakeholders to resist the privatisation of the NHS; iii) oppose the use or sale of NHS patient information for commercial purposes; iv) insist on an open national register of private contracts with full transparency of accounts, staff qualifications and quality of service. <p>(2019)</p>
1704.	<p>This meeting:-</p>

	<p>i) opposes the proposition of the Naylor report that NHS land and property be sold off to the private sector;</p> <p>ii) calls upon regional councils to oppose local instances where this is proposed and to work with local campaigns.</p> <p>(2018)</p>
1705.	<p>That this meeting believes that in order to provide the necessary funding for the NHS:-</p> <p>i) taxation should be increased.</p> <p>(2018)</p>
1706.	<p>That this meeting believes that the NHS should be fully resourced to meet the increasing demands facing it and:-</p> <p>i) that privacy and patient safety is now being compromised to unacceptable levels;</p> <p>ii) finds it abhorrent that patients are being assessed and treated in hospital corridors due to lack of acute beds;</p> <p>iii) that the system is not providing doctors with the resources to fulfil their professional duty of care;</p> <p>iv) is concerned about the difficulties and pressures doctors face daily;</p> <p>v) that the NHS is no longer a safe place for patients or staff;</p> <p>vi) calls upon the BMA to promote wider public awareness about the impact of unsafe working conditions;</p> <p>vii) demands that the government adequately fund health and social care delivery that will prevent the destruction of our NHS.</p> <p>(2018)</p>
1707.	<p>That this meeting believes the NHS funding crisis cannot continue to be managed by pay restriction.</p> <p>(2017)</p>
1708.	<p>That this meeting calls for social care to be available free at the time of need, financed out of general taxation and provided as part of the comprehensive health service.</p> <p>(2017)</p>
1709.	<p>That this meeting demands governments urgently rectify the severe and chronic underfunding of health and social care which:-</p> <p>i) places extreme pressure on services and the workforce;</p> <p>ii) puts at risk services to patients and the health of the public;</p> <p>iii) undermines sustainable, publicly provided, universal healthcare;</p> <p>iv) is not addressed by the unrealistic savings of sustainability and transformation plans.</p> <p>(2017)</p>
1710.	<p>That this meeting calls on UK governments to commit to funding the NHS to at least the average levels spent on healthcare by comparable leading European countries.</p> <p>(2017)</p>
1711.	<p>That this meeting believes that NHS funding allocations should take account of:-</p> <p>i) the increased costs in rural areas of providing, and for patients of accessing, NHS services;</p> <p>ii) the increasing costs of financial compensation for clinical negligence consequent on the changes to the discount rates.</p> <p>(2017)</p>
1712.	<p>That this meeting deplores the current blame culture in the NHS and:-</p> <p>i) believes that the woeful government underfunding of the NHS coupled with continued austerity cuts is the greatest threat to quality and safety in the NHS;</p>

	<p>ii) believes that the crisis in NHS hospitals has been consciously created by the government, in order to accelerate its transformation plans for private sector takeover of health care in England;</p> <p>iii) firmly believes this scapegoating is a deliberate attempt to distract the public from an under-funded service under severe and intense strain.</p> <p>(2017)</p>
1713.	<p>That this meeting asks the BMA to condemn the government for regarding the balancing of financial budgets as more important than safe staffing in hospitals and the community.</p> <p>(2016)</p>
1714.	<p>That this meeting agrees that, in allocating health and social care funding for geographical populations, resources should reflect need as well as challenges to delivery and should therefore take account of factors including:-</p> <ul style="list-style-type: none"> i) demographic factors; ii) disease prevalence; iii) rurality; iv) deprivation. v) the age structure of populations, having regard however to the earlier dependency that occurs in deprived areas. <p>(2015)</p>
1715.	<p>That this Meeting reminds the government that the NHS is already funded by tax and national insurance and:-</p> <ul style="list-style-type: none"> i) rejects any proposal of a means tested monthly levy to pay for the NHS; ii) rejects the proposals from the Commission on Health and Social Care that the way to pay for social care is to charge for either GP or hospital appointments; iii) demands that the funding of long-term social care is resolved without jeopardising the principles of the NHS; iv) reasserts our belief as doctors that universal healthcare must be free at the point of delivery and available to all regardless of an individual's ability to pay. <p>(2014)</p>
1716.	<p>That this Meeting calls for governments to introduce a fair NHS funding formula which recognises that predicted demographic changes will require additional investment. The formula should include:</p> <ul style="list-style-type: none"> i) weighting for health inequalities and social deprivation; ii) reflection of the cost of providing services in rural areas; iii) full funding for interpretation and translation services; iv) sufficient resources to enable waiting lists to be reduced; v) an element of flexibility across the year to enable appropriate management of seasonal illness. <p>(2014)</p>
1717.	<p>That this Meeting opposes the view that the NHS is unaffordable and:- (Lapsed 2019)</p> <ul style="list-style-type: none"> i) highlights the return of billions of pounds to the Treasury from the English Department of Health in recent years; ii) believes that underspent resources are the result of service restrictions and funding cuts; iii) believes that hospital and primary care services are being pushed into deficit by the requirement for ongoing efficiency savings; iv) demands that underspent resources should be reinvested in the NHS; v) calls on the BMA to publicly call for an end to efficiency savings programmes and demand that future NHS funding increases in line with the clinical needs of the population.

	(2014)
1718.	That this Meeting believes that caring for deprived populations requires extra resources compared with age/sex matched affluent populations in order to reduce health inequalities, and that this should be recognised by an enhanced deprivation element in capitation payments for clinical commissioning groups and general practitioners. This Meeting calls on the BMA to negotiate such enhanced payments. (2013)
1719.	That this Meeting condemns the setting aside of large sums of public money to fund failure regimes with the intention of closing hospitals. (2013)
1720.	That this Meeting believes that Private Finance Initiatives (PFI) continue to be a drain on the public purse and demands that:- i) government directly fund new NHS capital projects; ii) government renegotiate PFI contracts to ensure a better deal for the taxpayer; iii) government enables existing PFI schemes to be bought out by the NHS. (2013)
1721.	That this Meeting is opposed to the £20 billion “savings” being cut from NHS resources and:- (i) deplores the fact that the government have reneged on a commitment to increase the NHS budget in real terms; (ii) believes that these savings will only be achieved by cutting and rationing services; (iii) believes that Clinical Commissioning Groups will be forced to become the primary agents for this programme; (iv) insists that the Department of Health show transparency in how such savings are being re-invested in the NHS. (2012)
1722.	That this Meeting believes that with the current programme of cuts, redundancies and enforced reconfiguration of clinical services:- (i) there will be adverse effects on the delivery of high quality care to patients; (ii) there are risks to the provision of essential services in some geographic areas; (iii) there are threats to the future of some departments; (iv) there is the risk of hospital closures; (v) the BMA must oppose these changes when they are imposed purely for financial reasons; (vi) all alternative options must be reviewed before considering staff cuts. (2012)
1723.	That this Meeting believes that the requirement for year end financial balance in NHS organisations:- i) can endanger quality and safety of service delivery; ii) should not be achieved by deferring the treatment of patients; iii) should not be achieved by pressure on doctors to compromise in their duty to make the care of their patient their first concern; iv) should be managed even-handedly across all sectors by commissioners; v) must not be achieved by withholding funding from NHS staff; vi) should be underpinned by a contingency fund to reduce the risks from financial pressures. (2011)
1724.	That this Meeting deplores that current financial constraints and efficiency savings result in both vacancy control measures and staffing cuts which destabilise services and reduce patient

	safety. This Meeting demands that the governments come clean on the effect on front line staff and the effect on clinical services to patients. (2011)
1725.	That this Meeting deplores that widespread government spending cuts across all government areas, particularly health and social care and government services, will be harmful for the nation's health and well-being, and believes that the scale and speed of these cuts are not economically justifiable. This Meeting calls on the government to radically revise the scale and speed of these cuts and to ensure that the most vulnerable are protected from them. (2011)
1726.	That this Meeting notes the current financial climate and the subsequent inevitable financial pressures on the NHS, and: (i) reiterates that quality of patient care must be maintained; (ii) insists that NHS bureaucracy should be reduced before any cuts in clinical services; (iii) believes that clinical development and technological advances should be maintained. (2010)
1727.	That this Meeting deplores the fact that many millions of pounds announced for specific NHS projects as diverse as for Alzheimers disease, cancer care and for the implementation of Working Time Regulations, have been directed through general NHS funding and cannot be locally accounted for in pursuance of those projects. (2010)
1728.	That this Meeting believes that the time has come for the majority of hospice and palliative care funding to come directly from NHS resources. (2009)
1729.	That this Meeting deplores the situation where the NHS deliberately plans to under spend its resources when there remain large numbers of patients waiting for treatment. (2009)
1730.	That this Meeting calls on the BMA to demand the inclusion of "front-line" primary and secondary care clinicians in the annual service planning and negotiation talks with local commissioners to ensure agreement on efficient integrated pathways of care and appropriate PBR tariffs that cover the true cost of providing care for patients. (2008)
1731.	That this Meeting believes that financial flexibility, whilst welcome, must be accompanied by proper accountability. (2007)
1732.	That this Meeting deplores unreasonable charges to patients and their carers by NHS hospitals. (2007)
1733.	That this Meeting urges the government to ensure that sufficient funding is available to provide adequate and appropriate health services to the more rural areas of the UK. (2004)
1734.	That this Representative Body acknowledges the benefit of additional resourcing to meet increased seasonal pressures on health services and demands that there is forward planning based on realistic assessment of needs. (1999)

1735.	<p>Health and Social Care Bill/Act</p> <p>That this meeting calls for repealing the competition regulations in the Health and Social Care Act which is wasting significant sums of monies in procurement processes, fragmenting care and destabilising NHS providers through accelerating private sector provision.</p> <p>(2018)</p>
1736.	<p>That this meeting:-</p> <ul style="list-style-type: none"> i) supports the principle of integration of health and social care; ii) calls on politicians from all parties UK-wide to stop raising false expectations regarding what integration can achieve when it comes to reducing the admissions of elderly patients to hospital; iii) calls for government to provide enough hospital beds and social care to meet the demands being placed on these services; iv) calls for government to acknowledge that integration of health and social care cannot be done properly without adequate additional funding; v) calls for government and NHS lead bodies to have an open dialogue with the public and patients about what services the NHS should provide for the funding available and what services can no longer be provided by the NHS. <p>(2017)</p>
1737.	<p>That this meeting supports the NHS Bill 2015.</p> <p><i>[Note: full motion as follows: That this meeting;- i) supports the NHS Bill 2015; ii) calls on the BMA to lobby for the NHS Bill 2015 to be adopted by the Westminster government.]</i></p> <p>(2015)</p>
1738.	<p>That this Meeting believes that Section 75 of the Health and Social Care Act 2012 and its regulations remain incompatible with assurances given during the passage of the Act and subsequently; and:-</p> <ul style="list-style-type: none"> i) will obligate competitive tendering for NHS services; ii) will fragment patient care; iii) will increase privatisation of NHS care; iv) calls for a campaign to repeal Section 75 of the Act and its regulations. <p>(2013)</p>
1739.	<p>That this Meeting</p> <ul style="list-style-type: none"> (i) asserts that the Health and Social Care Act 2012 is bad for patients, bad for the NHS, and bad for the public. (ii) demands the repeal of the Health and Social Care Act 2012 and calls for a co-ordinated campaign to achieve that aim. <p>(2013)</p>
1740.	<p>That this Meeting condemns the passing of the Health and Social Care Act and resolves that the BMA must:-</p> <ul style="list-style-type: none"> (i) highlight how the Act will lead to increasing NHS privatisation; (ii) continue to call for full publication of the NHS risk register; (iii) monitor and collate information about the effects of the Act on the NHS and the profession; (iv) co-ordinate the presentation to the public of the view of the medical profession on the Act; (v) provide guidance and support to doctors on mitigating damage to the NHS;

	<p>(vi) continue to strive to find mechanisms to protect an NHS which is both sustainable and free at the point of delivery for all UK patients;</p> <p>(vii) make proposals to mitigate and reverse its damaging effects.</p> <p>(viii) campaign for repeal of the Health and Social Care Act.</p> <p>(2012)</p>
1741.	<p>That this Meeting:-</p> <p>(i) notes and deplores the conflicts of interest apparent in Parliamentary debates and lobbying around the Health and Social Care Bill where MPs and peers have vested personal interests in passing the Bill;</p> <p>(ii) also notes that private health care companies have been involved in formulating aspects of the Health and Social Care Bill, particularly in areas involving competition, allowing greater entry of the private sector into NHS provision;</p> <p>(iii) instructs the BMA to demand that all MPs and peers make transparent their financial or personal interests in private healthcare companies, foundation trusts, health charities or other organisations which benefit from the passage of the Health and Social Care Bill;</p> <p>(iv) instructs the BMA to call for full disclosure of the input of private health care companies into the formulation of the Health and Social Care Bill.</p> <p>(2012)</p>
1742.	<p>That this Meeting believes that the NHS Health and Social Care Act will worsen health inequalities. This Meeting is appalled that the Act:-</p> <p>(i) does not extend to local authorities a statutory duty to reduce health inequalities;</p> <p>(ii) reduces the funding weighting for health inequalities;</p> <p>(iii) will damage patient care, particularly of vulnerable groups;</p> <p>(iv) does not place a duty on Clinical Commissioning Groups to promote population-wide health;</p> <p>(v) will damage public health provision;</p> <p>(vi) will lead to a more fragmented and bureaucratic NHS;</p> <p>(vii) does not require the Secretary of State for Health to specify how commissioners, regulators and local authorities will be held accountable for reducing health inequalities.</p> <p>(2012)</p>
1743.	<p>That this Meeting recognises the strength and importance of the debates and resolutions at the Special Representative Meeting held in March 2011 and:-</p> <p>i) believes that BMA policy leaves the government in no doubt about the strength of feeling in the profession regarding many aspects of the Health and Social Care Bill;</p> <p>ii) calls on the BMA to continue to oppose damaging elements of the Health and Social Care Bill unless suitable amendments are made;</p> <p>iii) totally refutes any government held view that the pragmatic decision by GPs to engage in commissioning is an endorsement of the Health and Social Care Bill;</p> <p>iv) remains concerned about the pace and scale of the implementation of major change to the NHS in England, including the implementation of elements of proposals before enactment by Parliament;</p> <p>v) calls on the BMA to consult its members as to what action should be considered if the Bill is enacted without the significant changes called for.</p> <p>(2011)</p>
1744.	<p>That this Meeting believes that the response of the government to the Future Forum report fails to satisfactorily address the concerns of the profession:-</p> <p>i) with regard to the duty of the Secretary of State for Health to provide comprehensive health services;</p> <p>ii) with regard to the function of Monitor to promote competition in the provision of health services;</p>

	<p>iii) that Monitor, the Care Quality Commission, the NHS Commissioning Board and consortia must have a legal duty to act so as to avoid the undermining of existing NHS services;</p> <p>iv) that competition should not be forced on the NHS by imposing any duties on commissioners to promote choice as a higher priority than tackling fair access and health inequalities;</p> <p>v) and calls on the BMA to continue to call for the Health and Social Care Bill to be withdrawn.</p> <p>(2011)</p>
1745.	<p>That this Meeting believes that the exposure of the NHS to competition law will embroil commissioners in endless legal action at the hands of unsuccessful bidders for NHS services. Such legal action will either waste consortia resources if contested or result in capitulation to bidders supported by large legal resources. This Meeting therefore calls on the BMA to campaign against the application of competition law to the NHS.</p> <p>(2011)</p>
1746.	<p>That this Meeting believes that current and proposed reforms to the NHS in England are associated with significant and wasteful costs and:-</p> <p>i) condemns the diversion of resources away from patient care and into reorganisation;</p> <p>ii) condemns the recent lengthening of waiting times for non-urgent care;</p> <p>iii) mandates the BMA to publicise the high costs of restructuring the NHS, and to continue to campaign for better use of resources;</p> <p>iv) calls upon the government to address the underlying structural financial problems of the NHS before implementing NHS reforms.</p> <p>(2011)</p>
1747.	<p><u>Healthcare for London</u></p> <p>That this Meeting:</p> <p>(i) opposes the introduction of the 'minimal core services local hospital' model for London as proposed by Healthcare for London as it is a clinical risk to patients; and</p> <p>(ii) calls for the BMA to promote the district general hospital model.</p> <p>(2009)</p>
1748.	<p><u>Management/clinical engagement</u></p> <p>That this meeting recognising that decisions made by non-clinical managers in the NHS and other health service providers affect the health of our nations, this meeting calls for a system of regulation for such staff, in line with the manner in which clinical staff are regulated by professional bodies.</p> <p>(2017)</p>
1749.	<p>That this meeting reaffirms the duties of a doctor outlined in Good Medical Practice (GMC) and calls on the BMA to enhance patient care by reinforcing medical professionalism as the cornerstone of healthcare delivery.</p> <p>(2015)</p>
1750.	<p>That this meeting seeks the promotion of patient safety through accountability of healthcare provision, in the workplace by:-</p> <p>i) coding of patients and hospital activity against clinicians who provide the service;</p> <p>ii) taking forward the concept of named clinician with delegated responsibility for the patient;</p> <p>iii) ensuring that all SAS doctors have access to appropriate clinical data systems;</p> <p>iv) mandating availability of individual outcome data for appraisal and revalidation.</p>

	We exhort the BMA to promote this concept and lobby DoH, Health and Social Care Information Centre and employers to implement these initiatives. (2015)
1751.	That this Meeting believes that medical professionalism is under assault by government and media, and:- i) affirms that professionalism is at the heart of quality healthcare delivery; ii) calls on the BMA to work to increase public awareness and understanding of the value, integrity and professionalism of doctors. (2014)
1752.	That this Meeting believes that reports commissioned by the NHS from external management consultants: (i) may have a major impact on NHS staff and services; (ii) should be readily available to NHS staff and the public; (iii) should be widely accessible without the need for an explicit Freedom of Information Act request; (iv) should be accompanied by publication of their cost; (v) should demonstrate high standards of academic rigour. (2010)
1753.	That in respect of the management of the NHS, this Meeting: (i) believes that there must be a system of public accountability for senior executives in the NHS; (ii) believes that the number and cost of NHS management staff should be kept under continual review; (iii) believes that commissioning organisations should have effective clinical advice; (iv) calls on all doctors to invite local NHS management staff to gain exposure to clinical practice. (2010)
1754.	That this Meeting strongly advocates that the economic challenges facing the NHS call for responsible leadership and demands: (i) that clinicians are central to any strategies developed in reconfiguration of services; (ii) that clinical engagement is undertaken in a way which harnesses and does not undermine the skills, motivation and professionalism of clinicians; (iii) that any changes are economically viable, sustainable and able to recruit and retain clinicians of good quality. (2010)
1755.	That this Meeting is concerned with the practice of non-clinical managers giving priority to waiting list targets rather than clinical needs of patients. (2010)
1756.	That this Meeting calls for medical leadership and quality to be at the heart of health services and their development and: (i) calls for meaningful standards of care and clinical outcome measures to be adopted both for commissioning and delivery of care; (ii) insists that Health Departments ensure investment in time and resource for busy clinicians to develop the necessary skills and to drive service innovation. (2009)
1757.	That this Meeting believes that Lord Darzi's pledge for all change to be clinically led and locally determined runs contrary to the reality of centralist, politically-dictated NHS reforms in England. If government pronouncements on clinical leadership are to be realised:

	<ul style="list-style-type: none"> (i) there must be freedom for clinicians to “lead” in the interests of patients and clinical care; (ii) clinical leaders must not be driven primarily by the financial and political motives of a trust or primary care organisation; (iii) clinicians must have freedom of speech to highlight concerns regarding local or national health policy where it adversely impacts on patient care. <p>(2009)</p>
1758.	That this Meeting believes that the role of NHS management is to facilitate and support clinical decisions based on patients’ needs rather than hindering them for the sake of expedience. (2009)
1759.	That this Meeting welcomes that where there has been genuine engagement of clinicians in the management and development of healthcare there have been positive benefits, but deplores government rhetoric that purports to devolve policy and decision-making to clinicians whilst implementing a centralist politically driven programme of system reform. (2008)
1760.	That this Meeting insists that: <ul style="list-style-type: none"> (i) the medical profession would welcome change and reform that delivers positive benefits to patients; (ii) positive reform requires meaningful consultation with patients and front-line clinicians; (iii) if local managers continue to fail to engage in genuine partnerships with local clinicians this will be to the detriment of patient care and services; (iv) healthcare professionals need dedicated time to improve and develop clinical services; (v) clinical staff should be driving the clinical governance agenda; (vi) doctors be involved as equal partners and not merely as consultees at all levels of NHS management, from policy development and implementation to service delivery. <p>(2007)</p>
1761.	That this Meeting believes that the government’s contemptuous disregard for the views of the profession on many recent government policies has resulted in “reforms” and proposals that are not fit for purpose and are damaging to medicine and healthcare in the UK. The BMA calls upon the medical profession to reassert professional leadership in the interests of our patients and the public. (2007)
1762.	That this Meeting believes that managers should consult with the medical profession before making decisions affecting and involving patient care. (2006)
1763.	That this Meeting recognises the benefits of junior doctor representation within management structures and calls upon the NHS confederation (and equivalents) to ensure all employing authorities invite junior doctors to be involved in any group whose decisions could affect junior doctors’ working lives. (2004)
1764.	That this Meeting urges NHS managers to focus on providing the essential support and infrastructure needed by healthcare professionals to deliver patient care. (2002)
1765.	That this Meeting believes that clinician influence has been progressively diminished in the new NHS and recommends: <ul style="list-style-type: none"> (i) greater collaboration of NHS managers with clinical staff to bring about better quality patient care;

	<p>(ii) all clinicians in managerial roles to undertake accredited managerial training in line with best practice in private industry and other health care systems;</p> <p>(iii) doctors of minority ethnic origin and female doctors should be fairly represented in strategy, planning and decision making at all levels of the NHS.</p> <p>(2001)</p>
1766.	<p>That this Meeting deplores the variability in the provision and quality of management training for doctors and calls upon COPMED or its national equivalent to consult the BMA and provide access to high quality management training.</p> <p>(2000)</p>
1767.	<p>That the BMA believes strongly in the autonomy of the profession in clinical matters and should:</p> <p>(i) be proactive in developing an overall plan to address the problems of the NHS in a constructive way;</p> <p>(ii) affirm the need for general practice to continue to function on the basis of the sound ethical principle of the primacy of the interests of individual patients over the interests of the community.</p> <p>(1998)</p>
1768.	<p>That this Association demand formal recognition of the need for comprehensive representative medical advice to management at all levels within the National Health Service.</p> <p>(1994)</p>
1769.	<p>That this Meeting believes that clinicians fulfilling management roles should be provided with adequate support.</p> <p>(1992)</p>
1770.	<p>That this Meeting believes that management is a vital aspect of professional activity for all doctors and believes that training in management skills should be incorporated into all levels of medical education.</p> <p>(1992)</p>
1771.	<p>That this Meeting recommends that the Government should fund properly evaluated pilot studies of new methods of management before introducing them as nationwide practices.</p> <p>(1988)</p>
1772.	<p><u>NHS Direct and Walk In Centres</u></p> <p>That NHS Direct must be encouraged to communicate more with GPs about their patients.</p> <p>(2001)</p>
1773.	<p>That this Meeting:</p> <p>(i) deplores the Government's failure to evaluate NHS Direct pilots properly prior to national roll out;</p> <p>(ii) requires proper consultation with the profession nationally and locally prior to roll out of NHS Direct;</p> <p>(iii) demands clarification of where NHS Direct's responsibilities end and those of GPs begin;</p> <p>(iv) believes that resources allocated to NHS Direct will be insufficient to meet demand and will constitute a drain on the already inadequate funds available to the NHS as a whole.</p> <p>(1999)</p>
1774.	<p>That this Meeting believes that NHS Direct:</p> <p>(i) will damage the fundamental role of the primary care team and GP as gatekeeper, resulting in an increase in NHS expenses;</p> <p>(ii) will increase patient demand and GP workload;</p>

	<p>(iii) must not control access to GP practices. (1999)</p>
1775.	<p>That this Meeting believes that walk-in primary care centres:</p> <ul style="list-style-type: none"> (i) will fuel demand rather than address need; (ii) hold grave dangers for the consistent and co-ordinated treatment of patients; (iii) will divert scarce resources that would be better used enhancing the current model of GP services; (iv) should be expanded only after proper evaluation and with the agreement of the profession. <p>(1999)</p>
1776.	<p><u>NHS plan for England</u></p> <p>That this meeting, in respect of the NHS Long Term Plan: -</p> <ul style="list-style-type: none"> i) believes that many of the ambitions of the Plan will be largely unachievable because of underfunding of the NHS; ii) asks the BMA to highlight to government and the public that the reforms and structural changes proposed are not in the interest of the NHS; iii) believes launching the Plan without an adequate workforce strategy will precipitate a greater crisis. <p>(2019)</p>
1777.	<p>That, in respect of the NHS Long Term Plan, this meeting: -</p> <ul style="list-style-type: none"> i) does not support the imposition of funding cuts through efficiency savings; ii) does not support the shift of care from hospitals into the community without concomitant increase in resources; iii) believes that the NHS should be a system to provide healthcare according to clinical need; iv) opposes the NHS Long Term Plan as a plan for a market-driven healthcare system. <p>(2019)</p>
1778.	<p>That this Meeting believes that:</p> <ul style="list-style-type: none"> (i) more emphasis should be placed on collaboration as opposed to competition in health care delivery; (ii) the health service should be based on the NHS as the main provider of health care; (iii) the new competitive market must not prejudice the NHS through any guaranteed flow of income to the private sector. <p>(2005)</p>
1779.	<p>That this Meeting believes:</p> <ul style="list-style-type: none"> (i) that the NHS Plan will never be delivered in its entirety without an increase in funding, medical and nursing manpower and support staff; (ii) the pace of change for such a complex plan is too quick leading to low morale; (iii) the public should be educated away from a demand (without responsibility) and blame (litigious) culture; (iv) a major change in attitude by politicians to the caring professions is required. <p>(2001)</p>
1780.	<p><u>NICE</u></p> <p>That this Meeting believes in any advisory committee of NICE, when guidance on any drug is issued, it must be made clear that none of the members must have a financial interest in pharmaceutical companies which manufacture the drugs.</p> <p>(2014)</p>

<p>1781.</p>	<p>That this Meeting believes that the working of NICE should be improved to:</p> <ul style="list-style-type: none"> (i) evaluate existing medicines and treatments currently provided by the NHS; (ii) evaluate existing national screening programmes for cost effectiveness and advise discontinuation of any schemes which fall outside NICE criteria; (iii) stop prioritising its medicines assessments in response to political pressure; (iv) clearly identify the resources needed to implement its decisions regarding new drugs and treatments. <p>(2010)</p>
<p>1782.</p>	<p>That this Meeting believes that NICE:</p> <ul style="list-style-type: none"> (i) undermines the clinical freedom of doctors to implement treatments that they believe to be in the best interests of their patients; (ii) is losing credibility as an independent advisor; (iii) must remain advisory rather than regulatory. <p>(2005)</p>
<p>1783.</p>	<p>That this Meeting is not convinced that the postcode lottery is resolved and urges our government to fund NICE recommendations fully.</p> <p>(2005)</p>
<p>1784.</p>	<p>That there should be more co-ordination and communication between NICE, academics and voluntary organisations eg, British Heart Foundation, Diabetes UK, British Thoracic Society in producing consistent guidelines to assist professionals.</p> <p>(2005)</p>
<p>1785.</p>	<p>That this Meeting upholds evidence based practice, but deplores pressure from outside the profession to treat guidelines, such as NICE and NSF, as exclusive arbiters of good practice.</p> <p>(2004)</p>
<p>1786.</p>	<p>That this Meeting demands all future government recommendations for change or improvement including NICE Guidance and Guidelines must be accompanied by adequate additional funding.</p> <p>(2004)</p>
<p>1787.</p>	<p>That this Meeting believes that NICE and the Health Technology Board for Scotland should work more closely together to ensure a seamless approach to new developments in medicines and health technologies.</p> <p>(2001)</p>
<p>1788.</p>	<p>That primary, secondary, tertiary health care consequences, and social care consequences of all national framework and NICE guidelines should be fully resourced, where appropriate, from new monies.</p> <p>(2000)</p>
<p>1789.</p>	<p><u>NHS Sustainability and Transformation Plans (STPs)</u></p> <p>That this meeting believes that sustainability and transformation plans have not produced a sustainable funding model for the NHS in England, and the BMA calls for:-</p> <ul style="list-style-type: none"> i) the maintenance and improvement of the quality of patient care to be the absolute priority; ii) patients and the public to be consulted on realistic, evidence-based STPs; iii) there to be no further reduction in inpatient beds until after a comprehensive assessment of the clinical needs of the local population; iv) clinical education and training to be protected and promoted;

	<p>v) any service reconfiguration to be clinician-led;</p> <p>vi) at least one doctor appointed by regional councils to be engaged in a meaningful clinical forum with each STP;</p> <p>vii) STPs to be fully funded to achieve true transformation.</p> <p>(2017)</p>
1790.	<p>That this meeting condemns the woeful manner in which STPs have been progressed, turning them into vehicles to try to legitimise further cuts to vital NHS services, and proposes STPs are abandoned.</p> <p>(2017)</p>
1791.	<p><u>Out of hours care</u></p> <p>That this Meeting recognises that a significant proportion of palliative care occurs in the out-of-hours setting and therefore demands that:</p> <p>(i) all providers of out-of-hours services receive regular training in palliative care;</p> <p>(ii) there are formal mechanisms for hand-over between daytime and out-of-hours services;</p> <p>(iii) there is easy access to essential medications out-of-hours.</p> <p>(2006)</p>
1792.	<p>That this Meeting considers that the NHS Direct/NHS 24 Service is seriously flawed, particularly with regard to ease of access for the genuinely sick, and to other issues of clinical safety in relation to triage: the system requires radical rethinking to clearly improve safety mechanisms and also restore a responsive local aspect to out-of-hours care.</p> <p>(2005)</p>
1793.	<p>That this Meeting believes that the changes to out-of-hours primary care services have resulted in poorer care for patients and increased demand on A&E departments in some areas. The health departments must re-evaluate the system and develop national standards for out-of-hours primary care, in partnership with the BMA.</p> <p>(2005)</p>
1794.	<p>That this Meeting recognises that the provision of primary care services out of hours is changing, and calls upon the UK Health Departments to ensure that:</p> <p>(i) Primary Care Organisations work with general practitioners to develop and implement schemes to take over out of hours responsibilities from GPs;</p> <p>(ii) all necessary funding is provided to deliver an out of hours service that is consistent with the aims and objectives of the Carson report;</p> <p>(iii) there is no consequent adverse effect upon A&E services;</p> <p>(iv) emphasis is placed on educating the public on how to access appropriate services.</p> <p>(2004)</p>
1795.	<p><u>Patients</u></p> <p>That this meeting calls on government to work with stakeholders to promote engagement of the public in appropriate self-management of long term conditions.</p> <p>(2018)</p>
1796.	<p>That this meeting:-</p> <p>i) believes that the Prevent programme leads to racial profiling;</p> <p>ii) calls on the BMA to support all members who refuse to take part in the Prevent programme.</p>

	(2018)
1797.	That this meeting calls on all governments of the UK to ensure there are adequate chronic pain services to support primary care management of patients with chronic long term conditions, to provide support to decreasing opioid consumption in this cohort and to teach patients strategies to decrease their pain experience. (2018)
1798.	That this meeting notes the introduction of requirements for patients to prove their eligibility for NHS treatment. This meeting:- i) believes that NHS Trusts may be inappropriately denying NHS treatment on these grounds; ii) strongly condemns the denial of treatment of patients with longstanding legal residency due to a lack of documentation; iii) believes this causes distress and potential harm to patients; iv) calls on the BMA to lobby for NHS care to be provided to all long-term residents; v) calls for requirements to be simplified and brought in line with actual eligibility criteria. (2018)
1799.	That this Meeting believes that the notion of patient choice noisily promoted by the government does not offer any actual choices desired by patients, and insists that the government must work with the BMA and patient bodies to identify the real needs of patients. (2013)
1800.	That this Meeting supports meaningful, and facilitative patient feedback on NHS services but deplores: (i) the Health Departments' support for patients rating their doctor on websites, which reduces the complexity of patient care to that of holiday and consumer item user reviews, and with the potential to mislead patients and the public on the basis of self selected feedback and anecdote; (ii) the National Patient Survey of GP practices which is unfit for purpose and represents a politically motivated scrutiny of general practice unparalleled in any other part of the public sector. (2009)
1801.	That this Meeting believes that the BMA should commission a report on whether patient choice and the Choose and Book system have changed referral patterns significantly. The reasons for changes in referral patterns need to be identified to inform local service development and improvement. (2008)
1802.	That this Meeting believes that the concept of "patient choice" loudly promoted by the government pays scant attention to the actual choices that patients wish, and demands that the government work with the BMA and the public to identify and address the real needs of patients. (2008)
1803.	That this Meeting acknowledges that difficulties exist in communicating with patients who do not speak fluent English, and (i) reaffirms that using relatives to interpret is not best practice; (ii) suggests that adequate time is allocated to communicate with patients whose first language is not English; (iii) calls for consistent high quality language translation services across the NHS with assistance accessible in a timely manner 24 hours a day. (2008)

1804.	That this Meeting believes that the notion of patient choice noisily promoted by the government does not offer any actual choices desired by patients, and insists that the DH must work with the BMA and patient bodies to identify the real needs of patients. (2007)
1805.	That this Meeting believes that Choose and Book: (i) is currently unfit for purpose; (ii) cannot currently replace the sending of a letter directly from GP to specialist; (iii) actually limits patient choice; (iv) is a politically driven initiative to reduce NHS deficits and to give the illusion of meeting targets; (v) should have its impact on referral patterns investigated by the BMA. (2007)
1806.	That this Meeting: (i) believes that the "Patient Choice" initiative does not incorporate the actual choices desired by patients and offers no additional choice to those requiring non-operative medical care for chronic illnesses or cancer; (ii) calls on the Department of Health to allocate the resources necessary to support decision making by patients that is based on accurate and relevant information with appropriate medical recommendations. (2005)
1807.	That this Meeting supports choice for patients, but believes that the "Patient Choice" initiative: (i) does not deliver choice for patients; (ii) is wasteful of NHS resources; (iii) is unclear about lines of clinical accountability; (iv) is contributing to the creeping privatisation of healthcare; (v) should be piloted before considering national implementation. (2004)
1808.	That this Meeting insists that there be a national insurance policy to cover injuries to medical personnel involved in inter-hospital transfer of patients and attending injured patients at remote sites and during major incidents. (2003)
1809.	That this Meeting believes that, with regard to non-English speaking patients: (i) existing translation services should be well publicised and accessible; (ii) the government should provide a national medical translation service to improve confidentiality and care of patients; (iii) translation services should be made available through NHS Direct. (2003)
1810.	That this Meeting believes in a more patient focused NHS. This Meeting calls for the BMA to promote: (i) more patient representation on statutory bodies; (ii) more education for the medical professions re: patient empowerment. (2002)
1811.	That this Meeting reaffirms its belief in the philosophy of freedom of choice for patients and their doctors and recognises that fixed budgets and a contracting service have resulted in less patient choice. (1992)

	<u>Payment by results and independent sector treatment centres</u>
1812.	That this Meeting demands that the Department of Health urgently increases the payment by results tariffs for treating complex trauma patients so that the costs of care are adequately reimbursed and to facilitate the investment required in rolling out the national programme of trauma networks and centres. (2013)
1813.	That this Meeting maintains its opposition to the system of Payment by Results because it: <ul style="list-style-type: none"> (i) does not reflect the true relative cost of treatment, which is resulting in erroneous funding to providers; (ii) creates inherent perverse incentives with consequent behaviours that damage patient care; (iii) creates division between primary and secondary care, using patients as financial pawns; (iv) is resulting in bureaucracy and transaction costs which increases expenditure on administration rather than on patient care; (v) is in conflict with the government vision of “care closer to home”; (vi) places an unnecessary burden on primary care. (2010)
1814.	That this Meeting deplores examples of private sector providers being offered more favourable terms and financial arrangements compared to local NHS trusts, as part of the government’s drive for private sector procurement in the NHS, and demands that this inequity is immediately halted. (2007)
1815.	That Payments by Results (PBR) is a payments tool facilitating a health policy of fragmenting care into saleable bits on which a profit can be made. It disadvantages NHS units providing complex and comprehensive care. This Meeting calls on the BMA to oppose payment by results. (2007)
1816.	That the BMA should vigorously oppose Payment by Results as currently proposed because: <ul style="list-style-type: none"> (i) low cost private treatment centres will cherry pick uncomplicated cases and leave more complex cases to comprehensive NHS hospitals; (ii) NHS trusts are threatened by diverting funds to the private sector; (iii) strategic planning of health services based on need will be undermined; (iv) it will increase bureaucracy and management costs. (2005)
1817.	That, with regard to independent sector treatment centres (ISTCs), this Meeting: <ul style="list-style-type: none"> (i) demands a robust independent monitoring system to compare clinical outcomes from ISTCs and NHS establishments; (ii) insists that the health departments must ensure that ISTCs will not be detrimental to the training and experience of junior doctors; (iii) calls on the health departments to engage in meaningful discussion to enable this welcome increase in capacity to be planned into the needs of each health economy. (2005)
	<u>Polyclinics</u>
1818.	That this Meeting: <ul style="list-style-type: none"> (i) endorses the Darzi pledges that changes to NHS services should be to the benefit of patients, be clinically driven, be locally led, involve those affected, and that existing services should not be withdrawn until new and better services are available;

	<ul style="list-style-type: none"> (ii) regrets the Darzi pledges are not being applied; (iii) calls on UK Health Departments to ensure that all NHS organisations adhere to the Darzi pledges; (iv) demands that NHS changes must be driven by evidence not by dogma and ideology; (v) strongly asserts the time has now come for patients to be put before profits. <p>(2010)</p>
1819.	<p>That this Meeting supports the District General Hospital model, which has a long safety track record and opposes the Darzi 'Local hospital Model'.</p> <p>(2010)</p>
1820.	<p><u>Primary Care Organisations</u></p> <p>That this Meeting notes with concern the increasing involvement of private sector organisations in the provision of primary care, and:</p> <ul style="list-style-type: none"> (i) believes this potentially threatens the continuity and holistic care provided by general practice; (ii) believes this fragments the concept of a publicly funded and provided NHS; (iii) instructs the GPC to investigate and report on the extent of the threat this poses; (iv) instructs the GPC to alert the public to the risks this poses; (v) calls on GPC to provide leadership and guidance to LMCs in dealing with this threat. <p>(2005)</p>
1821.	<p>That this Meeting believes that primary care organisations that employ consultants should:</p> <ul style="list-style-type: none"> (i) ensure that a functional infrastructure is in place to provide adequate and appropriate professional support to such staff; (ii) have a statutory requirement for the PEC to include at least one consultant member; and urges the BMA to campaign for these. <p>(2005)</p>
1822.	<p>That this Meeting believes that the distribution of GMS monies by primary care organisations (PCOs) should:</p> <ul style="list-style-type: none"> (i) be clear and open to scrutiny by Local Medical Committees; (ii) not be vired to cover other potential overspends; (iii) be clearly defined in terms of “ring-fenced” and “floor” and should not be removed at the PCO’s discretion. <p>(2002)</p>
1823.	<p>That this Meeting strongly recommends that the government reconfigure the PCT to include:</p> <ul style="list-style-type: none"> (i) a medical director; (ii) consultant representation on the PEC [Professional Executive Committee]. <p>(2002)</p>
1824.	<p><u>Private Finance Initiative</u></p> <p>That this Meeting:-</p> <ul style="list-style-type: none"> i) notes the enormous burden of PFI debt that threatens to sink the NHS; ii) demands that government legislates to rescind all NHS PFI debt; iii) demands that government does not enter into any new PFI scheme. <p>(2014)</p>
1825.	<p>That this Meeting believes with regard to the Private Finance Initiative in the NHS that:-</p> <ul style="list-style-type: none"> i) it represents unaffordably poor value for money in the current financial climate; ii) NHS PFI contracts should be renegotiated to ensure better terms, better value for money for the NHS and to release resources for patient care;

	<p>iii) the BMA should lobby for all health PFI contracts to be made public. (2011)</p>
1826.	<p>That this Meeting requests government, in view of new found enthusiasm for the nationalisation of banks, to nationalise the NHS and bring PFIs into public ownership. (2009)</p>
1827.	<p>That the legal requirement for trusts to achieve financial balance on an annual basis is:</p> <ul style="list-style-type: none"> (i) resulting in short-term, expedient and perverse behaviour by trusts and commissioners; (ii) thwarting investment in strategies to achieve health gain and liberate cost efficiencies in the medium and longer term; (iii) resulting in iniquitous ad-hoc cuts in services to patients at the financial year-end; and this Meeting therefore calls for trusts and commissioners to be allowed to work to longer meaningful financial timescales. <p>(2007)</p>
1828.	<p>That this Meeting deplores the improperly researched, non evidence-based, current wave of private finance initiative schemes, which are mortgaging the NHS of the future, and believes any further such schemes will make the NHS unsustainable in the future. It calls upon the government to:</p> <ul style="list-style-type: none"> (i) put a halt to any further PFI schemes; (ii) produce long-term (10 and 25 year) projections of the costs of these schemes; (iii) include future debts to PFI companies when calculating the NHS deficit; (iv) introduce and deliver a policy of public ownership of all future NHS hospitals. <p>(2007)</p>
1829.	<p>That this Meeting believes that the apparent government determination that all new NHS buildings in secondary or primary care be funded by private finance:</p> <ul style="list-style-type: none"> (i) is not supported by robust evidence of cost effectiveness; (ii) can have serious consequences on the revenue stream of trusts and GPs due to the associated extra costs; (iii) lacks flexibility and reduces the ability of localities to reconfigure service provision as trusts are tied to 20 or 35 year leases; (iv) is ill conceived and will prove to be a millstone around the NHS for the next generation. <p>(2006)</p>
1830.	<p>That this Meeting believes that the BMA should oppose the financial support provided by the Government to PFI schemes, as they divert funds from core NHS resources. (2005)</p>
1831.	<p>That this Meeting deplores the continued use of PFI funding in the health service when it is evident that it is an excessively costly option, both for the present and for the future. (2004)</p>
1832.	<p><u>Purchaser/provider arrangements</u></p> <p>That this meeting:-</p> <ul style="list-style-type: none"> i) notes the administration of the purchaser/provider split costs the NHS billions of pounds which could be better spent on patient care; ii) believes the purchaser/provider split has created opposing financial incentives for primary and secondary care providers, undermining collaboration between primary and secondary care clinicians to the detriment of patient care; iii) calls on the BMA to lobby governments for the abolition of the purchaser / provider split. <p>(2015)</p>

<p>1833.</p>	<p>That this Meeting believes that the purchaser/provider split in the NHS:</p> <ul style="list-style-type: none"> (i) has not delivered significant benefit to patients; (ii) has proved unaffordable to implement; (iii) is a major source of inefficiency and a drain on resources; (iv) inhibits clinician involvement in planning services; (v) should be abandoned in England as it has been in Scotland; (vi) should be replaced with a system that promotes greater collaboration. <p>(2007)</p>
<p>1834.</p>	<p>That this Meeting believes that LMCs should have statutory recognition in the commissioning process.</p> <p>(1993)</p>
<p>1835.</p>	<p><u>Quality of care</u></p> <p>That this meeting, with respect to Care Quality Commission inspections, calls for:-</p> <ul style="list-style-type: none"> i) the BMA to challenge unrealistic standards; ii) recognition of the context and resources in which services are delivered; iii) clarity of requirement for necessary data collection to be undertaken before the inspections. <p>(2017)</p>
<p>1836.</p>	<p>That this meeting asserts that the CQC has proven itself to be not fit for purpose;-</p> <ul style="list-style-type: none"> i) and continues to damage the morale and professionalism of all doctors; ii) and has demonstrably failed to deliver the tasks they were set to do; iii) and has become a bureaucratic and incompetent nightmare. <p>(2015)</p>
<p>1837.</p>	<p>That this Meeting:-</p> <ul style="list-style-type: none"> i) believes CQC is not fit for purpose; ii) believes CQC should be held to account and public scrutiny following the Francis Report; iii) has no confidence in the ability of CQC to regulate health services; iv) believes that a chief inspector of primary care is unnecessary and should not be appointed; v) believes that the information governance function of the CQC should be removed forthwith <p>(2013)</p>
<p>1838.</p>	<p>That this Meeting demands providers of health services are properly regulated where there are potential risks to patients in the form of invasive procedures, interventions with the potential for harm, or the exercise of judgement which could substantially impact on the health or welfare of vulnerable patients.</p> <p>(2011)</p>
<p>1839.</p>	<p>That this Meeting supports the emphasis on quality of care in the Darzi next stage review, and believes that excellent communications between all NHS staff, and between them and their patients is vital to these aims.</p> <p>(2009)</p>
<p>1840.</p>	<p>That this Meeting strongly supports the pursuit of the highest standards of care for patients.</p> <p>(1998)</p>

1841.	That indices of NHS performance should focus on quality, equity and outcomes of patient care, rather than meaningless, misleading and politically motivated statistics. (1997)
1842.	That this Meeting believes that when national quality initiatives are implemented they should be accompanied by adequate resources. (1997)
1843.	That doctors must be involved in setting quality standards and take an increasing interest in outcomes, and ensure that, where a particular outcome needs to be looked at on a long-term basis, decisions on provision of care are not made on inadequate short-term information. (1992)
1844.	<u>Rationing</u> That this meeting, in light of increased rationing by CCGs which denies or defers certain treatments and interventions requests BMA council to lobby NHS England and other Health Departments to establish both uniform criteria and a uniform process across the country for approving elective surgical procedures so as to abolish the present post code lottery. (2018)
1845.	This meeting deplores the recent policy by a CCG, approved by the local council, to deprive adult patients with a mild hearing loss from receiving NHS funded hearing aids. This meeting calls upon the BMA to work with relevant stakeholders to ensure all patients who require NHS funded hearing aids to have access irrespective of their postcode. (2015)
1846.	That this Meeting does not accept that doctors should be held responsible for rationing healthcare, and insists that rationing must always be the ultimate responsibility of the government, who are directly answerable to the public who elected them. (2012)
1847.	That this Meeting believes that if "low priority treatments" and "referral thresholds" are truly evidenced based as claimed by PCOs then:- (i) all should be implemented nationally; (ii) local "low priority treatments" should then be correctly described as rationing. (2012)
1848.	That this Meeting deplores the variable definitions and thresholds of "low priority" treatments that are being implemented in different Primary Care Organisations, which are denying patients equitable access to services nationally, and this Meeting calls for consistent national standards and thresholds of services available to patients on the NHS. (2011)
1849.	That this Meeting deplores the continued practice of UK governments to refuse openly to acknowledge the rationing of health care in today's NHS. (2009)
1850.	That this Meeting holds that treatment must be evidence based and related to clinical need rather than to age alone. (2008)
1851.	That this Meeting believes that: (i) with finite resources for healthcare some rationing of services is inevitable;

	<ul style="list-style-type: none"> (ii) the government and local healthcare economies should be honest about rationing in the NHS; (iii) where rationing occurs it must be evidence based, explicit and publicised; (iv) the BMA must lobby for the development of evidence and value based minimum basic healthcare needs; (v) healthcare resources should follow nationally set policies, and not be decided on a case by case basis; (vi) any rationing should be on the basis of both clinical need and clinical effectiveness. <p>(2007)</p>
1852.	That this Meeting believes that the NHS should provide a comprehensive range of services setting priorities based on clinical need and clinical effectiveness. (2007)
1853.	That this Meeting believes that all patients should be offered equal access and quality of care irrespective of their age. (2000)
1854.	That this Meeting deplores the continuing inequalities in provision of healthcare in different parts of the UK. (1999)
1855.	<p><u>Reconfiguration</u></p> <p>That this Meeting believes that combining all sectors of care into Health Maintenance Organisation style bodies would harm patient care and should be actively resisted. (2014)</p>
1856.	That this Meeting: <ul style="list-style-type: none"> i) deplores the actions of the Secretary of State for Health in trying to legislate so that future Trust Special Administrators can make binding recommendations for trusts outside that to which they were appointed; ii) urges the BMA to continue to lobby against non-clinically driven service reconfiguration plans. <p>(2014)</p>
1857.	That this Meeting opposes any reconfiguration that is driven purely by financial considerations; and <ul style="list-style-type: none"> i) opposes any reconfiguration that is not supported by local Clinical Commissioning Groups (CCGs); ii) insists reconfiguration should only be considered if there is sound evidence of benefits to patients in terms of quality of service, outcome measures, and addressing health inequalities; iii) insists that reconfigurations must not destabilise neighbouring trusts; iv) insists that the impact of reconfiguration on primary care be addressed. <p>(2013)</p>
1858.	That this Meeting deplores the heavy expenditure by successive governments on repeated reorganisation of the NHS. (2012)
1859.	That this Meeting reminds Health Boards and trusts that withdrawal of trainees by Deaneries does not mean automatic closure of services and that there are many opportunities for providing enhanced services run by consultants and experienced SAS doctors. (2012)

<p>1860.</p>	<p>That this Meeting deplores the government's use of misleading and inaccurate information to denigrate the NHS, and to justify the Health and Social Care Bill reforms, and believes that:-</p> <ul style="list-style-type: none"> i) the Health Bill is likely to worsen health outcomes as a result of fragmentation and competition; ii) the NHS needs to respond to the challenges presented by altered patient demographics, and by development of medical technology and medical care provision; iii) the NHS needs national planned and coordinated strategies and frameworks to improve health outcomes. <p>(2011 Special Representative Meeting)</p>
<p>1861.</p>	<p>That this Meeting believes the government's risky plan for wholesale change within the NHS in England should not have been carried out at the same time as trying to save £20bn.</p> <p>(2011 Special Representative Meeting)</p>
<p>1862.</p>	<p>That this Meeting believes that when changes to the organisation and delivery of NHS care are being proposed the government must involve the public and patients as well as doctors and managers.</p> <p>(2011 Special Representative Meeting)</p>
<p>1863.</p>	<p>That this Meeting calls on government to ensure that the process and outcome of reconfiguration of services should make the care and safety of patients the paramount concern.</p> <p>(2009)</p>
<p>1864.</p>	<p>That this Meeting believes that a measure of clinically led reconfiguration of acute services is important to improve patient care. We call on the BMA to:</p> <ul style="list-style-type: none"> (i) educate the public and politicians that this is the case; (ii) take the lead in devising tools to ascertain the optimum clinical configuration of services; (iii) publicise the results to help local clinicians make their community aware of safe minimal levels of service. <p>(2007)</p>
<p>1865.</p>	<p>That this Meeting:</p> <ul style="list-style-type: none"> (i) supports the provision of fully functioning comprehensive acute district general hospitals with properly supported A&E services; (ii) demands that the BMA vigorously oppose money saving schemes to close A&E departments or reduce their acute services back up; (iii) insists the BMA adopt a policy of opposition to reconfigurations that are not supported by doctors and patients. <p>(2007)</p>
<p>1866.</p>	<p><u>Referral management</u></p> <p>That, with regard to referral management systems, this meeting:-</p> <ul style="list-style-type: none"> i) notes with concern that many Clinical Commissioning Groups operate referral management systems to constrain referrals of patients to acute care; ii) notes that these systems have the potential to undermine sharing decision-making and to harm patients by delaying their management; iii) deplores the blanket application of referral management policies; iv) calls on the BMA to publicise tick-box referral management systems as rationing; v) calls upon the BMA to lobby for the abolition of referral management systems. <p>(2017)</p>

1867.	That this meeting supports the concept published in the GPC document "Quality First" that one specialist should be able to use their professional acumen to refer directly to another specialist and asks for its promotion and implementation by NHS England and the devolved departments of health. (2017)
1868.	That this Meeting believes that the decision to refer for further care is made between a GP and patient, following a clinical assessment and rejects the use of referral centres and other crude methods to reduce referrals for financial reasons rather than for the benefit of patients. (2011)
1869.	That this Meeting believes that clinical referral decisions should be returned to doctors in consultation with their patients and not belong to PCTs, commissioning groups, foundation trust managements or 'choice' agendas. (2010)
1870.	That this Meeting believes that demand management and referral management schemes: (i) are used to ration secondary care and divert patients towards ISTCs, polyclinics and ICATS; (ii) destroy the inter-professional interface between consultants and general practitioners; (iii) should not permit interference with a direct referral from a GP to a named consultant; (iv) must not allow non-clinicians to interfere with referrals; (v) must adopt the principles outlined in the BMA's "Referral management schemes: Guiding principles" paper; (vi) carry a risk to patients that must rest with the commissioning primary care organisation. (2007)
1871.	That this Meeting believes that referral management schemes and clinical assessment services: (i) are an underhand mechanism to ration patient care; (ii) make a nonsense of patient choice; (iii) are a threat to the GP/patient/consultant relationship and freedom of referral; (iv) should take full medico-legal responsibility for delays and failures of referrals to reach GP's preferred consultants or other preferred providers resulting from the policy; (v) are bad for patients, bad for doctors and bad for the NHS and calls upon the GPC to launch a campaign against the adoption and operation of referral management schemes. (2006)
1872.	That this Meeting condemns the use of referral management centres, which may lead to loss of patients' right to choose (advised by their family physician) the most clinically-appropriate professional for their care, and calls for GPC to press for the restoration of the right for a GP to refer to a named specialist. (2006)
1873.	<u>Targets</u> That this meeting believes that performance targets within the NHS: - i) must be evidence-based and must not be driven purely by political agendas; ii) must not attract financial sanctions for non-achievement; iii) should not include the measurement of productivity. (2019)
1874.	That this Meeting welcomes the government's drive to focus on clinical outcomes rather than political targets, but: i) views with serious concern the proposed wholesale use of non-evidence based outcome indicators to measure clinical effectiveness;

	<p>ii) believes that clinical effectiveness indicators should be evidence based;</p> <p>iii) demands that health outcomes are published and used to assess quality in NHS care rather than measurements of the process of care.</p> <p>(2011 Special Representative Meeting)</p>
1875.	<p>That this Meeting is seriously concerned that the issues highlighted by the Healthcare Commission investigation into Mid Staffordshire NHS Foundation Trust are at risk of happening elsewhere and:</p> <p>(i) insists that quality of care and patient safety must take priority over financial and other targets;</p> <p>(ii) deplores trusts being driven by perverse competitive targets to achieve foundation status;</p> <p>(iii) calls for primary care organisations, provider organisations and those responsible for monitoring standards, to collate and share concerns raised by clinicians regarding the quality of clinical care, and to respond within a timeframe similar to current arrangements for patient complaints.</p> <p>(2009)</p>
1876.	<p>That this Meeting:</p> <p>(i) believes that widespread use of centrally-imposed and clinically-inappropriate targets has many unintended consequences, distorts clinical priorities and harms patients;</p> <p>(ii) calls for NHS organisations to be driven by excellence in patient care, led by patients and doctors.</p> <p>(2009)</p>
1877.	<p>That this Meeting believes that implementation of the government's 18 week target is resulting in perverse behaviour and manipulation of waiting lists and has had an adverse impact upon the care pathways available to follow-up patients, and calls on the BMA to highlight these issues.</p> <p>(2008)</p>
1878.	<p>That the target-driven NHS distracts from quality of care by distorting the true needs of patients. We demand that the BMA ensure that NHS services are outcome-led rather than target-driven.</p> <p>(2007)</p>
1879.	<p><u>Waiting lists</u></p> <p>That this meeting:-</p> <p>i) recognises autism as an important health concern in children and adults, affecting more than 1% of the UK population;</p> <p>ii) is disappointed by the disparity in waiting times for referral, assessment and diagnosis of autism;</p> <p>iii) supports our government's commitment to collect and publish autism diagnosis waiting times;</p> <p>iv) calls upon NICE for clear guidance on the acceptable waiting times from referral to diagnosis when suspecting autism;</p> <p>v) calls upon our government for more funding to ensure national standards on autism care are met.</p> <p>(2018)</p>

1880.	That this Meeting deplores waiting lists mechanisms that differentiate patient waits by post code rather than clinical need. (2013)
	NORTHERN IRELAND
1881.	That this meeting is seeking assurance that an indemnity solution is found for GPs in Northern Ireland and agreed with NI Department of Health in the near future. This is urgent as the upcoming decision on the discount rate could increase indemnity subscriptions to a level where it would not be viable to work as a GP in NI. (2021)
1882.	That this meeting warns that attaching criminal sanctions to the professional duty of candour for individual doctors in Northern Ireland is out of step with patient safety developments elsewhere in the UK and Ireland and calls on the department of health in Northern Ireland to: i) create the conditions for openness and transparency by providing protections for doctors, such as the Open Disclosure provisions in the Republic of Ireland to enable doctors to raise concerns and protect patients; ii) acknowledge best practice in patient safety and raising concerns from other health jurisdictions and urgently adopt these in Northern Ireland; iii) commit to the development of a culture where learning not blaming is a priority, lessons are learnt and disseminated across the healthcare system. (2019)
1883.	That this meeting is dismayed at the ongoing lack of a functioning devolved government in Northern Ireland and is concerned that this is having a negative impact on the delivery of health and social care. We call on politicians to urgently re-form the devolved Northern Ireland Executive and to take the key decisions that are needed to protect the health and social care needs of the population in Northern Ireland. (2019)
1884.	That this meeting recognises the unacceptably high suicide rate in Northern Ireland, with more people having died by suicide since the Good Friday Agreement 1998 than the total number of lives lost due to the Troubles and calls on the government to fund mental health services and other stakeholders adequately, at least to the level of that in the rest of the UK, in order to address this. (2019)
1885.	That this meeting calls for the Northern Ireland department of health to urgently ensure:- i) that doctors work within a culture which is committed to supporting openness and transparency; ii) that Northern Ireland health and social care trusts be subject to an organisational duty of candour to match the duty doctors are already under from their professional regulator; iii) that Freedom to Speak Up guardians be appointed in Northern Ireland to support a culture of openness and transparency. (2018)
1886.	That this meeting extends its full support to the GPs of Northern Ireland for their robust defence of the provision of safe care to their patients. (2017)
1887.	That this meeting believes that reconfiguration of services in Northern Ireland must:- i) be evidence based and result in better outcomes for patients; ii) be carried out in an integrated way, taking patients' primary, secondary and social care needs into account and not confined to local HSC trust level;

	<p>iii) include full and meaningful clinical engagement with doctors at all levels. (2017)</p>
1888.	<p>That this meeting recognises that the lack of full implementation of the recommendations from numerous workforce planning reviews has contributed directly to the current shortage of doctors in Northern Ireland. This meeting believes that the Department of Health in Northern Ireland:-</p> <ul style="list-style-type: none"> i) must be held accountable for ensuring there is the appropriate medical workforce to deliver care to the population of Northern Ireland; ii) must recognise that increased investment in the medical workforce is required to ensure that Northern Ireland is an attractive place to work. <p>(2017)</p>
1889.	<p>That this meeting considers that a population health model is necessary to meet the needs of the population of Northern Ireland and should be explored in any service reforms. This meeting believes that:-</p> <ul style="list-style-type: none"> i) the new model should use Northern Ireland's integrated health and care structures to their full potential; ii) priorities should be based on an assessment of local population health needs; iii) funding mechanisms should support the delivery of effective care outcomes for patients; iv) the current mechanism of funding HSC Trusts through a block contract can lead to stagnation and service fragmentation. <p>(2016)</p>
1890.	<p>That this meeting welcomes the retention of the public health agency (PHA) in Northern Ireland with a renewed focus on prevention and early intervention. This meeting believes that:-</p> <ul style="list-style-type: none"> i) the PHA should employ the appropriate number of public health physicians; ii) budgetary cuts to the PHA must not adversely impact on services or doctors; iii) enhanced functions should be appropriately resourced; iv) health protection, health promotion and health care improvement must be retained as core components of public health services. <p>(2016)</p>
1891.	<p>That this meeting notes the consideration being given by the Ulster University to establish a graduate entry medical school in the North West. That this meeting believes that:-</p> <ul style="list-style-type: none"> i) any establishment of a second medical school in Northern Ireland should be accompanied by an appropriate number of fully funded training places; ii) any expansion of training places needs to be part of an overall medical workforce plan for Northern Ireland; iii) the entry criteria to medical school in Northern Ireland must not disadvantage young people in Northern Ireland, particularly those from low-income families. <p>(2016)</p>
1892.	<p>That this meeting demands that:-</p> <ul style="list-style-type: none"> i) the Northern Ireland Executive acknowledges the funding crisis in Northern Ireland healthcare and puts an end to targeting doctors and the services they provide for cuts; ii) the Minister for Health, Social Services and Public Safety lead changes to the administration of health funding in Northern Ireland that will result in more effective patient services. <p>(2015)</p>
1893.	<p>That this meeting welcomes the Donaldson report into Northern Ireland healthcare and calls for:-</p>

	<p>i) public debate to consider how the population of Northern Ireland would be better served by taking a whole Northern Ireland approach to Healthcare rather than considering local issues above all else;</p> <p>ii) commissioning to be abandoned in Northern Ireland due to the past history of ineffectual commissioning as recognised by Sir Liam Donaldson;</p> <p>iii) the Minister for Health to set up the recommended impartial independent international panel of experts and meaningfully involve doctors in its implementation.</p> <p>(2015)</p>
1894.	<p>That this Meeting believes that transformational change, as envisaged in Transforming Your Care, can only progress through effective primary and secondary care interface and calls on the HSC Board to facilitate true primary and secondary liaison through its commissioning plan.</p> <p>(2014)</p>
1895.	<p>That this Meeting recognises the two strands of work being carried out on medical workforce planning in Northern Ireland i.e. the specialty by specialty approach and the discussions with the Centre for Workforce Intelligence to support this, however, there is grave concern over the timescales involved and urges the Department of Health, Social Services and Public Safety (DHSSPS) to develop a strategy for planning the medical workforce as a matter of urgency in terms of overall numbers required and for the specific requirements of individual specialties.</p> <p>(2014)</p>
1896.	<p>That this Meeting:-</p> <p>i) condemns that the average pay of Northern Ireland consultants has fallen below the UK average and requires that this should be taken into account in the current contract negotiations for consultants;</p> <p>ii) demands adequate funding for career development for Staff and Associate Specialist doctors within Northern Ireland.</p> <p>(2013)</p>
1897.	<p>That this Meeting believes that IT provision for healthcare in Northern Ireland is not fit for purpose and calls on the Northern Ireland Health Minister for Health to establish a coherent and practical IT strategy for Northern Ireland working in collaboration with the BMA.</p> <p>(2013)</p>
1898.	<p>That this Meeting insists that the Department of Health in Northern Ireland reinstate Clinical Excellence Awards for consultants so that consultants can be incentivised to seek to implement the essential healthcare reform that Northern Ireland so badly needs.</p> <p>(2012)</p>
1899.	<p>That this Meeting condemns the withdrawal of Clinical Excellence Awards to consultants in Northern Ireland in 2010, is concerned that this will result in a disparity of consultant recruitment across the United Kingdom and demands that clinical excellence awards in Northern Ireland remain on a par with similar schemes across the UK.</p> <p>(2011)</p>
1900.	<p>That this Meeting condemns the Health Department in Northern Ireland for failing to support the promotion of quality in Northern Ireland secondary care by its reluctance to require trusts to meet the minimum award of Clinical Excellence Awards of 0.25 per eligible consultant as recommended in its own 2009 report into CEAs and insists that the Health Department in Northern Ireland ensures that its CEA system is equitable with those in the rest of the UK as noted by the DDRB.</p> <p>(2010)</p>
1901.	<p>That this Meeting believes that due to the fundamental flaws in the Payment by Results system used in England with its adverse effects on patient care and the stability of secondary care</p>

	<p>services in hospitals and due to the small size of Northern Ireland, a Payment by Results or similar system must not be introduced in Northern Ireland.</p> <p>(2009)</p>
1902.	<p>That this Meeting believes reconfiguration of services should not occur simply to save money and that:</p> <ul style="list-style-type: none"> (i) clinical services should only be reconfigured in Northern Ireland if enhanced benefits for patients can be shown in any new service configuration; (ii) reconfiguration of services must not take place if the quality of the affected service will decrease; (iii) reconfiguration of clinical services must be fully risk assessed taking into account benefits and disadvantages of any such reconfiguration including indirect effects on other services and their viability. <p>(2008)</p>
1903.	<p>That, with regard to Clinical Excellence Awards, this Meeting believes that:</p> <ul style="list-style-type: none"> (i) the application procedure must be open and transparent and calls for anonymised application forms to be made available at an employer level for all consultants of that employer to examine; (ii) the emphasis must be shifted away from research and insists that employers place significantly more emphasis on work relevant to the treatment consultants provide for patients including clinical audit, service enhancement and development, clinical management, clinical leadership and providing quality care for patients; (iii) there should be LNC representation and a random selection of a number of consultants with and without clinical excellence awards onto Lower Awards Committees or Employer Based Awards Committees to ensure that they are representative of consultants working for an employer; (iv) since the 2008 DDRB report has stated that there should be equity in CEA allocations throughout the United Kingdom, the Northern Ireland Department of Health should increase funding of Clinical Excellence Awards so that at least 0.35 awards are available per eligible consultant each year. <p>(2008)</p>
1904.	<p>That this Meeting</p> <ul style="list-style-type: none"> (i) believes that the lack of new funding for Clinical Excellence Awards (CEA) in Northern Ireland has created a CEA system in crisis and led to a severe reduction in the morale of consultants as they now perceive that any extra work they perform to improve the quality of care for patients or to develop new services is unrewarded; (ii) demands that the Department of Health (HPSSNI) restore the CEA funding to the levels elsewhere in the United Kingdom. <p>(2007)</p>
1905.	<p>That this Meeting condemns the action of the Department of Health in Northern Ireland to reduce funding for the Clinical Excellence awards for Consultants which creates the situation in which new points are only awarded when a consultant retires or dies and demands that Northern Ireland consultants receive the same level of funding for clinical excellence awards that exists in the rest of the United Kingdom.</p> <p>(2006)</p>
1906.	<p>That this Meeting supports government initiatives to improve the health service in Northern Ireland provided that they do not impinge upon educational opportunities for medical students and junior doctors, and calls on the BMA to consult with those involved to ensure that training opportunities are included in all initiatives.</p> <p>(2006)</p>

1907.	That this Meeting, with respect to the development of the ICATS system in Northern Ireland calls on government to ensure that if the ICATS system is implemented, that training of doctors occurs when patients receive investigation and treatment under the ICATS system. (2006)
1908.	That this Meeting calls on the NI Executive to fully and properly fund all sections of our NHS, end the disparity of level of service compared to the rest of the UK and ensure that unnecessary and excessive waiting times for patients are reduced immediately. (2002)
NUCLEAR POWER/WAR AND WEAPONS	
1909.	That this Meeting condemns the use of "Depleted Uranium" in weaponry. (2007)
1910.	That this Meeting condemns the iniquitous international arms trade which, apart from the direct death, destruction and misery caused, distorts national economies and increases debts, diverting resources from alleviation of poverty and sustainable development. (2006)
1911.	That this Meeting deplores the continued manufacture and use of anti-personnel mines in any part of the world. (2004)
1912.	That this Meeting condemns in the strongest terms the use of cluster munitions in recent conflicts and calls on the BMA to demand an international moratorium on the production and use of such weapons. (2003)
1913.	That this Meeting calls upon the UK Departments of Health to strengthen national and international responses against biological and chemical deliberate release by: <ul style="list-style-type: none"> (i) the stockpiling of antibiotics and vaccines; (ii) the sharing of epidemiological information; (iii) the development of disaster planning strategies; (iv) a significant increase in the health protection workforce. (2002)
1914.	That this Meeting considers it a duty to work towards the elimination of nuclear weapons, which are a worldwide threat to public health: <ul style="list-style-type: none"> (i) by condemning the development, testing, production, deployment, threat and use of nuclear weapons; (ii) by requesting that all governments refrain from all of these activities, and work in good faith for their elimination; (iii) by calling for commencement of negotiations for a nuclear weapons convention similar to those for biological and chemical weapons. (1998)
1915.	That this Meeting affirms its concern at the severe lack of co-ordination of information services at the time of the Chernobyl incident; since it has no evidence that a satisfactory system has since been developed to deal with such problems in the future, it calls on the Government to set up an efficient mechanism for ensuring that there is co-ordination of the activities of the various monitoring agencies involved in dealing with nuclear incidents.

	(1987)
1916.	That this Meeting calls for a massive and progressive reduction in world arms spending, both nuclear and conventional, with the diversion of the resources thus freed to health care and welfare, at home and in developing countries. (1984)
1917.	That this Meeting recognises the hazards to safety in the nuclear industry and recommends that Council should maintain an alert watching brief. (1980)
	NURSES
1918.	That this Meeting believes that inadequate nursing resources have led to falling standards of hospital care. (1996)
1919.	That the pattern of remuneration of senior nursing staff should encourage them to continue to use their clinical skills and not to encourage their transfer to administrative tasks. (1982)
1920.	That this Meeting is deeply concerned with the increasing burden of patient care that is placed upon an already overworked nursing staff and feels that there is an urgent and pressing need to increase the number of trained nursing staff who are directly concerned with the immediate care of the patient. (1978)
	OBSTETRICS
1921.	That this Meeting supports the BMA policy statement on fertility treatment as written in the 1997 annual report of BMA Council. (1997)
1922.	That this Meeting believes that sex selection should be reserved for genetically indicated reasons only, to avoid major genetic problems in the future. (1994)
	<u>Embryo research</u>
1923.	That this Meeting strongly condemns the use of foetal tissue for reproductive purposes. (1994)
1924.	That this Meeting approves paragraph 10.4 of the Annual Report of Council and is in sympathy with research using human embryos but insists that it should be carefully controlled. (Paragraph 10.4 of the Annual Report of Council for 1984-85: "10.4 The Council believes that "the prime objectives of fertilising a human ovum using in vitro techniques are to produce a normal child within the context of an infertile family where infertility cannot be relieved by other means, and by the use of donated gametes or embryos in those at risk of transmitting hereditary diseases.") (1985)

	OCCUPATIONAL MEDICINE
1925.	That this meeting: - i) notes with regret that the UK is the only major European country that does not have a legal requirement for the mandatory provision of occupational health services (other than for 0.1% of the working population); ii) deplores the 2016 All-Party Parliamentary report findings that 87% of UK workers have no access to an occupational physician and consequently are denied access to the specialist medical expertise required for the prevention of further harm to their health and on the work adjustments required to allow them to continue to work; iii) calls on government to introduce a statutory requirement for the provision of high quality occupational health services for all working people in the UK, either through the NHS or as an obligation on employers. (2019)
1926.	That this meeting expects equal treatment for mental and physical ill health for medical students and doctors to reduce stigma for people taking sick leave due to mental ill health, and calls on the BMA to produce best practice guidelines for universities and employers. (2019)
1927.	That this meeting notes the publication of the green paper 'Improving Working Lives' and:- i) regrets the short timescale for consultation; ii) supports initiatives which encourage occupational health support and workplace assessments for employers designed to keep people in employment through periods of ill health or to enter the workplace where possible; iii) believes that any additional burden of workload and costs with respect to implementation of the recommendations should fall to the DWP and not the NHS. (2017)
1928.	That this meeting believes the existing system of occupational health support for doctors is inconsistent and at times inadequate and calls for: i) adequate ring-fenced funding for, and access to, occupational health services for doctors; ii) occupational health services that are mindful of the pressures of working and training as a doctor. (2016)
1929.	That this meeting calls on all NHS employers to recognise the emotional needs of staff with caring responsibilities, or who are recently bereaved, and to put in place individualised support tailored to that person's needs. (2016)
1930.	That this meeting notes with concern the crisis in occupational medicine in the UK caused by an alarming fall in the number of qualified occupational physicians and of doctors entering the specialty; and reaffirms the urgent need to increase the number of trainees and accredited specialists. This meeting demands that:- i) occupational medicine specialist training posts are wholly centrally funded; ii) salary protection is clarified and better publicised to attract those doctors who may wish to change career and commence training in occupational medicine. (2015)
1931.	That this Meeting recognises that occupational medicine is a broad specialty that has a particular emphasis on protecting and promoting the health of people at work and:- i) regards the government's proposed 'Health and Work Service' to be misleading both in name and by its claims to provide occupational health advice and support; ii) calls on the BMA to lobby the Department of Work and Pensions to immediately stop

	<p>using the term 'occupational health' in a misleading and damaging way when describing this service.</p> <p>(2014)</p>
1932.	<p>That this Meeting is concerned about the threat to occupational health services for general practitioners and their staff and insists that specialist-led occupational health services for all NHS staff, including general practitioners and their staff, are provided and protected.</p> <p>(2013)</p>
1933.	<p>That this Meeting in respect of Work Capability Assessments (WCA) as performed by Atos Healthcare:-</p> <ul style="list-style-type: none"> (i) believes that the inadequate computer-based assessments that are used have little regard to the nature or complexity of the needs of long term sick and disabled persons; (ii) calls on the BMA to demand that the WCA should end with immediate effect and be replaced with a rigorous and safe system that does not cause avoidable harm to some of the weakest and most vulnerable in society. (iii) calls on the BMA to work with disability groups and political parties to change public policy on this issue. <p>(2012)</p>
1934.	<p>That this Meeting acknowledges that whilst doctors have higher rates of mental illness and suicide than the general population, for a number of well recognised reasons they have difficulty in accessing appropriate care. The Practitioner Health Programme is an award winning service of proven benefit but accessible free of charge only to those in the London area and we believe that there is an urgent need for this service to be extended throughout the UK where there is no equivalent.</p> <p>(2011)</p>
1935.	<p>That this Meeting believes in the principle that work is good for health and well-being and recommends that doctors work closely with all interested parties to facilitate their patients' safe and timely return to the most suitable and meaningful employment.</p> <p>(2010)</p>
1936.	<p>That this Meeting considers that it is a national disgrace that only a small proportion of the workforce has access to a doctor trained in occupational medicine and that many do not even have access to an occupational health service; and insists that:</p> <ul style="list-style-type: none"> (i) all employees in the NHS and elsewhere must have access to specialist-led occupational health services; (ii) the role of work place assessment for those ill or with disabilities is properly the role of occupational health services. <p>(2008)</p>
1937.	<p>That this Meeting believes that:</p> <ul style="list-style-type: none"> (i) the inclusion of Pre-Employment Health Questionnaires (PEHQs) as part of job applications is bad practice, a breach of patient confidentiality and encourages disability discrimination; (ii) the BMA should recommend that it is good practice for applicants to be subject to a confidential occupational health assessment by trained occupational health professionals; (iii) the BMA should advise that doctors not engage in a process that departs from the above, and report it to the BMA; (iv) the BMA should work with appropriate and relevant bodies such as the Health Departments, NHS employers, the Disability Rights Commission, and the GMC, towards outlawing the use of PEHQs.

	(2008)
1938.	That this Meeting regrets the stigma that still surrounds blood-borne virus infections such as HIV and hepatitis B and C. We call upon the medical profession (as represented by the BMA) to lead the way in changing attitudes towards people infected with blood-borne viruses, especially doctors and other healthcare workers, so that they are not discriminated against unfairly in the workplace. (2007)
1939.	That this Meeting calls for trusts to provide for all employees at all levels access to relevant sources of support. (2006)
1940.	That this Meeting believes that occupational health services should be provided to all medical students and calls upon the BMA to work with the Council of Heads of Medical Schools to ensure that such services are provided. (2006)
1941.	That this Meeting believes that suggestions that doctors or medical students should be compulsorily tested for HIV, hepatitis and other blood-borne viruses are a breach of human rights, and: <ul style="list-style-type: none"> (i) believes that compulsory testing after low-risk needle-stick injuries will only serve to discourage affected staff from seeking medical help; (ii) believes that being forbidden to work after declining a non-compulsory test is constructive dismissal; (iii) calls on the BMA immediately to rebut compulsory testing, using all available evidence and working, if necessary, with other interested and expert bodies. (2005)
1942.	That the BMA accepts the role of a nurse practitioner providing the nurse works in a defined field answerable to a medically qualified doctor; but find it outrageous and totally unacceptable that a nurse consultant has been appointed as the lead clinician in occupational health and that she, with the assistant director of human resources, will perform the annual appraisal of the occupational health consultant. (2005)
1943.	That this Meeting believes that the NHS Executive and all health trusts must implement robust risk management strategies to ensure that no health worker develops asthma or any other allergy to latex or to glutaraldehyde; strategies must include substitution of latex and glutaraldehyde with safer alternatives, health surveillance for exposed workers and making employees aware of the risks to themselves and, in the case of latex, potentially to their patients. (2004)
1944.	That the Government should immediately resource and organise a national occupational health scheme for primary care workers, staffed by fully trained occupational health physicians. (2001)
1945.	That this Meeting supports proper resourcing of occupational health interventions which are accessible and acceptable to all doctors. (1999)

1946.	That this Meeting considers that the provision of a consultant-led occupational health service should be an essential requirement for the licensing of all trust and private hospitals in the United Kingdom. (1992)
	OPHTHALMIC MEDICAL SERVICES
1947.	That this Meeting believes optometrists should have the professional right to make direct referrals to ophthalmologists and ophthalmologists should accept these referrals. (2000)
1948.	That contact lenses for aphakic patients should be provided free under the NHS. (1986)
	PARENTAL BENEFITS
1949.	That this Meeting whilst welcoming the new 'extended paternity leave' provisions, notes that male partners have no access to independent occupational paternity funding. We believe that the lack of proper funding of the scheme is a significant disincentive to families taking up the scheme and is discriminatory against men. We ask the BMA to campaign to improve the provision of funding for 'extended paternity leave' in line with more family-friendly working practices. (2013)
	PENSIONS
1950.	That this meeting is concerned that:- i) large numbers of doctors are now swelling the ranks of retirees much earlier in their careers due to low morale, higher workload and punitive pension taxation; ii) the effect of punitive pension taxation on doctors retiring early has not been properly addressed by HM Government; iii) current pension policy does nothing to address the medical workforce crisis; iv) the lifetime allowance is a disincentive to doctors, should they wish, to work above their contracted hours and on to normal retirement age; v) this meeting, while recognising the work already done by the pensions committee, calls on the association to continue to engage in hard negotiations to eliminate these disincentives to encourage our colleagues to remain longer in active clinical practice. (2021)
1951.	That this meeting welcomes the 2020 High court judgement that ruled against suspending NHS pension benefits for doctors charged with a crime but calls on the BMA to now lobby for further changes to end the grossly unfair suspension of pensions for those convicted of a crime. (2021)
1952.	That this meeting believes that the UK Governments should negotiate a fair tax-unregistered pension scheme for NHS doctors.

	(2021)
1953.	That this meeting believes that the government have been wilfully ignorant about the impact that the annual allowance and taper is having on members of the NHS pension scheme and calls for the removal of the annual allowance and taper in defined benefit schemes with immediate effect. (2021)
1954.	That this meeting: - i) notes that restrictions on annual and lifetime allowances in the NHS pension scheme have had a detrimental effect on retaining doctors in clinical practice; ii) believes that increasing the NHS pension scheme Employer Contributions Rate to over 20% will inevitably reduce the impact of any increase in NHS funding; iii) calls on the BMA to actively lobby the Treasury to act decisively to improve the NHS pension scheme; iv) demands that all NHS workers should have a choice to pension only part of their earnings in the NHS pension scheme; v) demands that NHS workers should not be subject to annualisation of their earnings for NHS pension scheme contribution rate purposes; vi) demands that, in a Career Average Revalued Earnings (CARE) scheme, all NHS workers should contribute the same net rate to the NHS pension scheme. (2019)
1955.	That this meeting acknowledges the unfairness of calculating pension contributions on the basis of full time equivalent earnings for doctors who work LTFT and that they should instead be based on actual earnings. We call on the government to calculate the loss of earnings to affected individuals and recompense them in full. (2019)
1956.	That this meeting demands that NHSE and Government stop prevaricating and take action to: i) terminate, or at least sanction, the contract with Capita due to its catastrophic failings in dealing with GP pension contributions; ii) declare a tax amnesty for doctors facing excessive tax bills due to Capita failing to forward their pension contributions for several years and then the backdated contributions are found to exceed the annual or lifetime allowances; iii) investigate and, where necessary, compensate doctors who have become ill as a result of Capita's failings in handling their pension contributions; iv) compensate doctors who have not been able to retire due to Capita's inability to manage their pension contributions. (2019)
1957.	That this meeting believes that tiered net contributions in a CARE pension scheme like the NHSPS are entirely unfair and that contributions should be equal net of tax relief and asks the BMA to negotiate to secure this. (2018)
1958.	That this meeting calls upon the BMA to oppose and take action against the Annualisation regulations within the practitioner section of the NHS Pensions scheme. (2018)
1959.	That this meeting notes with concern the recent acknowledgement by the Department of Health and Social Care that the reduction in the Life Time Allowance and cap on pension contributions together with tax implications of pension contributions has contributed significantly to the number of doctors retiring early and that this is having a detrimental effect on those doctors and nurses left behind who have to carry an increasing workload. This

	meeting asks the BMA to have urgent discussions with the government on ways to alleviate this effect and the consequences of such changes in fiscal policy. (2018)
1960.	That this meeting recommends that members who are forced to withdraw from the NHS pension scheme on breaching their Life-Time Allowance should be refunded future NHS employer contributions. (2017)
1961.	That this meeting is appalled by the delays that are being reported by practitioners, in payment of doctors' pension lump sum and even delays of payments of regular pension payments and calls on the BMA to:- i) undertake a full inquiry into the size of the problem and reasons for these delays; ii) ensure that doctors are awarded full financial compensation for any loss as a result of any delay; iii) ensure that the NHS Pensions Agency pays interest on delayed pension lump sums. (2017)
1962.	That this meeting believes that the plight of locum doctors not being protected by the pension scheme death in service benefits unless occurring within the individual's working hours is an absolute disgrace and should immediately be remedied. (2016)
1963.	That this meeting notes with concern yet another damaging set of changes to the NHS pension scheme. (2015)
1964.	That this meeting is concerned that significant sums of NHS pensions contributions are 'lost' or incorrectly allocated, and insists NHS pension authorities and their agents:- i) conduct a transparent investigation into the accuracy of their systems and allocation of past contributions; ii) fully correct any incorrect allocations or lost contributions immediately; iii) to enable online access for contributors so they can check their contributions are correctly allocated in future. (2015)
1965.	That this Meeting deplores the unilateral decision by the government to increase pension contributions and age of retirement. (2014)
1966.	That this Meeting believes that the changes being made to the NHS pension scheme will no longer be fair and calls upon the BMA to further lobby the UK government to remove such injustices. (2014)
1967.	That this Meeting:- iii) believes the BMA should ensure that any future action on pensions should be supported by both primary and secondary care doctors; iv) believes the deterioration in NHS pensions for doctors will have significant detrimental effects on recruitment and retention; v) calls on the BMA to seek urgent negotiations with government to improve the current pensions' situation; (Parts i, ii and vi lost) (2013)

1968.	That this Meeting believes it is wrong that senior doctors in the NHS pension scheme pay a higher proportion of their pay towards their pension than any public sector employee or politicians. (2013)
1969.	That this Meeting firmly opposes the proposed changes to doctors' pensions. (2013)
1970.	That this Meeting condemns continuing pension contribution increases being implemented by the government in the light of the total lack of logical or financial rationale for tiered pension contributions for CARE schemes and demands that any further increases in the rates of pension contributions are halted. (2013)
1971.	That this Meeting feels the new pensions contribution rates, demanded by this government, represents nothing less than a "stealth" tax on those who choose to work in the public sector and to be part of the NHS Pensions Scheme. (2011)
1972.	That this Meeting insists that in any revision of the pension scheme the arrangements for retirement on health grounds must be no less beneficial than the current arrangements. (2011)
1973.	That this Meeting commends the work achieved by the BMA Pensions Committee in the last three years and: (Lapsed 2015) (i) calls for the pension arrangements agreed with government in that time to be maintained; (ii) calls for the BMA to continue to work with allied health unions to maintain and protect current pension arrangements. (2010)
1974.	That this Meeting believes that the BMA should ensure that: (i) there is proper protection of the pension and employment rights of healthcare staff who transfer to the private sector under TUPE rules; (ii) staff providing services under a NHS clinical contract with a private healthcare provider should have the right to accrue that service towards the NHS pension scheme with the employer's contribution funded by that provider. (2008)
1975.	That this Meeting: (i) is horrified at the delays experienced by members seeking updated statements from the NHS Pensions Agency; (ii) requires the agency to put in place arrangements so that statements are available within a month of a request being made; (iii) insists that, when the new NHS pension scheme is introduced, all members must be given statements of their benefits under the current scheme; (iv) requires that interim pensions should be updated and paid in full within three months of the requisite information being made available. (2007)
1976.	That this Meeting demands that there should be equal pension rights for spouses and civil partners of both male and female doctors. (2007)

1977.	That this Meeting is concerned that the current pension scheme penalises widows and widowers who lose their pensions if they cohabit or marry a new partner and urges the BMA to negotiate a change in this for members of the current scheme and those in receipt of pensions. (2007)
1978.	That this Meeting believes that: <ul style="list-style-type: none"> (i) the proposed changes to the public sector pensions represent a deterioration in workers' pay and conditions; and will exacerbate recruitment and retention problems, raise absence rates through sickness and lead to premature retirements; (ii) existing NHS pension scheme members must retain the right until they retire to choose whether to remain in the current pension scheme or transfer to a new pension scheme; (iii) NHS staff must retain the right to a final salary pension scheme; (iv) there should be equality of entitlement to pension rights for both sexes; (v) the BMA should strongly oppose any compulsory increase in the current normal NHS pension age; (vi) BMA Council must take all steps necessary to stop the imposition of deleterious changes to the NHS pension scheme for new and existing staff; (vii) the NHS pension scheme must be available to doctors if they are forced to work for NHS patients in the independent sector through pluralisation of provision; (viii) the BMA must ballot its members for industrial action if deleterious changes to the NHS pension scheme are threatened. (2005)
1979.	That this Meeting: <ul style="list-style-type: none"> (i) reaffirms the view that pension benefits for women doctors derived from contributions prior to 1988 must be the same as for men; (ii) insists that the existing discriminatory position relating to these benefits is addressed during the current NHS pension review process to the satisfaction of women doctors; (Lapsed 2011) (iii) instructs the BMA to ensure that this iniquitous situation is taken to the European Court of Human Rights as a matter of urgency. (2005)
1980.	That the sexual discrimination inherent in the arrangements for pensions for doctors and their spouses be abolished forthwith. (2004)
1981.	That this Meeting believes that widowers of female doctors should be entitled to exactly the same pension rights as would be available to the widow of a male doctor. These benefits must be fully recognised retrospectively. (2004)
1982.	That this Meeting notes the flexible retirement proposals outlined in the Department for Work and Pensions green paper, however, it: <ul style="list-style-type: none"> (i) deplores the increase in retirement age for public sector employees; (ii) warns the government that if it imposes a £1.4 million ceiling on personal pension funds above which extra taxation will be charged, then many senior doctors will retire prematurely; (iii) instructs the BMA to negotiate with the government to remove the £1.4 million ceiling on personal pension funds; (iv) insists that psychiatric staff who presently retain mental health officer status should not be stripped of it as this would accelerate the catastrophic work force crisis in psychiatry. (2003)

1983.	That this Meeting believes that women doctors are discriminated regarding their pension rights, specifically their widower's pension to which they have contributed throughout their working career via their superannuation contributions to the NHS Pension Agency, but only benefit from these contributions made after 1988. Male doctors have had all their superannuation contributions counted towards their widow's pension prior to 1988. (2002)
	PRISON
1984.	That this Meeting is concerned about the continuing inequality of access to timely and appropriate community and secondary psychiatric care for prisoners with psychiatric illness and asks Council to bring this urgently to the attention of the appropriate authorities. (2004)
1985.	That this Meeting requires that there must be statutory co-ordination between the prison health service and the NHS to ensure that doctors can access the medical history and records of patients' entering or leaving prison. (2001)
1986.	That the Representative Body urges the Department of Health to ensure that psychiatric services to prison services should be no less than that which was available to NHS psychiatric patients before the recent reduction in acute psychiatric services, and urges the Government to provide adequate community care. (1991)
1987.	That this Meeting believes that condoms and health education on the risks of HIV infection should be freely available in prisons. (1988)
1988.	That the Council's statement of 26 June 1974 (see Chapter 7 of the BMA publication "Medicine Betrayed", 1992, which states that "the final decision must be for the prison medical officer to make") concerning artificial feeding of prisoners be approved as Association policy. (1974)
	PRIVATE PRACTICE AND MEDICAL CARE
1989.	That this meeting condemns the actions of the major medical insurance providers in using their monopoly position to:- i) restrict patients free access to a consultant of their choice; ii) limit the ability of general practitioners to refer patients to a specialist who they believe can offer the best care to their patient; iii) exclude clinically competent consultants from recognition for insurance reimbursement without good cause; iv) threaten de-recognition of consultants in private practice if consultants choose to negotiate and agree fees directly with patients and fail to use direct e-billing with the insurance provider, excluding patient involvement. (2018)

1990.	<p>That this Meeting welcomes the Office of Fair Trading (OFT) market healthcare report and its proposed decision to recommend that the Competition Commission (CC) undertakes a market investigation, but is extremely concerned that the policies of some private healthcare insurance companies are preventing or restricting patients exercising choice about:-</p> <ul style="list-style-type: none"> (i) the consultants who treat them; (ii) the hospital at which they are treated; (iii) making top up payments to cover any gap between the funding provided by their insurance company and the cost of their chosen private treatment <p>We call on the Competition Commission to fully investigate these concerns as part of their market review, and to make recommendations that will ensure that patients are fully informed when making choices about private healthcare insurance.</p> <p>(2012)</p>
1991.	<p>That this Meeting is extremely concerned that the policies of some private healthcare insurance companies are preventing or restricting patients exercising choice about:</p> <ul style="list-style-type: none"> (i) the consultants who treat them; (ii) the hospital at which they are treated; (iii) making top up payments to cover any gap between the funding provided by their insurance company and the cost of their chosen private treatment. <p>This Meeting calls on the BMA to publicise these concerns so that patients are fully informed when making choices about private healthcare insurance.</p> <p>(2009)</p>
1992.	<p>That this Meeting notes that BUPA and AXA PPP Healthcare are singling out specialties to impose restrictions on practice and force down medical fees and calls upon GPs to support their consultant colleagues by refusing to acquiesce to the insurers' intention to direct referrals to their preferred consultants.</p> <p>(2007)</p>
1993.	<p>That this Meeting calls upon the medical insurance companies to allow patients the choice of seeing general practitioners privately.</p> <p>(2007)</p>
1994.	<p>That this Meeting insists that the Healthcare Commission inspects private practice premises, not private doctors and that premises used only for consultations, examinations and non-invasive treatment should not have to be registered.</p> <p>(2005)</p>
1995.	<p>That this Meeting welcomes the decision of the House of Lords that the Government should require the same standards of hospitals in the private sector as those in the National Health Service.</p> <p>(2000)</p>
1996.	<p>That this Meeting insists that all doctors retain existing rights to private practice.</p> <p>(2000)</p>
1997.	<p>That this Meeting believes that, with reference to the Annual Report of Council (para 23.4) 1987, standards in private laboratories should be no less than those in neighbouring NHS pathology departments.</p> <p>(1987)</p>
1998.	<p>That the BMA should continue to support the principle of private patients being treated in NHS hospitals.</p> <p>(1981)</p>

1999.	That Council be asked to press central Government to allow tax relief on insurance premiums for private medical care. (1977, reaffirmed in 1981)
	PROFESSIONAL FEES
2000.	That this meeting instructs the BMA to publish its Professional Fees Calculator on the internet for members use before the end of the calendar year. (2021)
2001.	That this meeting is appalled and highlights the moral blackmail of doctors by local authorities such as Northamptonshire County Council in their refusal to pay doctors under the collaborative fee arrangements for their work undertaken at the request of county council employees or their agents. It instructs the BMA council to mount a campaign clarifying that collaborative fee payments are not optional and to consider and take all appropriate legal steps necessary to secure the large sums of money outstanding to doctors. (2018)
2002.	That this meeting instructs council to sort out and modernise the “collaborative fees” structure in respect of work done by doctors on behalf of local authorities. (2017)
2003.	That this Meeting believes that the fee for photocopying medical records under the Data Protection Act remains woefully inadequate. (2008)
2004.	That this Meeting welcomes the DDRBs' recommendation that practices set collaborative fees themselves and: (i) urges the GPC to reissue guidance on disaggregating the costs of individual services; (ii) believes that the fees should represent the true cost of the work to the practice; (iii) reminds contractors that the fees should include a professional element for the performer, administrative costs to the practice and employers superannuation payments; (iv) requests the BMA to publish its legal advice on LMCs and LNCs negotiating collaborative arrangements fees with local bodies. (2006)
2005.	That, in the light of the proposals contained in the Queen’s Speech to Parliament concerning the review of incapacity benefit this Meeting: (i) instructs the GPC/BMA to negotiate the removal of doctors from sickness certification or reporting requirements before the 28th day of incapacity; (ii) instructs the GPC/BMA to negotiate a reduction in the use of the DBD/DLA and similar forms together with an appropriate fee structure when such forms are requested; (iii) instructs the GPC/BMA to negotiate proper terms and remuneration for all doctors undertaking any form of medical work connected with the payment and control of social security benefits. (2005)
2006.	That this Meeting believes that the maximum charge of £50.00 for providing copy medical records under the Data Protection Act 1998 remains unrealistic and demand that it be changed to equate to the actual cost of provision including the medical time involved. (2003)

2007.	That this Meeting reaffirms the right of all registered medical practitioners to practice within the state or private sectors subject only to satisfactory professional controls. (2001)
2008.	That this Meeting deplores the failure of BUPA to raise benefits in line with inflation and therefore rejects the BUPA Consultant Partnership Scheme. (1997)
2009.	That this Meeting asks Council to negotiate with the Benefits Agency Medical Service to improve terms and conditions of service and workload, with a focus on quality rather than quantity. (1997)
2010.	That this Meeting deplores the attitude of those Government departments which refuse to honour the fees agreed with the Treasury for doctors undertaking part-time work for central Government. (1994)
2011.	That the general practitioner should be the doctor normally eligible to sign the authorisation section of the claim form for reimbursement in private medical insurance schemes. (1983)
	PROFESSIONAL INDEMNITY
2012.	That this Meeting notes medical defence organisations (MDOs) impose special conditions on some members on the basis of risk assessments, and believes that the factors that are used for these calculations should be made public, so that doctors can make an informed choice as to the true benefits, costs, and risks of membership. (2014)
	PUBLIC HEALTH MEDICINE
2013.	That this meeting believes there should be timely publication and peer review of SAGE opinion and advice to government on incidents with the potential to affect public health. (2021)
2014.	That this meeting condemns the English Government's decision to dismantle Public Health England in the middle of a global pandemic. We call upon the Department for Health to ensure greater investment in the Public Health function to ensure the country is better prepared for the next pandemic. (2021)
2015.	That this meeting welcomes the UK government's agreement to scrap the annual cap on the number of tier 2 visas, but believes there are still too many barriers to the recruitment of international healthcare professionals. This meeting calls on the BMA to: - i) lobby the government to significantly reduce the £30 000 salary threshold to reflect NHS pay scales; ii) lobby the government for the abolition of the Immigration Health Surcharge; iii) join with other unions and professional organisations to campaign for changes to the tier 2 visa system. (2019)
2016.	That this meeting notes that in a pilot to check eligibility for free NHS Care only 1/180 people were deemed ineligible and: -

	<p>i) this meeting believes that it is not cost effective to monitor eligibility for NHS Care;</p> <p>ii) this meeting calls for the policy of charging migrants for NHS care to be abandoned and for the NHS to be free for all at the point of delivery.</p> <p>(2019)</p>
2017.	<p>That this meeting:-</p> <p>i) condemns councils in England that have utilised money ring-fenced for smoking cessation to attempt to decrease their deficit;</p> <p>ii) calls on councils to ensure public health money is spent on improving public health.</p> <p>(2018)</p>
2018.	<p>That this meeting believes that Local Authorities must only use Public Health funding budgets for Public Health purposes, and independent scrutiny needs to be put in place to ensure this is adhered to.</p> <p>(2018)</p>
2019.	<p>That this meeting:-</p> <p>i) condemns the disparity in salaries of public health consultants/specialists depending on whether they are working in local governments, NHS or Public Health England;</p> <p>ii) believes the disparity contributes to difficulty in recruiting to and/or maintaining a skilled specialist workforce, especially in local authorities and discriminates between medically qualified Consultants in Public Health Medicine and their colleagues in other clinical specialities.</p> <p>(2018)</p>
2020.	<p>That this meeting deplores the severe funding cuts being made to public health services and calls for:-</p> <p>i) government immediately to stop further reductions in public health budgets;</p> <p>ii) a mechanism to ensure the consistency and equity of nationwide public health provision;</p> <p>iii) the reinstatement of public health within the National Health Service.</p> <p>(2017)</p>
2021.	<p>That this meeting:-</p> <p>i) condemns the public health budget cuts enacted by the government;</p> <p>ii) believes that public health cuts will have a devastating effect, both on the health of the public and on primary care workload and sustainability;</p> <p>iii) demands that Public Health funding must be protected.</p> <p>(2016)</p>
2022.	<p>That this meeting believes that public health medicine is under threat with wholesale reductions in medically qualified jobs in Local Authorities and Public Health England (PHE), and we call on the BMA to negotiate to ensure that:-</p> <p>i) medical consultant posts in Local Authorities must continue to be remunerated as, and subject to, national consultant salary scales and terms and conditions of service;</p> <p>ii) public health medical consultants should be key in delivering NHS strategy in executive roles within commissioning groups.</p> <p>(2015)</p>
2023.	<p>That this meeting notes with serious concern that many public health doctors may feel unable to speak up in the interests of the public's health because of lack of clarity over contractual requirements or threats of disciplinary action or other detriment and:</p> <p>i) calls on all UK Public Health employers, including local authorities and Public Health England, to state clearly and in writing to all their employees, that they should never hesitate to raise concerns if they believe government or employer</p>

	<p>policies are not in the interest of the public's health;</p> <p>ii) calls on all UK employers of public health doctors to assure these employees that they understand that duty to the public's health overrides any other contractual requirements;</p> <p>iii) calls on Public Health England to assure all public health doctors it employs that they are "free, without the prior consent of the employing authority, to publish [...] or speak [...]" and that this contractual and moral right takes primacy over the PHE Code of Conduct or Civil Service Code.</p> <p>(2015)</p>
2024.	<p>That this meeting supports the principle of a public health nursing service for children and young people with a school nurse presence in every school.</p> <p>(2015)</p>
2025.	<p>This meeting condemns the Westminster government's decision to cut £200 million from the public health grant which runs counter to the governments' stated commitment to increase funding for ill health and:-</p> <ul style="list-style-type: none"> i) rejects the spurious justification that the public health grant is non-NHS funding; ii) believes this cut will directly damage the public's health and increase costs and pressures on the NHS; iii) calls for the BMA to work with other concerned organisations to campaign against this cut. <p>(2015)</p>
2026.	<p>That this Meeting notes recent criticism of Public Health England (PHE) that as part of the Department of Health it is insufficiently independent. This Meeting calls on the BMA to:-</p> <ul style="list-style-type: none"> i) lobby for greater autonomy and independence for PHE; ii) specifically, PHE doctors should not be bound by the Civil Service Code of Conduct or any similar civil service regulations. <p>(2014)</p>
2027.	<p>That this Meeting urges the Dept of Health to ensure that funds are ring-fenced by the local authorities for public-health work.</p> <p>(2014)</p>
2028.	<p>That this Meeting notes with concern the amount of "public health" work done by unregulated management consultancy firms. As such, this meeting calls for any public health advice provided by these companies to be published with a clear declaration of all conflicts of interest those preparing the advice have. We also call upon the government to report regularly on:-</p> <ul style="list-style-type: none"> i) the proportion of public health advice provided by these companies; ii) the amount of public expenditure given to these companies; iii) and the qualifications and competencies of the staff in these companies who are providing the advice. <p>(2013)</p>
2029.	<p>That this Meeting objects to the use of health inequalities information to criticise the performance of the NHS, because health inequalities are not primarily caused by the NHS. We ask the Secretary of State to desist in the future from such statements.</p> <p>(2013)</p>
2030.	<p>That this Meeting believes that when statutory registration of non-medical public health specialists has been introduced, and if it complies with current BMA policy and includes revalidation, all public health consultants, whether or not medically qualified working for Public Health England (PHE), the NHS or local authorities should be offered employment on the medical and dental health service consultant contract.</p>

	(2013)
2031.	<p>That this Meeting believes that public health specialists working in public sector or third sector organisations should retain:-</p> <ul style="list-style-type: none"> (i) the right to be appointed on NHS equivalent terms and conditions of service; (ii) access to NHS pension provision; (iii) a contractual duty to advocate on behalf of their patient; the population; (iv) a contractual right to speak out on matters of professional importance; (v) a primary duty to the population served above and beyond all other considerations. <p>(2012)</p>
2032.	<p>That this Meeting welcomes plans to register and regulate public health specialists from professional backgrounds other than medicine on a statutory basis, and believes this should most appropriately take place under the Health Professions Council and to standards directly equivalent to those applied to public health doctors regulated by the General Medical Council and comparable to other health professions already regulated by the Health Professions Council.</p> <p>(2012)</p>
2033.	<p>That this Meeting believes that in order to maintain standards of practice in public health medicine, all appointments at consultant level including directors of public health should be subject to the Appointment of Consultants Regulations and the proper scrutiny of Advisory Appointments Committees, regardless of the appointing organisation.</p> <p>(2012)</p>
2034.	<p>That this Meeting firmly believes that the plans for Public Health Services should:-</p> <ul style="list-style-type: none"> i) recognise the role that public health doctors and staff play advising on healthcare needs, service planning, commissioning, quality and effectiveness; ii) ensure the Public Health function is not split to avoid fragmentation and disruption of services and loss of valuable experienced staff; iii) create a single NHS public health agency in England including specialists in all three domains of public health practice – improving services (including support to commissioning), health protection, and health improvement; iv) ensure that public health professionals are employed on NHS terms and conditions of service; v) ensure that the budget will be held centrally by Public Health England and deployed directly to Directors of Public Health as local leaders for health improvement; vi) ensure that during any changes, public health capacity is not reduced so as to maintain the existing comprehensive arrangements for health protection. vii) ensure that in areas of two tier local government the public health function should operate at both tiers. <p>(2011)</p>
2035.	<p>That this Meeting notes with concern the significant influence private businesses have had in the Government's Responsibility Deal Networks and believes this has and will continue to prevent the creation of strong, effective, and evidence-based policy making in public health issues. It calls upon the government to:-</p> <ul style="list-style-type: none"> i) place health organisations at the helm of chairing any current and future public health policy group; ii) consider within these groups' remit all possible options for improving the nation's health, including legislation, marketing bans, and price control measures; iii) create without delay, a comprehensive, transparent, cross-department and evidenced-based strategy for minimising the harm to UK public health caused by alcohol, tobacco, obesity, and inactivity. <p>(2011)</p>

2036.	<p>That this Meeting believes that public health training must remain open and attractive to medical professionals and to that end calls on the BMA to work to ensure:-</p> <ul style="list-style-type: none"> i) that recruitment to public health training remains part of the current specialty recruitment process; ii) that public health training continues to include training across three domains of public health; iii) that a period of formal, funded academic study remains part of the training programme; iv) that completion of training leads to award of a qualification allowing entry to the GMC specialist register and that the GMC remains the statutory regulator for public health trainees from a medical background; v) that access to training opportunities and accredited supervision should be available regardless of principal location of the trainee; vi) that public health trainees from a medical background should have the opportunity to remain on the same nationally negotiated terms and conditions of service as other junior doctors; vii) that suitable support is available during the transition phase and the number and quality of training posts is maintained. <p>(2011)</p>
2037.	<p>That this Meeting believes that, in recognition of the role of health care services in improving health and addressing health inequalities, public health doctors (including Directors of Public Health) should retain the right to remain employed by the NHS under the proposed new public health arrangements.</p> <p>(2011 Special Representative Meeting)</p>
2038.	<p>That this Meeting is concerned that the development of the Joint Strategic Needs Assessment by local Health & Wellbeing Boards is likely to bring them into conflict with the NHS Commissioning Board. We call for government to clarify the mechanism for resolving such conflicts.</p> <p>(2011 Special Representative Meeting)</p>
2039.	<p>This Meeting calls upon the BMA to negotiate with government to ensure that those filling the role of Director of Public Health within a local authority are:-</p> <ul style="list-style-type: none"> i) professionally independent and free to act as an advocate for the health of their population; ii) properly appointed according to the appointments advisory committee process and registered specialists in public health or public health medicine; iii) given appropriate authority and control over sufficient resources to deliver public health functions effectively; iv) responsible and accountable for the ring-fenced public health budget; v) afforded the status of 'Executive or Corporate Director' and able properly to influence all funding streams with public health impacts. <p>(2011 Special Representative Meeting)</p>
2040.	<p>That this Meeting supports statutory regulation of all public health specialists in line with doctors' statutory regulation.</p> <p>(2010)</p>
2041.	<p>That this Meeting notes the concerns expressed both in the Faculty of Public Health Workforce Survey 2009 and in the Marmot Report, and condemns the failure of governments to address the concerns previously expressed by the Association. This Meeting calls for governments to affirm that reductions in management costs will not impact on the recruitment and retention of public health doctors.</p> <p>(2010)</p>

2042.	That this Meeting welcomes the government's commitment to improving public health and the ambitious agenda set out in Choosing Health, but notes with alarm the recent Specialist Public Health Workforce in the UK report, by the Faculty of Public Health, which demonstrates a fall in consultant level public health staff by 29.5% since 2003. This Meeting calls on Council to lobby the four Health Departments to take urgent action to ensure that public health teams are adequately resourced and supported. (2008)
2043.	That this Meeting: (i) asks the Health Departments to acknowledge that public health physicians have an essential role in commissioning; (ii) welcomes the opportunity for public health doctors to work with GPs in implementing practice based commissioning (PBC); (iii) urges the Health Departments to insist that PCOs include dedicated public health support within all commissioning structures to ensure that clinical interventions and services are effective, cost-effective and of high quality. (2007)
2044.	That this Meeting views with concern the latest attrition of the numbers of public health physicians, and calls upon the government to take urgent action to safeguard the future of an adequate service. (2006)
2045.	That in view of the world-wide increase in transport-related morbidity and mortality, there should be a much greater input by public health doctors at all stages (from planning to monitoring) of the transport process. (2004)
2046.	That the BMA should pursue a policy with regard to public health medicine that ensures that this small specialty does not become fragmented between health authorities and trusts and maintains the integrity of, and a national structure for, public health medicine. (2001)
2047.	That every health authority and primary care trust be required to have a properly appointed (by AAC) medical officer with appropriate public health training and qualifications who has full rights of speech at health authority meetings and is required and enabled to produce regular and independent publications on issues concerning the health and health care of the population covered by the authority. (2000)
2048.	That this Meeting considers that the professional role of public health medicine in providing clinical and professional services should be enhanced and the costs should not derive from management budgets. (1997)
2049.	That this Meeting believes that public health medicine should (i) fulfil the role defined by the Acheson Report (Public Health in England); (ii) be provided with adequate and appropriate support to carry out its duties; (iii) retain its traditional independence of Government. (1992)

	RAPE AND SEXUAL ABUSE
2050.	<p>That this meeting notes with great sadness the June 2021 Ofsted 'Review of sexual abuse in schools and colleges' and calls on the UK government to:-</p> <ul style="list-style-type: none"> i) seek to protect children from sexual abuse and harassment; ii) provide sufficient funding, protected time and support for classroom practitioners to address issues around sexual harassment and sexualised language that arise within the class; iii) increase digital security to protect children from accessing sexually explicit material online; iv) deliver public education on the damaging effects of children being exposed to sexually explicit videos and images; and v) support parents and caregivers to take an active role in safeguarding their children's digital lives. <p>(2021)</p>
2051.	<p>That this Meeting recognises that trafficking, sexual violence and poverty force many women into sex work and calls upon the BMA to lobby the appropriate agencies to:</p> <ul style="list-style-type: none"> (i) support the healthcare needs of these individuals through promotion of good sexual health and increased availability of sexual health screening; (ii) work with government to stop human trafficking. <p>(2010)</p>
	REMUNERATION AND REVIEW BODY
2052.	<p>That this meeting notes the lack of a published plan regarding how the BMA will influence decisions on doctors' pay once the BMA leaves the DDRB process. We call on the BMA to:-</p> <ul style="list-style-type: none"> i) immediately advise the membership of what alternative routes for pay negotiations will be pursued when the BMA leaves the DDRB process; ii) ensure there is a mandatory requirement for all branches of practice to publish annual reports as to the state of their workforce and requests for pay, in line with the standard expected for submission to the DDRB <p>(2021)</p>
2053.	<p>That this meeting acknowledges the significant work of UK doctors and medical students in fighting the COVID-19 pandemic and that this work was performed on a background of sustained real-terms pay erosion for doctors in the UK. We call on the BMA to:-</p> <ul style="list-style-type: none"> i) survey members as to their opinions of the pay recommendations suggested by the DDRB in their 48th report (2020); ii) survey members as to what actions they believe the BMA should take next, in regard to tackling this real-terms pay erosion, including the option of industrial action; iii) to demand significant above inflation pay rise to compensate for a decade of freezes and sub-inflation pay rises; iv) to formulate an action plan in case doctors are not offered a fair pay settlement; v) withdraw from the DDRB before the end of 2020. vi) include different forms of industrial action in the survey and ask the council to formally ballot members if the survey suggests majority support. <p>(2020)</p>
2054.	<p>That this meeting: -</p> <ul style="list-style-type: none"> i) believes that future discussions on doctors' pay should be informed by earnings data for other comparable jobs in the modern economy; ii) has no confidence in the Review Body on Doctors' and Dentists' Remuneration (DDR);

	<p>iii) calls on the Review Body on Doctors' and Dentists' Remuneration (DDRDB) to be replaced by a transparent, fair and independent system of reviewing doctors' pay;</p> <p>iv) calls on the BMA to ballot members of the Association for industrial action if the next pay award is deemed not acceptable.</p> <p>(2019)</p>
2055.	<p>That this meeting requires that the evidence the BMA submits to the DDRB:-</p> <p>i) reflects the differences in health service organisation and/or contractual differences across the nations of the UK.</p> <p>(2018)</p>
2056.	<p>That this meeting urges the BMA to highlight the gender pay gap in medicine and to:-</p> <p>i) lobby governments, health departments and the NHS to focus on the root causes of the gender pay gap;</p> <p>ii) promote more representative participation by women in leadership positions in the NHS at all levels;</p> <p>iii) uphold gender pay equalisation as an essential aim of contract negotiations;</p> <p>iv) launch a campaign reminding members of their rights regarding pay and equality in the workplace;</p> <p>v) communicate with members on efforts made over the next 12-18 months to close the gender pay gap between doctors.</p> <p>(2018)</p>
2057.	<p>That this meeting believes that prolonged pay restraint has severely damaged the NHS and its staff and:-</p> <p>i) the BMA should identify actions to reflect the feeling of the profession and support achieving a fair settlement for medical staff;</p> <p>ii) rapid remedial action is needed to restore morale among all NHS staff;</p> <p>iii) demands a real-terms pay rise.</p> <p>(2018)</p>
2058.	<p>That this meeting notes the on-going gender pay gap and consistent under-representation of women in leadership positions and:-</p> <p>i) insists that employment contracts do not contain clauses which discriminate against women;</p> <p>ii) insists that equality impact assessments have equal status to other documents when considering contracts;</p> <p>iii) calls for the BMA to encourage improved diversity in representation locally, regionally and nationally.</p> <p>(2017)</p>
2059.	<p>That this meeting deplores the negative effect of the recent cap on hospital doctors' locum rates and calls for its abolition.</p> <p>(2016)</p>
2060.	<p>That this meeting believes that the BMA should demand restitution of a powerful, independent pay review body.</p> <p>(2015)</p>
2061.	<p>That this meeting is absolutely opposed to any proposed legislation which would threaten NHS medical and dental terms and conditions of service by inadvertently forcing a move to Agenda for Change conditions.</p> <p>(2015)</p>

2062.	That this Meeting deplores the actions of some NHS trusts which seek to undermine the national terms and conditions of employment for NHS medical staff. (2014)
2063.	That this Meeting:- i) believes that nationally agreed terms and conditions for all NHS staff is an essential prerequisite for an equitable health service; ii) opposes attempts to create local variations on nationally negotiated NHS terms and conditions. (2014)
2064.	That this Meeting:- i) believes the pay of doctors in the NHS has been steadily eroded for years and fails to take account of falling morale, falling job satisfaction, rising work intensity, taxation changes and loss and emigration of the workforce; ii) requires the BMA to be less apologetic about medical pay; iii) asserts the future viability of the NHS should not be made dependent upon reductions in pay of any of its staff. (2014)
2065.	That this Meeting:- i) notes the DDRB was set up as a result of a Royal Commission to avoid manipulation of doctors pay by governments for political purposes; (Lapsed 2019) ii) is concerned that the recent DDRB pay award is non-consolidated in England other than in Scotland, and demands that this be made consolidated; iii) deplores the failure of all governments other than Scotland to implement in full the recommendations of the DDRB; iv) demands that the BMA puts pressure on the government for doctors to be given annual pay awards, at a minimum, in line with inflation. (2014)
2066.	That this Meeting:- i) does not recognise any emergent local or regional pay and conditions consortia; ii) refuses to enter into negotiations with any local or regional pay and conditions consortia; iii) insists that national terms and conditions of service for medical staff in the NHS are maintained. (2013)
2067.	That this Meeting:- i) recognises that there is a 28.6% pay gap between men and women among medical practitioners in the UK; ii) believes that the reasons for this are multi-factorial and include factors which affect women in other occupations such as geographical limitations and a hostile culture; iii) recognises that currently only pay guidelines are published; iv) calls for more research in this area and for lessons to be drawn from other healthcare professions where gender pay differences are closer to zero; v) calls for the BMA to lobby to policy makers for more measures aimed at eradicating this gender divide which is closing in many other professions but still persists in medicine. (2013)

2068.	That this Meeting believes that clinicians wish to engage in delivery of quality care for patients, but that reduction in Supporting Professional Activity time is hindering availability to attend meetings on planning strategy for delivery of care, and calls on employers to facilitate engagement. (2013)
2069.	That this Meeting notes the likelihood of contract negotiations in the near future and rejects calls for a sub consultant grade or post CCT fellowships designed solely for service provision. (2013)
2070.	That this Meeting notes that the government seeks to impose locally determined pay on public sector workers. This Meeting believes that:- (i) it would only be a matter of time before it is applied to doctors; (ii) the aim of this policy is to undermine national terms and conditions for public sector workers, including pay and pensions; (iii) this is part of the ongoing plan to dismantle public services and outsource them to private companies; (iv) it would inhibit the free movement of doctors around the country during their careers; (v) it would have a negative effect on the training of doctors; (vi) it would create recruitment problems in deprived areas; (vii) it would lead to wasted time and resources in negotiating local contracts; (viii) it would be the “final nail in the coffin” of a comprehensive NHS; (ix) BMA Council should campaign to maintain national contracts (2012)
2071.	That this Meeting deplores the erosion of Supporting Professional Activities (SPA) time in the job plans of both new and existing posts. We recognise that this may have an adverse impact on an individual’s ability to provide evidence for revalidation and:- (i) insist that SPAs are detailed within the job description of new posts and that there should be a job plan review within 6 months of commencement; (ii) call on royal college representatives who approve job descriptions for new posts and/or who sit on appointments committees to insist that the nature of the SPA work is fully specified in job plans in line with the SPA Guidance from the Academy of Medical Royal Colleges; (iii) remind employers that the quality of education and training will be at risk; (iv) demand that the contractual position on SPAs is protected. (2012)
2072.	That this Meeting believes that proposals by employers and government to attack doctors’ pay progression, and excellence award schemes in addition to the real terms earnings reduction over recent years, will be hugely demotivating for the medical profession and calls on the BMA to:- i) oppose any suspension of pay progression and defend nationally agreed terms and conditions of service; ii) urgently explore action, including industrial action, that might be taken should this be necessary and assuming that the lawful requirements have been met. (2011)
2073.	That this Meeting demands that the DDRB takes into account any reduction in doctors’ NHS pensions in future pay awards when it considers the total pay package for doctors. (2011)
2074.	That this Meeting calls on the Department of Health to protect the integrity of the NHS workforce by ensuring that 'any willing provider' of NHS services must employ healthcare

	professionals on national NHS terms and conditions, with access to accredited professional development and training, structured appraisal and supervision and NHS pensions. (2011)
2075.	That this Meeting believes that, despite the derisory 2007 DDRB pay award: (i) the BMA and its branch of practice committees should take a longer term view to the submission of evidence to the DDRB and should provide more focused, tailored evidence and not present items in the evidence which are outside the remit of the DDRB; (ii) BMA evidence, both written and oral, to the DDRB from any branch of practice committee should not be to the detriment of any other branch of practice committee; (iii) the BMA should continue to take part in the DDRB process, but keep this under review in the light of future pay awards. (2007)
2076.	That this Meeting congratulates the DDRB on showing some independence in its 2006 recommendations on doctors' pay, and: (i) condemns government action in the staging the award for consultants; (ii) calls for the immediate full implementation of the award; (iii) demands that any future pay awards for doctors are not staged simply to save money. (2006)
2077.	That this Meeting believes that all out-of-hours work performed by doctors should be remunerated at premium rates. (2003)
2078.	That this Meeting believes in national pay scales and terms of service for medical staff in the NHS and is concerned by government policy that may undermine this. (2002)
2079.	That this Meeting demands that the DDRB: (i) should remain independent; (ii) should make pay award recommendations on the basis of changing complexity and volume of workload; (iii) should not be constrained in its recommendations by national inflationary figures. (2002)
2080.	That this Meeting affirms its total opposition to the introduction of a single, unified pay review body for all NHS workers. (1998)
2081.	That this Meeting is strongly opposed to the inclusion of medical professional remuneration within a National Health Service "single pay spine". (1998)
2082.	That this Meeting demands that the Government recognises the leading professional role of doctors in the NHS and increasing workload which must be suitably remunerated. (1996)
2083.	That this Meeting will not tolerate performance related pay for salaried doctors. (1994)
2084.	That this Meeting considers that any consideration of assessing pay by performance should apply to quality of outcome as well as quantity. (1992)

2085.	That, in future, the medical profession should not be used as a regulator of public service pay. (1991)
REPORT OF THE FRANCIS INQUIRY	
2086.	That this meeting is appalled by the disconnect between recommendations of the Berwick and the Francis reports and the reality of working in the current NHS. (2016)
2087.	That this Meeting agrees with Don Berwick's recommendation in the wake of the Francis Inquiry, for the NHS to promote a culture of learning and openness, not of blame and fear, and calls upon government to take action to:- i) eradicate the current bullying culture within the NHS which inhibits clinicians from raising patient safety concerns and demonises doctors, nurses and other healthcare workers for failures of delivery of healthcare; ii) remove the stigma surrounding whistleblowing which inhibits clinicians from raising patient safety concerns, and support staff and students to raise concerns without fear; iii) develop a culture in the NHS of transparency, respect, learning and continuous quality improvement by focusing on the needs of patients above financial constraints. (2014)
2088.	That this Meeting insists that, in the wake of the Francis report, any statutory duty of candour is placed on organisations rather than individuals. (2014)
2089.	This Meeting welcomes the announcement of The 'Freedom and Responsibility to Speak Up' Review to be chaired by Sir Robert Francis QC, and: i) calls upon the Secretary of State to make this a full public inquiry under the Inquiries Act 2005; ii) calls upon Council to set up a working party to look at this issue of doctors raising serious concerns and determine how the Association can better support doctors and medical students who raise concerns to ensure patient safety is prioritised. (2014)
2090.	That this Meeting welcomes the opportunity offered by the publication of the Report of the Francis Inquiry to affirm that patient care is the first duty for all involved in healthcare, and:- i) deplores any culture of secrecy and bullying within health services; ii) insists that the culture of the NHS must move away from the pursuit of financial and activity targets and revert to the attainment of quality in patient care; iii) calls for NHS managers to be subject to professional regulation such that they are held accountable for their actions and omissions; iv) calls for funding and staffing levels sufficient to assure high quality, safe care. (2013)
2091.	That this Meeting:- i) calls for a review of incident reporting and feedback mechanisms in the NHS and in social care to focus on identifying errors and facilitating improvement and development; ii) calls for mandatory reporting periods for Serious Untoward Incidents and Never Events, informing the reporting staff member within 3 months of the outcome of the investigation; iii) believes that protecting those who report adverse events is more likely to help improve patient safety than prosecuting those who do not; iv) insists that gagging clauses or unwritten gagging pressure must not be allowed to

	<p>prevent individuals from raising issues about patient safety; v) requires systems to be developed to allow health professionals to express concerns in a climate of free speech and, if required, confidentiality. (2013)</p>
	RESEARCH
2092.	That this meeting believes that adequate provision of maternity leave for women in academia should be incorporated as a requirement in the Athena Swan criteria. (2016)
2093.	That this Meeting condemns the appropriation of research funding for non-research purposes within the NHS. (2010)
2094.	That this Meeting believes that medical research for patient benefit is essential to the delivery of medical healthcare, and reasonable steps should be taken to construct a mechanism for patient-based research to be carried out. (2009)
2095.	That this Meeting believes that the reconfiguration of the NHS threatens access to patients by medical students and clinical researchers. This meeting urges the BMA to campaign locally, regionally and nationally for medical students and clinical researchers to have access to patients in all areas of health care delivery and for the impact on medical research and education to be taken fully into account in any proposals for the reconfiguration of health services, with the aim of ensuring that the opportunities for research and education should, at least, be no worse than under the existing configuration of services. (2009)
2096.	That there should be no restrictions on the publication of the full results of research funded by the DHSS, providing that peer review considers that publication is warranted. (1988)
	RETIRED DOCTORS
2097.	That this meeting calls on the General Medical Council to change its retiral, revalidation and re-entry processes in order to retain senior members of the profession to contribute to clinical services, teaching and research. (2019)
2098.	That this Meeting appreciates the valuable work done by retired doctors who work voluntarily (often in the Developing World) and who are required to continue paying for the GMC registration fee, membership of learned societies, and journal subscriptions in order that the service and training they provide is recognised and up - to - date and urges the appropriate tax authorities to allow such expenses to be included in tax allowance (against the pension) of the individual voluntary worker. (2011)
2099.	That this Meeting believes that the BMA should investigate the merit of producing publications specifically for the retired both for the medical profession and the general public. (2010)
2100.	That this Meeting recognises the contribution which licensed but retired members of the profession make to: <ul style="list-style-type: none"> (i) voluntary clinical work; (ii) medical charities;

	(iii) medical ethics. (2010)
2101.	That this Meeting recognises that retired doctors are a vital resource, for example during disasters and medical emergencies, and urges the BMA to negotiate with the Health Departments to secure sufficient financial support for those doctors who wish to update their professional knowledge and practice annually. (2008)
2102.	That this Meeting believes that the experience of retired members is not used enough and that they have an important role to play in the education of junior doctors by virtue of their experience and by means of the dissemination of this experience in several ways: (i) by emphasising the learned and caring nature of the medical profession; (ii) through the structure of the BMA locally, either within divisions, regional fora or other means; (iii) by establishing a database of retired members utilising their experience and expertise as well as their geographical location. (2007)
2103.	That the BMA: (i) urges the GMC to abandon the proposed annual fee for those retired doctors who wish to remain registered, but not to be licensed to practice; (ii) recognises the value of retired doctors in giving emergency help and urges the GMC to find a way for this to continue; (iii) should strongly support retired doctors' right to retain the title "doctor" and to prescribe from a limited list. (2005)
2104.	That this Meeting believes that fully retired doctors should continue to be licensed by the General Medical Council, at reasonable cost, so that they can still be useful in their communities and calls on the BMA to support this process, including issuing appropriate guidance. (2004)
	ROAD SAFETY/DRINK DRIVING
2105.	That this meeting:- i) requests the BMA Board of Science to investigate the increasing problem of the potential impairment of judgement of some elderly drivers, with particular reference to those in the early stages of dementia, and to offer guidance to clinicians in front-line specialties such as general practice; ii) believes that the criteria for obtaining a blue badge should be amended to make them available for patients diagnosed with dementia. (2015)
2106.	That this Meeting condemns the coalition government's refusal this year to lower the drink drive level to 50mg alcohol per 100ml blood as recommended in the expert report by Sir Peter North. This will mean a further 168 people will die needlessly on our roads this year and in every subsequent year. (2011)
2107.	That this Meeting, in the light of the North committee report on drink driving (published 16 June 2010): (i) recognises the evidence basis of their findings; (ii) agrees with the recommendation that the drink drive blood alcohol limit be reduced to 50mg per 100mls;

	<p>(iii) notes the avoidable financial and social costs to the NHS and the nation of drinking and driving;</p> <p>(iv) mandates the BMA to lobby the government for suitable changes in the law to give effect to the North Committee recommendations on the drink drive limit.</p> <p>(2010)</p>
2108.	<p>That this Meeting calls upon Parliament to mandate (except in exceptional circumstances) the use of 20 mph speed limits on roads close to schools, along with more extensive use of “living streets” and 20 mph limits in residential streets and more extensive parking restrictions as a means to reduce risk of injury, promote physical activity and reduce road congestion.</p> <p>(2008)</p>
2109.	<p>That this Meeting commends the Board of Science on its recent report on “alcohol misuse: tackling the UK epidemic” and calls on the:</p> <p>(i) BMA to continue its lobbying on this issue and actively progress the evidence based recommendations detailed in the report;</p> <p>(ii) UK governments to reduce the legal limit for the level of alcohol permitted while driving from 80mg/100ml to 50mg/100ml which has been estimated would save around 80 road deaths per year in England alone;</p> <p>(iii) UK governments to introduce legislation permitting the use of random roadside breath testing for alcohol without the need for prior suspicion of intoxication.</p> <p>(2008)</p>
2110.	<p>That this Meeting calls on Parliament to debate the merits of more extensive use of 20 mph speed limits on roads, to cover all “walk to school” routes, as a measure that will reduce risk of injury, promote physical activity in school aged children and help shift the balance between motorist and pedestrian.</p> <p>(2007)</p>
2111.	<p>That this Meeting believes that the current alcohol level permitted whilst driving is too high and:</p> <p>(i) demands that the legal limit in the UK be reduced to no more than 50mg/100ml;</p> <p>(ii) demands that the BMA works to ensure that no country in Europe retains a legal limit exceeding 50mg/100ml;</p> <p>(iii) supports a change in legislation enabling police to carry out random roadside testing without the need for prior suspicion of intoxication.</p> <p>(2007)</p>
2112.	<p>That this Meeting would wish the maximum alcohol level for drivers to be reduced from 80mgs to the European norm of 50mgs in line with the recommendations of the Association of Chief Police Officers.</p> <p>(2005)</p>
	ROYAL COLLEGES
2113.	<p>That the BMA call upon the Academy of Royal Medical Colleges to:</p> <p>(i) commission an independent enquiry into the actual cost of postgraduate exams and the current fees charged; and</p> <p>(ii) monitor and publish the results of and surveillance of the outcomes of the examinations of their constituent colleges and faculties.</p> <p>(1997)</p>
	SCOTLAND

2114.	<p>That this meeting notes that GP locums can be deemed not to be eligible for the full life assurance cover provided through an NHS Pension Scheme membership, should their death occur on a day when they are not scheduled to be working, and:-</p> <ul style="list-style-type: none"> i) welcomes the temporary NHS Scotland Coronavirus Life Assurance Scheme (Scotland), noting that it will not exclude GP locums simply because they do not meet the definition of being active members of an NHS Pension Scheme at the time of their death; ii) welcomes the fact that the temporary NHS Scotland Coronavirus Life Assurance Scheme (Scotland) will provide the beneficiaries of all eligible relevant persons with benefits comparable to those with access to the full death in service cover provided through an NHS Pension Scheme; <p>2020</p>
2115.	<p>That this meeting:-</p> <ul style="list-style-type: none"> i) requires that BMA Scotland should have the ability to initiate e-mail communication with BMA members in Scotland whenever necessary, without needing prior ratification from BMA UK; ii) recognises that on some issues UK wide communication is appropriate, and therefore requires BMA UK and BMA Scotland to develop a process of communication to ensure that there is no conflict between BMA Scotland and BMA UK email communications. <p>(2018)</p>
2116.	<p>That this meeting acknowledges the implementation of a new graduate-entry medical degree in Scotland, but requires any such programme to:-</p> <ul style="list-style-type: none"> i) be able to deliver to its students an adequate amount of clinical training in settings that are shared by more than one medical school; ii) not reduce the clinical opportunities for learning that students at existing medical schools already receive; iii) allow staff to continue to provide the same level of service to their patients. <p>(2018)</p>
2117.	<p>That this meeting:-</p> <ul style="list-style-type: none"> i) commends BMA Scotland for setting up a 'respect at work' helpline to offer support and advice to members with problems relating to bullying, harassment, discrimination and dignity at work; ii) calls on the rest of the BMA to follow this example. <p>(2017)</p>
2118.	<p>That this meeting:-</p> <ul style="list-style-type: none"> i) believes that doctors in Scotland should be entitled to attend Fitness to Practise proceedings at a venue within Scotland; ii) believes that the GMC is creating a climate where doctors practise in fear for their registration; iii) demands that the GMC implement the recommendations of the independent report by Sarndrah Horsfall, 'Doctors who commit suicide while under GMC fitness to practise investigation'. <p>(2015)</p>
2119.	<p>That this Meeting believes that BMA Scotland must actively negotiate for a substantial increase in funding available to general practice in Scotland, without defunding secondary care, as current levels are grossly inadequate to meet the needs of the patient population in the community.</p> <p>(2014)</p>
2120.	<p>That this Meeting:-</p>

	<ul style="list-style-type: none"> i) notes that the Scottish Government has made the decision to remove the means tested student travel expenses budget from academic year 2011-2012; ii) believes that this will have a significant negative impact on medical students, especially those from low income backgrounds, at a time when the Scottish Government is in contrast trying to widen participation to Higher Education courses like Medicine; iii) calls on the Scottish Government to meet its commitment that no existing student would see their living costs support decrease in academic year 2011-12 by introducing additional support for medical students travelling to clinical placements. <p>(2011)</p>
2121.	<p>That this Meeting believes the provision of free personal care for the elderly in Scotland remains a just and humane policy, that local authorities require both increased resources and funding to effect this policy and better central guidance on assessing and reviewing eligibility, and this meeting calls upon BMA Scotland to lobby the Scottish Government to assure these measures.</p> <p>(2008)</p>
2122.	<p>That this Meeting believes the Minister for Health in Scotland should focus on the health service in Scotland as a whole, and should not be obsessed with 4 hour waits or waiting list targets.</p> <p>(2005)</p>
2123.	<p>That this Meeting welcomes the refusal of the Scottish executive to implement top-up fees but mandates the SMSC to lobby them to increase funding for higher education institutions up to parity with English institutions.</p> <p>(2004)</p>
2124.	<p>That this Meeting:</p> <ul style="list-style-type: none"> (i) insists on the primacy of medical advice to health boards and trusts as expressed through area medical committees; (ii) believes that chairmen of area medical committees should continue to attend and be allowed to speak at all meetings of the new unified health boards in Scotland. <p>(2001)</p>
	SCREENING
2125.	<p>That this meeting is concerned with the lack of consistency in the Pre-school Visual Screening (PSVS) services provided by individual health boards/trusts across the United Kingdom, resulting in delayed / inadequate detection of some of the potentially reversible causes of amblyopia. This meeting:-</p> <ul style="list-style-type: none"> i) believes that there should be a more uniform effort across different health boards/trusts in the establishment of a consistent and sustained PSVS programme in the United Kingdom; ii) believes that streamlining PSVS services with orthoptist and optometrist led clinics is fundamentally crucial to the success of the service; iii) calls for a devised guideline for the provision of PSVS service across United Kingdom. <p>(2016)</p>
2126.	<p>That this Meeting notes the GMC code of fitness to practise governs the provision or publication of information about medical services, by registered medical practitioners to the public, preventing the manipulation of 'ill-founded fears for their future health' and</p> <ul style="list-style-type: none"> (i) recognises that there is no legislation in the UK preventing allied health professionals from promoting screening tests using direct marketing (mailings, door-to-door salespersons) to members of the public;

	<p>(ii) notes that screening tests have risks as well as benefits that extend above and beyond false positives and false negatives;</p> <p>(iii) calls on the BMA to lobby the government for legislation of the marketing of direct to consumer screening tests.</p> <p>(2009)</p>
2127.	<p>That this Meeting strongly recommends to the Department of Health Advisory Committee on Cervical Screening that the lower age limit for screening should be 20.</p> <p>(2009)</p>
2128.	<p>That this Meeting is doubtful about the ethical merits of screening for disease for which there is no effective or available treatment.</p> <p>(2009)</p>
	SEVEN DAY SERVICES
2129.	<p>That this meeting, with respect to seven day urgent and emergency services:-</p> <p>i) condemns the persistent misinterpretation by politicians of data on morbidity adjusted hospital mortality, by day of week;</p> <p>ii) demands that the government should be evidence based in its approach.</p> <p>(2016)</p>
2130.	<p>That this meeting:-</p> <p>i) is unequivocal in its support for patients having access to the same high standard of urgent and emergency care throughout the week;</p> <p>ii) believes that it is impossible to deliver routine non-urgent seven-day services across primary and secondary care, within the current five day financial resources and workforce;</p> <p>iii) calls on the government, to publish a fully funded model for how it will deliver on its manifesto commitment for a seven day service.</p> <p>(2016)</p>
2131.	<p>That this meeting applauds the BMA's DDRB evidence submission calling on the government to provide the detailed evidence and modelling on seven-day services, and demands that the government urgently publishes this vital data.</p> <p>(2015)</p>
2132.	<p>That this meeting believes that, as medical services are already provided 24/7 by doctors and other healthcare workers around the clock, existing employment contracts are not a barrier to the provision of high quality seven-day services.</p> <p>(2015)</p>
2133.	<p>That this Meeting:-</p> <p>i) recognises that many doctors already provide seven day emergency services and insists that seven day urgent care must not be conflated with seven day access to routine services;</p> <p>ii) believes that delivery of both seven day routine and elective services is not feasible within the current NHS budget constraints leading to reduced clinical services Monday to Friday and/or closure of hospitals;</p> <p>iii) insists that provision of seven day healthcare requires investment in medical staff and supporting resources and not merely the reorganisation of services;</p> <p>iv) insists that any contract negotiations on seven day working must take account of infrastructure and support services, compensation for antisocial hours, and family friendly working.</p> <p>(2014)</p>

2134.	That this Meeting calls on the appropriate bodies to assess how seven day services will shape undergraduate and postgraduate education, research and workforce planning. (2014)
	SHARPS – USE AND DISPOSAL
2135.	That this Meeting insists that hospitals should discharge their responsibility for the change and removal of filled "sharps" boxes in accordance with BMA guidelines and Department of Health Directive on the safe use and disposal of "sharps". (1992)
	SICK DOCTORS
2136.	That this Meeting recognises doctors' duty to look after themselves and their colleagues (as laid out in Duties of a Doctor). Sadly many doctors do not feel adequately trained to do so and we therefore call upon: (i) the GMC to ensure all undergraduates and postgraduate doctors receive training in recognising colleagues experiencing difficulties; and (ii) the BMA to work with other agencies in promoting support services available. (2007)
2137.	That the BMA should pressurise strategic health authorities to include short term reliever doctors in every hospital rota, to facilitate sick doctors into looking after their own physical and mental health without feeling like they are impacting on their colleagues in times of illness (as in the Australian and New Zealand scheme). (2007)
	SMOKING AND TOBACCO
2138.	That this meeting believes, noting that the US Surgeon General has concluded that “there is no risk-free level of exposure to tobacco smoke, and there is no safe tobacco product” and that NICE Guidance PH48 recommends all hospitals have no designated smoking shelters as smokefree hospital grounds motivate staff and managers to implement cessation processes to assist hospitalised smokers, that:- i) all healthcare workers have a right to work in smoke-free premises; ii) all healthcare services should adopt a smoke-free policy; iii) the wellbeing of clinicians should be a priority for all health services. (2018)
2139.	That this meeting recognises the 2002 NICE Technology Appraisal Guidance number 39 which states that smoking cessation treatments “are among the most cost effective of all healthcare interventions” and recommends that:- i) all junior doctors, and allied healthcare professionals should receive training in smoking cessation; ii) smoking cessation strategies should form part of all undergraduate curriculums. (2015)
2140.	That this meeting congratulates the previous government on its decision to support plain tobacco packaging, and exhorts politicians to investigate the advertising of E-cigarettes, particularly with reference to its appeal to young people.

	(2015)
2141.	That this Meeting believes that their new duty to improve the health of their population requires all Local Authorities not to hold any shares in tobacco companies. (2013)
2142.	That this Meeting:- <ul style="list-style-type: none"> i) is extremely concerned about the health impact that smoking near hospital entrances has on patients and staff; ii) believes that rules banning smoking near the entrances to hospitals are routinely ignored; iii) feels that the NHS must introduce and enforce tougher penalties for any staff or patients who smoke near the entrance to hospitals; iv) calls on NHS trusts to promote smoking cessation services more widely to patients and staff. (2013)
2143.	That this Meeting asks the government to introduce legislation to ban smoking while driving a motor vehicle. (2011)
2144.	That this Meeting demands that all companies involved in the production of tobacco products should be forced to publish all payments to politicians and political organisations. (2011)
2145.	That this Meeting applauds the plans by the Australian Government to remove all branding on cigarette packaging and to raise further tobacco taxes by a significant amount. We congratulate the Australian Medical Association on their efforts in this area and we agree with the WHO that this represents a new gold standard in tobacco product regulation and call on UK governments to lead by example in Europe and bring forth equivalent legislation at the earliest possible opportunity. (2010)
2146.	That this Meeting believes that the BMA should share its expertise in tobacco control to support national medical associations and other relevant bodies in reducing the health burden of tobacco use. (2010)
2147.	That this Meeting: <ul style="list-style-type: none"> (i) reaffirms the Association's 1999 condemnation of the advertising of tobacco at the point of sale; (ii) calls on the BMA to lobby for legislative change to make illegal all tobacco advertising throughout the UK; (iii) calls for restrictions on vending machines, where children can currently purchase cigarettes out of sight of adult supervision. (2009)
2148.	That this Meeting demands legislation to ensure that tobacco companies are held liable for the damage their products cause. (2009)

2149.	That this Meeting believes that supermarkets providing in-house medical services should not also sell tobacco products and calls on the BMA to campaign for the government to introduce this regulation. (2008)
2150.	That the BMA calls on government to ban the sale of tobacco products in vending machines as an essential measure to prevent the sale of tobacco to children. (2007)
2151.	That this Meeting welcomes the total ban on smoking in public places, but deplores the suggestion that alcohol and tobacco may be sold in the same place as Primary Care is delivered (Super stores). (2006)
2152.	That government should introduce legislation to place nicotine replacement therapy prominently and centrally in all retail displays of tobacco products. (2005)
2153.	That this Meeting believes: <ul style="list-style-type: none"> (i) that the government should be more active in denying supply of alcohol and tobacco to minors; (Lapsed 2011) <ul style="list-style-type: none"> (ii) that the minimum legal age for the purchase and sale of cigarettes should be raised from 16 to 18 years. (2005)
2154.	That in any guidance given by the BMA on partnership agreements, practices should be strongly discouraged from inserting clauses which discriminate against partners who: <ul style="list-style-type: none"> i) Become sick; ii) Develop addictive illnesses (2004)
2155.	That this ARM urges the government to take seriously the national service framework for coronary heart disease and the dangers and addictive nature of smoking by requiring all NHS organisations to employ a specialist in smoking cessation for the purpose of helping professionals and patients to stop. (2002)
2156.	That this Meeting notes that 120,000 deaths a year are related to smoking in the United Kingdom and welcomes the step taken to tackle this most pressing threat to public health, but calls upon the Government to enact the Health Select Committee recommendation that a Tobacco Regulatory Authority be established so that this most dangerous of products can be at last subjected to an adequate regulatory framework. (2001)
2157.	That this Meeting regrets that the Government is not acting forcefully or rapidly enough to reduce cigarette smoking in the country. It suggests: <ul style="list-style-type: none"> (i) a ban on smoking in public places; (ii) a ban on advertising in or on shops; (iii) stronger penalties for shopkeepers who serve under 16s with cigarettes. (1999)

2158.	That this Meeting condemns the European Union in its continued subsidy of tobacco growing through the common agricultural policy and supports the BMA in its continued campaigning to have this policy rescinded. (1997)
2159.	That the BMA should endeavour to seek the introduction of legislation to ensure that tobacco companies are required to compensate the National Health Service for its costs in treating tobacco related disease. (1997)
2160.	That this Representative Body asks that the BMA should press for a significant health tax to be added to the cost of each packet of cigarettes. (1994)
2161.	That this Meeting deplores moves by multi-national tobacco companies to increase sales in third world countries. (1993)
2162.	That this Meeting asks the Government to do everything in its power to reduce tobacco smoking by: (i) complying with EC directive on tobacco advertising; (ii) removing tobacco from the cost of living index so that fiscal measures could be taken without detriment. (1992)
2163.	That this Meeting deplores the granting of subsidies to EC tobacco growers. (1992)
2164.	That this Meeting wishes to see the abolition of duty free allowances on tobacco based products. (1987)
2165.	That the smoking of tobacco should be banned at all meetings of the British Medical Association. (1984)
STAFF, ASSOCIATE SPECIALISTS AND SPECIALTY DOCTORS	
2166.	That this meeting, regarding the holiday entitlement of SAS doctors: - i) welcomes the NHSE recommendation that these doctors should receive an extra 2 days paid holiday per year and congratulates those trusts which have implemented this; ii) instructs BMA to negotiate the inclusion of the recommended extra 2 days holiday into the national terms and conditions of service to ensure all SAS doctors will benefit. (2019)
2167.	That this meeting congratulates the BMA on agreeing the SAS charter in all four nations. We call upon the BMA to: - i) work with management to implement the charter using the toolkit; ii) provide evidence of this implementation; iii) ensure that the SAS LNC representative where present, is involved in the implementation and monitoring of the charter. (2019)
2168.	That this meeting calls on the BMA to consider promoting a CEA system for SAS doctors as part of a modernised reward and recognition regime for this hardworking and often very innovative cohort of the senior medical workforce. (2019)

<p>2169.</p>	<p>That this meeting calls on the BMA to open discussions with NHS Employers to recognise dedication and long service by ensuring that all SAS doctors across England are given two additional day's leave after seven years' service, in line with consultant colleagues and with several Trusts which have already implemented this for SAS doctors. (2018)</p>
<p>2170.</p>	<p>That this meeting:- i) deplores Health Education England's recent draft health workforce strategy which states that 12 million pounds are allocated towards SAS development when in reality there have been massive cuts to this funding resulting in no funds allocated across certain LETBs; ii) demands an urgent, open investigation into SAS development funding with reassurance from HEE that the SAS development funds will be transparently and fairly allocated across England. (2018)</p>
<p>2171.</p>	<p>That this meeting is concerned by the high incidence of bullying and harassment experienced by SAS doctors in the workplace and exhorts the BMA to require employers to promote a positive campaign to stamp out bullying and harassment in every form in the workplace with:- i) a positive declaration of adopting a zero-tolerance to bullying and harassment; ii) appointment of a SAS Respect guardian /Champion; iii) developing and implementing a robust anti bullying and harassment policy and; iv) appointing a non-Exec Director as the Trust lead to oversee implementation of the policy, showing a buy-in from the Trust board. (2018)</p>
<p>2172.</p>	<p>That this meeting recognises that it has been a few years since the BMA SAS charters were signed in all four nations. We urge the BMA to:- i) raise awareness of the charters; ii) ensure implementation of these charters through negotiation and agreement at LNCs; iii) develop a system to monitor their implementation. (2018)</p>
<p>2173.</p>	<p>That this meeting has concerns that currently there is a lack of SAS representation on the Local Education and Training Boards and the appointments of Associate Deans for SAS doctors are not being continued. It therefore calls on Health Education England to ensure that:- i) there is appropriate SAS representation on the Local Education and Training Boards and; ii) the appointments of Associate Deans for SAS doctors continue and that they are appointed from within the SAS grades. (2017)</p>
<p>2174.</p>	<p>That this meeting warmly welcomes the publication of the document "SAS Doctor Development" in partnership with the Academy of Medical Royal Colleges, Health Education England and NHS Employers and calls upon all these agencies to use their collective best endeavours to ensure that the principles outlined in the document are fully realised such that the disadvantaging of SAS doctors in terms of career development and leadership opportunities becomes a thing of the past. (2017)</p>

2175.	That this meeting congratulates UK SASC on the successful acceptance of the SAS charter by NHS employers and calls for the BMA and NHS employers to ensure its universal implementation in NHS. (2017)
2176.	That this meeting wholeheartedly endorses the principles of the nationally agreed SAS Charters and calls on all employers to implement their provisions as a minimum. Furthermore, this meeting recommends that the BMA, through Local Negotiating Committees, seek to further develop and agree local implementation arrangements that improve upon and extend the minimum recommendations of the national Charters. (2016)
2177.	That this meeting is deeply concerned about diversion of the SAS development fund for other purposes and strongly urges the Health Education England to give clear instructions to the Local Education and Training Boards so as to:- i) ensure that this funding continues to be utilised for SAS development needs; and ii) refrain from diversion of this funding for other purposes. (2016)
2178.	That this meeting believes that individual outcome data should be made available for SAS doctors in order to support their appraisal and revalidation. This would enhance accountability, productivity and allow for greater recognition of the work of SAS doctors. It therefore urges the BMA to call on NHS England to make this data available to SAS doctors. (2016)
2179.	That this meeting calls upon the BMA to work with appropriate bodies to ensure SAS doctors are given adequate resources, training and time to:- i) become clinical/educational supervisors and appraisers; ii) integrate into management structures. (2015)
2180.	That this meeting reaffirms the request to re-open the associate specialist grade in order to ensure greater recognition, job satisfaction and to improve the recruitment and retention of competent senior doctors and asks NHS employers to take appropriate action. (2015)
2181.	That this meeting welcomes the SAS charter for England (developed jointly by BMA, Academy of Medical Royal Colleges, Health Education England, and NHS Employers) and calls upon all employers in England to implement this in a timely manner. (2015)
2182.	That this Meeting believes that SAS doctors undertake a significant proportion of clinical care in the NHS and that their professional development is vital in delivering high quality patient care. It therefore urges Health Education England (HEE) and the Local Education and Training Boards (LETB) to:- i) guarantee that the funding for SAS development continues; ii) ensure that this fund is ring-fenced so as to assist with long-term planning. (2014)
2183.	That this Meeting exhorts the BMA to support professional accountability, patient safety, revalidation and job satisfaction by:- i) seeking effective data coding systems that attribute clinical activity to clinicians who perform this activity; ii) deploring the target-driven culture in favour of patient-focused outcome measures;

	<p>iii) empowering doctors to raise concerns in the interests of our patients, without institutional pressures preventing them from doing so.</p> <p>(2014)</p>
2184.	<p>That this Meeting calls on UK governments to permit existing Associate Specialists to retain their terms and conditions of service and salary scale when transferring to posts with new and existing employers.</p> <p>(2014)</p>
2185.	<p>That this Meeting is deeply concerned that the educational fund for SAS doctors allocated by Department of Health for their career development is being cut in several places by LETB, especially at a time when doctors are expected to be revalidated.</p> <p>(2014)</p>
2186.	<p>That this Meeting is appalled that the SAS career development funding has been withdrawn from trusts within one region in England and calls on Health Education England to ensure that equitable funding is maintained across all of the English regions.</p> <p>(2013)</p>
2187.	<p>That this Meeting calls on the BMA to:-</p> <ul style="list-style-type: none"> i) condemn the widespread practice of targeting SAS doctors as soft-targets for redundancy to achieve cost savings in any reconfiguration exercise; ii) reiterate the need for employers to work with BMA to help deliver any desired savings without having to resort to any redundancies; iii) ensure that where redundancies are inevitable, they should be arrived at after a rigorous, fair and equitable process which considers the whole workforce including managers. <p>(2013)</p>
2188.	<p>That this Meeting is concerned that insufficient SPA time is being granted to enable SAS grade staff to undertake the necessary activities required for revalidation, and calls on employers to ensure sufficient SPA time is included in job plans.</p> <p>(2013)</p>
2189.	<p>That this Meeting believes that, despite the current financial situation and the continuing threat to Deanery structures:-</p> <ul style="list-style-type: none"> i) current provision of SAS career development funding should be maintained to enable career progression; ii) SAS career development funding should be provided across the UK, and calls on the Northern Ireland administration to provide comparable funds to bring it in line with the other UK nations. <p>(2012)</p>
2190.	<p>That this Meeting asks the BMA to actively negotiate with employers through the Joint Negotiating Committee (SAS) and local negotiating committees to also provide SAS doctors with two days additional leave following seven years of service.</p> <p>(2012)</p>
2191.	<p>That this Meeting urges health service employers to recognise that professional development and SPA time are vital to good patient care and the future of the NHS and therefore calls upon NHS employers to recommend that employers should:-</p> <ul style="list-style-type: none"> i) not see SAS doctors as a soft target in times of financial difficulty; ii) provide sufficient SPA allocation for SAS doctors, with a minimum of 2, to fulfil requirements of revalidation and career progression; iii) not seek to further reduce the number of SPA allocations. <p>(2011)</p>

2192.	That this Meeting believes that, despite the current financial situation and the potential threat to Deanery structures:- <ul style="list-style-type: none"> i) current provision of SAS career development funding should be maintained; ii) SAS career development funding should be provided across the UK and calls on the government to fund this. (2011)
2193.	That this Meeting calls upon the Health Departments to instruct all employers to recognise that the CPD and revalidation requirements of SAS doctors are identical to those of other doctors, and to provide sufficient SPA allocation within job plans to meet those needs. (2010)
2194.	That this Meeting deplores the delay in the implementation of the new SAS contract and calls upon the BMA to do all it can to expedite implementation. (2010)
2195.	That this Meeting regrets the painfully slow implementation of the nationally agreed SAS contract in several trusts in England and requests the BMA to put pressure on NHS Employers to persuade the trusts concerned to expedite their negotiations towards implementation. (2010)
2196.	That this Meeting calls on the government to deliver on the promises made in Choice and Opportunity by instructing NHS employers to ensure that SAS doctors do not become de-skilled through limited areas of work by ensuring that they are offered balanced job plans with sufficient variety and CPD opportunity to enable them to develop throughout their careers. (2009)
2197.	That this Meeting applauds the financial grant to the English regions for the career development of SAS doctors and demands that: <ul style="list-style-type: none"> (i) this funding should be used strictly for the career development of SAS grade doctors and dentists including those employed in the higher education sector; (ii) this funding should be separate from study leave funding; (iii) all funding must be properly accounted for by an external independent body; (iv) if the money is not being used appropriately this outcome should be referred to the appropriate body for investigation; (v) this funding should be extended to the other UK nations. (2009)
2198.	That this Meeting demands that completion of the implementation of the new SAS contracts should be expedited and urges Health Departments to remind employers of their obligations. (2009)
2199.	That this Meeting regrets the complexity of the transfer process to the new SAS contract which is hampering applications. (2009)
2200.	That this Meeting calls upon BMA Council to ensure that employers provide adequate support and resources for SAS doctors in the form of secretarial support, office space and computer access. These are necessary in order that SAS doctors can: <ul style="list-style-type: none"> (i) provide the best clinical care; (ii) progress through the various stages and thresholds of their new contract; (iii) revalidate. (2009)

2201.	That this Meeting applauds the initiative of postgraduate deaneries and individual employers who have appointed associate deans and postgraduate tutors with the remit to assist the continuing development of SAS doctors and recommends that this good practice be adopted throughout the NHS. Appointment of SAS tutors should: (i) by open competition following advert for the post; (ii) preferably be from the SAS grade; (iii) be monitored in terms of numbers appointed, and the grade of post-holder. (2009)
2202.	That this Meeting calls upon the BMA to: (i) closely monitor the implementation of the new SAS contract, including the number of doctors moving on to the new contract, the number of doctors regrading to associate specialist in the window of opportunity, and the identification of employing authorities that fail to implement the new SAS contract in accordance with the guidance given; (ii) monitor the terms and conditions of service of those SAS doctors who have opted not to go onto the new SAS contract and ensure that the trusts continue the optional/discretionary points systems; (iii) lobby and put pressure on those trusts who have not invited SAS doctors to apply for optional/discretionary points to accept retrospective applications. (2008)
2203.	That this Meeting calls on the BMA to promote the SAS grades as a positive career choice and to work to achieve further improvements to TCS via the implementation process, ensuring opportunities for career progression. (2008)
2204.	That this Meeting believes that the closure of associate specialist grade, which was imposed on the SASC negotiators by the NHS Employers has been a big factor in the disappointment felt by many SASC doctors and dentists about this new contract. (2008)
2205.	That this Meeting is concerned about the number of SAS and non-standard grade doctors that are not members of the BMA and requests the BMA to hold a recruitment drive aimed at these doctors. Members should also promote recruitment of colleagues. (2008)
2206.	That this Meeting calls upon the Association to actively address the poor BMA membership proportion amongst SAS doctors looking not only at recruitment within this group but more importantly recruitment amongst these future SAS doctors earlier in their career. (2006)
2207.	That this Meeting congratulates the BMA on publicly acknowledging the skill and expertise of staff and associate specialist doctors in the recent dossier "Hidden Heroes", and calls on the BMA to continue to highlight the essential role played by this grade of doctor. (2006)
2208.	That all trusts establish Staff and Associate Specialist charters to ensure minimum working conditions. (2005)
2209.	That this Meeting believes that overseas consultant recruitment should be stopped and suitable SAS doctors should be given access to take up consultant jobs. (2004)

2210.	That this Meeting opposes the appointment of doctors to non-standard grades and believes this practice should cease. (2004)
2211.	That this Meeting believes that SAS doctors are being bullied by consultants and managers on a day to day basis. This practice should be investigated by the BMA. (2004)
2212.	That this Meeting believes that it should be possible to achieve a specialist status while remaining in the SAS grades. (2004)
2213.	That this Meeting recommends that the clinical experience of doctors working in NCCG posts in a specialty should be taken into consideration in the evaluation of their eligibility for short listing for higher training posts in that specialty, thereby allowing them the opportunity for career progression. (2002)
2214.	That this Meeting believes that before attempting to recruit doctors from overseas, priority should be given to facilitating those doctors already practising in the UK to achieve training and qualifications to allow them to be eligible for the specialist register. (2002)
2215.	That this Meeting condemns the profligate expansion in numbers of non-standard posts and calls on the Departments of Health to ensure that all non-consultant career grade posts established are of high quality and conform to recognised and agreed terms and conditions of service. (2002)
2216.	That this Meeting urges attention to the plight of doctors employed by trusts in non-standard grades. The abuses prominently include: (i) low basic salary; (ii) non-superannuable ADHs; (iii) excessive extra hours of duty on call; (iv) lack of security of tenure; (v) absence of a career structure; (vi) limited further training opportunities. We urge that their skills, dedication and overall contribution to patient care and the NHS be recognised by transfer of their contracts onto the standard grades recognised by the BMA and Health Departments. (2001)
	TERMS AND CONDITIONS OF SERVICE
2217.	That this meeting believes that contracts for doctors should reflect the following principles:- i) contracts should ensure a satisfactory work-life balance, safety for patients and be sufficiently attractive to aid medical recruitment and retention; ii) on-call requirements should take account of the risks of sleep deprivation and the need for safe practice; iii) contractual clauses limiting the freedom of speech of individual doctors are unacceptable; iv) all training is work and should be included in the work schedule; v) doctors should have autonomy over the use of personal study leave allocations. (2016)
2218.	That this Meeting believes that ensuring an equitable distribution of high-quality clinical staff is one of the great strengths of a National Health Service and that any reforms to health

	services should include robust safeguards to prevent employers from dismantling national terms and conditions of service to the detriment of consistent, high quality patient care. (2011 Special Representative Meeting)
2219.	That this Meeting deplores the government's negative attitude towards doctors and its approach to negotiations and discussion with a longstanding and responsible profession. (2008)
2220.	That this Meeting condemns delays in the issuing of accurate employment contracts to doctors and should work to ensure that, unless there are exceptional circumstances, these are always issued to doctors before they take up post. (2008)
2221.	That this Meeting believes that any moves by trusts to use foundation trust status to alter nationally agreed terms and conditions of service at a local level should be opposed with the full weight of the BMA. (2006)
2222.	That this Meeting urges the Government to bring travel and subsistence allowances for NHS medical and dental staff up to the present economic rate, thereby ending the subsidising of the NHS by its employees. (2000)
2223.	That this Meeting supports the maintenance of training grade contracts within the post-graduate education system rather than devolving to trusts. (1995)
2224.	That this Meeting reminds junior doctors, their senior colleagues and employing authorities that a consultant signature is not a legal pre-requisite for the payment of retrospective claims for payment for extra contractual work. (1994)
2225.	<u>Local Negotiating Committees</u> That this Meeting urges that the local negotiating committee should be recognised by all NHS trusts and that there should not be single table bargaining. (1994)
	TRADE UNION CONGRESS
2226.	That the British Medical Association should not seek affiliation to the Trade Union Congress. (1977)
	VACCINATION
2227.	That this meeting believes the HPV vaccination should be offered to all school age children of both sexes and should be administered at Primary school to be more effective. (2018)
2228.	That this Meeting supports universal Hepatitis B vaccination, in line with WHO policy. (2010)
2229.	That this Meeting believes that with regard to the vaccine against the Human Papilloma Virus:

	<p>(i) UK governments have been short-sighted in providing products which only protect against cervical cancer and have missed an opportunity to address genital warts, the most common viral sexually transmitted disease;</p> <p>(ii) the vaccine should be made available to boys as well as girls;</p> <p>(iii) the haphazard and piecemeal implementation of the vaccination programme was a scandalous missed opportunity to improve the health of young women in the UK.</p> <p>(2009)</p>
2230.	<p>That this Meeting believes that in respect of vaccine programmes, once the timetable for delivery has been decided and publicised, this should not be changed without good clinical reason.</p> <p>(2009)</p>
2231.	<p>That this Meeting believes that any timetable for the introduction and delivery of a vaccination programme must be decided on clinical grounds.</p> <p>(2009)</p>
2232.	<p>This Meeting:</p> <p>(i) is dismayed at the recent decision by the health departments indicating their preference for the bivalent HPV vaccine rather than the quadrivalent equivalent;</p> <p>(ii) calls on the BMA to lobby the health departments to reverse this decision immediately.</p> <p>(2008)</p>
2233.	<p>That this Meeting believes that the media, by way of ill informed and biased reporting, have been responsible for the decrease in uptake of the MMR vaccine in the UK which has resulted in the re-emergence of these diseases within the community causing increased morbidity and mortality for our patients and calls on all media to:</p> <p>(i) mount a campaign to extol the values of vaccination to try and reverse the detrimental effect on public health that they have been responsible for;</p> <p>(ii) to learn from their mistakes in future and ensure that they responsibly report all health issues to ensure that the public health of the nation is not adversely affected by its media and further calls on the BMA to lobby the relevant bodies to direct the media on this issue.</p> <p>(2006)</p>
2234.	<p>That this Meeting strongly believes that all children in the United Kingdom should be protected from tuberculosis by immunisation.</p> <p>(2001)</p>
	VIOLENCE
2235.	<p>That this Meeting calls upon the NHS to recognise harassment of staff from patients and/or their relatives as a form of bullying and provide appropriate support for staff experiencing it, and that assaults on NHS staff should attract equal consequences with assaults on law enforcement officers.</p> <p>(2003)</p>
2236.	<p>That this Meeting deplores the failure of most primary care organisations to make adequate arrangements for the treatment of violent patients in a safe environment.</p> <p>(2003)</p>
2237.	<p>That this Meeting believes that in the light of increasing threats to medical and nursing staff, trusts and primary care organisations must ensure the provision of appropriate security for staff.</p> <p>(2002)</p>

2238.	That the continuing violence suffered by staff in A&E departments should be countered by prosecution of offenders. (2002)
2239.	That this Representative Body demands that the Government and the NHS must address the problem of increasing violence directed against health service staff. We call for: <ul style="list-style-type: none"> (i) a public education campaign, funded by the Health Departments; (ii) NHS trusts to perform an effective risk assessment of potential violent areas, before acting to improve any identified areas of risk; (iii) NHS trusts to support members of their staff in bringing private prosecutions against perpetrators of workplace violence, if the relevant legal authority decides not to pursue a case; (iv) punitive measures for offenders; (v) assaults on hospital staff to be treated by the judicial system in the same way as assaults on the police. (2001)
2240.	That in view of the Government campaign of zero tolerance which aimed to reduce incidents of physical and verbal abuse of doctors and NHS staff, this Meeting urges the NHS management to pursue legal action against offenders and provide the necessary funding to protect the staff against that. (2000)
2241.	That this Meeting calls upon the NHS Executive to ensure that all trusts and health authorities/boards have adequate policies and procedures to: <ul style="list-style-type: none"> (i) reduce the risk of aggression and violence against staff; (ii) deal with it appropriately when it occurs; (iii) provide timely treatment and counselling for any affected staff; (iv) provide special secure arrangements to allow persistently violent patients to receive general medical services without danger to GPs or their primary health care teams. (1998)
	WALES
2242.	That this meeting notes with dismay that Welsh Government has stated that it supports GPs on the one hand but demonstrates contempt for them on the other in announcing that GP indemnity is to be funded from the GMS contract, and calls upon the BMA to campaign for formal health economic assessment of the costs of health board managed practices and the value of GP Partnerships. (2019)
2243.	That this meeting following on from the enactment of the Nurse Staffing Levels (Wales) Act 2016, and with particular regard to out of hours staffing of hospital cover, calls on the Welsh Government to take appropriate steps to similarly introduce an agreed safe minimum level of doctor cover to ensure the safety of patients that hospitals must provide. (2018)
2244.	That this meeting recognises the benefits of medical engagement in health systems and calls:- <ul style="list-style-type: none"> i) on BMA Cymru Wales to work with the Welsh Government to ensure all health boards follow the BMA principles for medical engagement with staff including academics; ii) on the Welsh local health boards and NHS trust to demonstrate progress made to develop work plans to address the results from their medical engagement surveys; iii) on the Welsh local health boards and NHS trust to provide regular updates on progress to LNCs.

	(2018)
2245.	<p>That this meeting notes the observations of the OECD in its 2016 report comparing health systems of the four UK nations that:-</p> <ul style="list-style-type: none"> i) Welsh health boards do not have sufficient institutional and technical capabilities and capacities to drive meaningful change; ii) a stronger central guiding hand may be needed. <p>This meeting therefore calls upon the Welsh government to take what steps are necessary to provide such a central guiding role, thereby ensuring that health boards and NHS trusts are subject to greater direction, scrutiny and accountability so they are clearer and better able to deliver what is expected of them.</p> <p>(2017)</p>
2246.	<p>That this meeting is concerned about the unfilled consultant and GP posts and gaps in junior doctor rotas particularly in North Wales due to the recruitment crisis in NHS WALES and calls upon BMA CYMRU WALES to urge the Welsh government and the Wales Deanery to take active steps to rectify the situation.</p> <p>(2016)</p>
2247.	<p>That this meeting:-</p> <ul style="list-style-type: none"> i) recognises the lack of fairness in the prescribing of drugs for the treatment of erectile dysfunction in Wales; ii) regrets that sufferers of this condition in Wales do not receive NHS drug therapy unless they have specific diagnostic conditions; iii) deplores the situation where sufferers of the condition receive treatment based on the cause and not the condition itself; iv) calls for the Welsh government to enable NHS prescriptions of these drugs to be available to all sufferers of the condition regardless of cause. <p>(2016)</p>
2248.	<p>That this meeting calls on Welsh government to make pressure sores a condition notifiable to Public Health Wales who are competent to map the epidemiology of such conditions and provide an alert to places of inadequate care of patients.</p> <p>(2015)</p>
2249.	<p>That this Meeting conveys its great concern regarding the continuing recruitment crisis in Wales across the board in primary and secondary care.</p> <p>(2014)</p>
2250.	<p>That this Meeting calls upon Welsh government, Health Boards and the medical profession as a whole to recognise and value the pivotal role of SAS doctors in NHS Wales and to help them develop and formalise their position in the planning and delivery of novel patterns of care in a changing NHS in Wales, with or without forms of credentialing and assistance with training and achieving CESR in creating a sustainable medical work force for Wales.</p> <p>(2014)</p>
2251.	<p>That this Meeting calls on the Wales deanery to investigate as an urgency the reasons for the shortfall in number of applicants to junior doctor posts in Wales in general and north Wales in particular and to look at ways of making these posts attractive to applicants.</p> <p>(2013)</p>
2252.	<p>That this Meeting demands that the BMA Cymru tell the Welsh government that blocking study leave applications for hospital doctors in the final quarter of the financial year is unacceptable and will inevitably result in members having difficulty in their continuing professional development and hence their revalidation.</p> <p>(2013)</p>

2253.	That this Meeting urges the Welsh Government to act quickly to improve the levels of literacy and numeracy in Wales to similar levels enjoyed by the other UK nations. Education can be a major determinant of social wellbeing and health and thus we are dismayed at the poor levels of educational attainment in Wales and its implications for the health of the nation. (2012)
2254.	That this Meeting commends the policy adopted in Wales of the abolition of the purchaser provider split, and a return to planning healthcare as an integrated whole. (2011)
2255.	That this Meeting:- <ul style="list-style-type: none"> i) believes that forensic medical services in Wales would best be provided on a collaborative and all-Wales basis; ii) supports the integration of forensic medical services into the Welsh NHS; iii) supports the deployment of only experienced, optimally trained doctors who have detailed knowledge of local NHS services in the provision of forensic medical services across Wales; iv) calls on Police Authorities in Wales to resist the trend to outsource police forensic medical services to the private sector, and to work collaboratively in providing a NHS-based police forensic medical service on a national all-Wales basis. (2011)
2256.	That this Meeting regrets the removal of many regional and national specialist services in Wales from national commissioning and their return to local health boards thus reintroducing the very real threat of the 'postcode lottery' and threatening the provision of low volume, high cost and emerging treatments. (2010)
2257.	That this Meeting congratulates the Welsh Assembly Government on its ongoing commitment to the development of IM&T in Wales that: <ul style="list-style-type: none"> (i) ensures that it is fit for purpose for the NHS in Wales; (ii) ensures that the NHS IM&T in Wales will 'join up'; (iii) has strong clinician involvement at all stages of development; (iv) has avoided most of the pitfalls that have been seen in the approach to IM&T in England. (2009)
2258.	That this Meeting supports the principle of structural change within NHS Wales and suggests that any change should: <ul style="list-style-type: none"> (i) ensure that changes made to structures and organisations are determined by the roles that they will play; (ii) recognise the important balance between preventative medicine and the treatment of those already ill; (iii) ensure that changes made are supported by evidence wherever possible; (iv) ensure that the views of professionals are influential in the design of change; (v) keep the needs of the patient at the forefront of policy. (2008)
2259.	That this Meeting calls on the Welsh Assembly Government to ensure that the delivery of public health services remains in the NHS in Wales and continue to work in partnership with local authorities at the local level. (2008)
2260.	That this Meeting supports the Welsh Assembly government policy of using predominantly Welsh NHS resources to treat the people of Wales and not pursue the path of commercialisation and fragmentation of healthcare as in England.

	(2007)
2261.	That this Meeting welcomes the initiative taken by BMA Cymru Wales in producing its report on Prison Health Services in Wales and looks forward to the implementation of its recommendations, with the aim of putting the prison health services in Wales into the lead in the UK and requests the BMA to undertake a similar review and produce recommendations to improve health care for prisoners in the remainder of the UK. (2007)
2262.	That this Meeting believes the Welsh Assembly government should set-up a fair funding system for medical students studying in Wales which tackles their currently high levels of debt, and addresses the current recruitment and retention problems of NHS Wales. It further calls on the BMA in London to support the WMSA fully to achieve this in Wales. (2004)
2263.	That this Meeting recognises that BMA Wales needs extra funding to keep pace with the development of devolution. (2003)