



Junior Doctor's Pay

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Juvenile Tactics & Unprofessional Politics are Destroying Public Confidence

The Government's standoff with Junior Doctors is intensifying and threatening a Winter of Discontent within the Health Service. Before irreparable harm is done to the medical profession and the record of the Conservative Government we must all see this for what it is and deal with it accordingly. This crisis is about a pay dispute. Doctors are both professionals and employees and the favourable image and goodwill of the public that the profession enjoys, is being leveraged for financial gain for a privileged group of doctors, and the advancement of the political careers of a vanishingly small number of them. Rival camps are briefing the press before talks have concluded.

This must stop now.

To see them dress up in their uniform of employment, not profession, and take to the streets, breaks my heart as a fellow Doctor. Using their knowledge and reputation for personal gain rather than the welfare of the public is grossly unprofessional. There is no basis for it regardless of how the Department of Health has handled this pay dispute so far. To find solutions to this we must understand the very peculiar arrangement of the Junior Doctor contract.

They have an average salary pension scheme, a basic salary, and a large overtime component which is formal training free and pension free, known as the 'job's banding'. A Doctor on £50,000 may only be pensioned on the first £30,000 of salary. This suits Junior Doctors as it allows more disposable cash as young adults. It means they pay less into their pension early on and reflects the time value of money to the young middle class. One of the criticisms I have heard is that Doctors will be worse off through higher pension payments, even though in the long term this lifts the value of their pension.

Junior Doctors are professionals, expected to act with independence of practice within their scope of training, under supervision of a Consultant. They have a duty to put the patient first, even as employees of the state, they represent patients' interests, not managers. Being professionals they accept this duty without self-aggrandisement, it is unprofessional to use the reputation they have through this precious duty to advance themselves. To do so would be to exploit their patients and betray their trust in being impartial.

The worst comments I have heard from the BMA camp is that this contract will affect public safety. I find this charge singularly revolting. I have seen no evidence that cutting pay affects safety. It hurts, it angers, but it is not unsafe. Jeremy Hunt has used weekend mortality figures to justify a 7 day working week for Doctors though has not

said those excess deaths are a sole consequence of hospital staffing. There are some specialities whose shifts require a sensible approach to planning breaks, but this is not an insurmountable problem.

I have issues around 7 day working for practicality sake but some weekend practices leave much to be desired. I have seen wards cleared of elderly patients when a chief executive orders in Consultants to review those suitable for discharge home. Not only does this help with bed blocking and hence improved A&E treatment times, but it also gives patients their dignity back. Why should anyone stew on a ward and be delayed from going home because of inconvenience?

While not every case needs to be seen urgently in primary care, some do. Winter admissions to hospital are characterised by an increase in respiratory problems, most other illnesses are not so dependent on the weather. 7 day primary care, focusing on preventing admissions for pneumonia and other infections by seeing those cases early, would save many lives.

Perhaps the worst working practice is the one we see as unavoidable: Black August. During the first week of the working year, death rates in hospitals soar as Junior Doctors start working for the first time. Every grade of Junior from F1 (rookies) to Registrars (consultants-to-be) all rotate to a new placement on the same day. This is purely for convenience of Deaneries and Human Resource managers. It just happens to kill people.

A single pay-off to Registrars to keep them in their post for two weeks longer doing very simple tasks would force annual rotas to be two weeks out of sync with F1s forever. The last two weeks of a Registrar's career before becoming a Consultant would be that much less glamorous and lives would be saved and F1 Doctors would not come home crying in shame and fear of failing their patients. Is this being proposed by Junior Doctors? No, and we must really demand, why not?

We work for a tax funded monopoly employer and provider of in-patient care, accountable to the public, with a duty to provide the maximum care for the minimum cost. We simply have to be employed by the state unless we propose a means of privatising clinical training (not necessarily a bad idea). To protest that the Government will impose a contract whether we negotiate or not is asinine: of course they will! The buck stops with the Government to provide health care. No one is forcing any medic to be employed in the UK.

Doctors have long enjoyed all the trappings of 'producer capture'. Consultants are near impossible to make redundant and their numbers are kept deliberately low by a training system that fixes the number of training places based on the funding they receive. This translates into salaries higher than EU comparisons, a reputation for poor behaviour with impunity which is now gladly waning, and of course never having to find work. A comparison of maximum and minimum salaries across the EU for all Doctors gives a hint as to the premium gained from a limited supply of specialists; the spread between the two figures is considerably wider than for Germany and France

It doesn't matter how poor one's reputation is as a NHS Consultant, the patients and paycheques will keep rolling in as long as real safety concerns aren't raised. In short, all the benefits of a modestly successful business without the pressure or the overheads (all NHS provided). A safe number and one ferociously protected.

"Trainees involved in this dispute benefit massively from the capping of training places. It is part of why they now have so much leverage."

The real nub of the current dispute is about pay, not professional standing or scope of practice. Both the latter were seriously limited by the last Labour Government, and during the MTAS training regime the BMA handling of it was so bad, a rival organisation, Remedy UK, was set up by grassroots Doctors. I have a soft spot for

Remedy, the job scene was so chaotic back then that the only place I found the job I wanted and needed to start my career was on their website, all done through volunteerism.

Pay plummeted after the imposition of the EWTD, bandings were slashed, but because they felt that they could do nothing about EU law, Junior Doctors simply accepted this. They were relatively well paid and now they had even more social time and less on-calls to do.

What is not recognised publicly is that Junior Doctors are apprentices and that training costs money; a lot of it. 60% of the NHS training budget is spent on 12% of staff – Doctors. That amounts to three billion pounds a year, yet you will never hear protests that medics leaving the UK are ripping hundreds of millions of pounds out of the NHS every year. Australia is littered with Doctors who claim to have passionately fought for the NHS all the way to the departure lounge, few ever return. It is not opposed for a reason. The leverage the medical profession enjoys is immense.

“Treat us nicely or we’ll take your training and run with it, crashing your health service and bringing down your health minister”

Reads well doesn't it? Very caring and understanding. Putting everyone before themselves. This is such a shame because the current pay proposal has many flaws. It uses a 'one size fits all' contract to do with professionals that varies massively in how they are paid. No one is going to lose 30% of their salary, but cuts to banding and unsocial hours punish some trainees far worse than others. The biggest cuts in salary over the long term come from the shifting of paying trainees based on their seniority to payment based on their level of competence and provision. This will cut increases to salary over the training period though this is common throughout the NHS and indeed wider working life. Who else in this world now expects their salary to rise just

for being around? This concept is so antiquated it may surprise many reading this that it continues at all in healthcare.

No speciality loses out quite like anaesthetics. The BMA chairman Mark Porter just so happens to be an anaesthetist which may not have helped the matter. It would be far better to work with both the BMA and Royal Colleges to offer the whole range of pay models proposed by the DDRB and allow specialities to choose the one that best suits their trainees' particular needs.

Jeremy Hunt has not misled anyone over proposed changes to Junior Doctors' contracts but I think rather he has been very selectively briefed by civil servants desperate to balance the books.

Proposals

I propose several changes to the contract proposals and to how this dispute is being handled by the Government to move matters forward in a far more constructive manner. The recommendations are not shy in calling for sanctions against behaviour which is unprofessional and disruptive to patient care when this could be easily avoided.

1. Make clear to the public that Junior Doctors salaries will no longer rise with seniority but based on what they can deliver, bearing in mind Junior Doctors are apprentices. This is a choice to control future wage costs.
2. Recognise that increasing the basic salary while cutting banding means Doctors pay more early on in their student loan repayments and pension contributions. Allow all new trainees to reduce or suspend NHS pension payments during training and “buy back years” as Consultants.
3. No imposition of a new contract until there has been arbitration through ACAS. This will give confidence to the BMA representatives returning to talks without fear of forced capitulation. Running commentary on negotiations by contracting parties must stop.
4. Distinguish between Doctors as professionals and as employees. Be firm in banning healthcare workers protesting in uniform and challenge assertions made that the contract proposed is unsafe. This is a very serious charge and the public deserve the truth. There is no excuse for pushing talks to the wire and then calling a strike within days when it is clear huge sums of money are now being consumed by hiring locums which may or may not be needed.

5. Lift the cap on speciality training places. Replace training places with scholarships based on achievement and means to pay. Convert Deaneries into Consultant led chambers offering training places on the ability to train and be trained, not Government funding. Doctors who do not achieve a scholarship should be allowed loans to purchase a pupillage through speciality training. Long term job security is highly prized by Junior Doctors and this should be maximised while more trainee places breaks the ‘producer capture’ enjoyed by Consultants today.
6. Build financial clawbacks into the training contract so Doctors that emigrate or choose to work part time after training return a share of their training costs to the NHS. These clawbacks can then be used to improve the basic salary offer to Junior Doctors, with the prospect of a return to pay progression based on experience.
7. Trainees who strike during their training hours should forfeit their National Training Number. This is the harshest recommendation but also the fairest. Many Doctors have failed to get on the training ladder and now watch as those who have, busily use this shortage of trainees to extort concessions from the Government. In a free and open market for training this extortion simply could not happen.
8. A Saturday morning service dedicated for urgent clerical work would ensure prescription cards were updated, medications for patients to take home were arranged and planned discharges confirmed on ward round. This “paper round” dfverf would free up oncall staff for essential clinical work and could be paid at basic rate while protecting the oncall doctors’ higher rate of pay.
9. Breakdown of negotiations involving state monopsonies such as the employment of junior doctors should trigger a parliamentary debate with attempts to arbitrate by Parliament before industrial action is taken.

The government has more than its reputation to salvage from this standoff. The country has decided it wants the state to have a monopoly on providing doctor training and medical cover. For as long this duty falls squarely on the government's shoulders it has every right and every duty to stand its ground. Fair breaks where safety is paramount is a must. So too is a fair contract based on the independent DDRB's recommendations but without the dogmatic application of a single deal for every speciality.

Based on estimates of excess deaths from weekend of around 6000 a year, a simple extrapolation to consider weekdays with emergency cover provided as equivalent to weekends estimates around 60 excess days will be lost to industrial action. Industrial action by doctors is exceedingly rare and the population has aged and hospital throughput has increased over the last forty years since the last strike. Deaths recorded by registrars should be highlighted to the coroners' officers if they followed an inpatient stay during the period of industrial action. This along with hospital mortality data collected routinely will give a more accurate representation of excess deaths caused by the current standoff.

A good financial settlement in return for clawing back the costs of training from those emigrating and a golden handcuffs requiring trainees to work a minimum term as a consultant, perhaps in hard to recruit regions, before leaving the profession is a fair price and an honest bargain the government would do well to drive for all our sakes. We need better doctors and better numbers of them. Better pay will have to wait.

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