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Junior doctors: how can we win?

By Pete Campbell, BMA junior doctors' committee (personal capacity)

On 6-7 April junior doctors will take 48 hours of emergency-care-only action; and on 26-27 April there will be a full walk-out of junior doctors between 8am and 5pm.

So far hospitals have adapted very quickly to junior doctors' strikes. They have prioritised elective work over discharges, and kept elective procedures going. The impact has mainly been via "bed-blocking" and increased pressure in A&E.

The full walk-out on 26-27 April will mean that consultants and "Staff and Associate Specialist" (SAS) doctors have to cover Accident and Emergency Departments and hold the on-call ward bleeps which junior doctors have been carrying. This will be a massive disruption for hospital management. It requires a lot of support from the other doctors to provide the emergency cover, and it is hospital bosses' job to ensure that is possible: the junior doctors have given far in excess of the notice required.

A possibility for future escalation of the junior doctors' action is to extend full walk-outs into all the hours considered plain time by the new contract, including evenings and Saturdays.

The idea of working with other trade unions seems like common sense to junior doctors, but challenges entrenched and traditional attitudes in the BMA.

To get action like:

* A call for a joint BMA-TUC demonstration to defend the NHS
* The BMA joining the TUC
* Co-ordinating strikes with other workers (for example teachers)

we will have to build a groundswell of opinion within the BMA.

That widening-out is logical. We should also work to bring the Labour Party behind the dispute. So far the Labour Party leadership has taken a cautiously supportive stance, but still treats it as a narrowly industrial dispute and and not part of a wider battle to save the NHS.

However, the junior doctors' dispute needs to advance at its own pace, and not wait for the teachers (for example). The NUT will probably not strike until 6 July, and then after that not until October.

The junior doctors' ballot also gave a mandate for industrial action short of strikes, and that has not been used so far. Such action is almost by definition more individualised than strike, and should not replace them, but can complement them.

"Soft" action short of strike could include the BMA asking every junior doctor to explain to each patient why they are taking industrial action. That could be followed up with a leaflet or similar encouraging the patient to contact their MP, etc.

"Harder" action short of strike could mean refusing to fill out some paperwork, particularly concerned with coding and payment-by-results methodology. That would have a large financial impact on trusts, and, if done properly, no impact on patient care. It would require careful planning.

Another possibility is a BMA call for no doctors to take locum shifts. That would bring a significant financial hit for some doctors, and we would need to ensure that the hardship fund is in a robust state.

The imposed contract: not fair, not safe

The Department of Health has published an "Equality Assessment" and a "Family Test" as companion documents to the new contract it wants to impose on junior doctors from August 2016/

These documents have angered many in the medical profession beyond junior doctors. For example, the President of the Royal College of Pathologists said: "We are very concerned by the language in the government's own equality analysis of the contract, which warns that features of the new contract 'impact disproportionately on women'."

The government's contract replaces a simple system ("banding") with a complicated one ("work scheduling").

Our previous contract had payments based on a "banding" given to junior doc-

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tors depending on the proportion of out-of-hours work they were required to do. The new contract replaces that by individualised work scheduling. The government admits that the aim is to save money - "to enable employers to roster doctors when needed across seven days, including evenings and weekends, more affordably". It claims it will reward out-of-hours work "more appropriately". But the new contract increases basic pay and not overall pay. Out-of-hours pay will go down.

The removal of annual pay progression is makes the new contract indirectly discriminatory against women. It will hit those who take maternity leave, less-than-full-time workers, and those who take time out of training - predominantly women.

There are a number of other issues in the contract, particularly around the pay for non-resident on-calls (NROC) when a doctor is at home but is answering phone calls to provide advice, sometimes 20 or 30 times a night.

The government's excuse for a raft of complicated changes is that junior doctors work too-long hours, and sometimes shifts are dangerous. That is true, but the cause is the shortage of staff at all times of the day, combined with an ageing population and the decimation of social care, not the current contract.

Many hospitals already don't have enough junior doctors. This is particularly true in certain areas, such as the North East of England.

Trainees rotate through different specialities during their training. This is particularly important in Accident and Emergency and on medical inpatient hospital wards. Where there is a gap, either the hospital can attempt to find a locum (agency) worker, or they can ask their existing junior doctors to cover the slack by greater out-of-hours commitments.

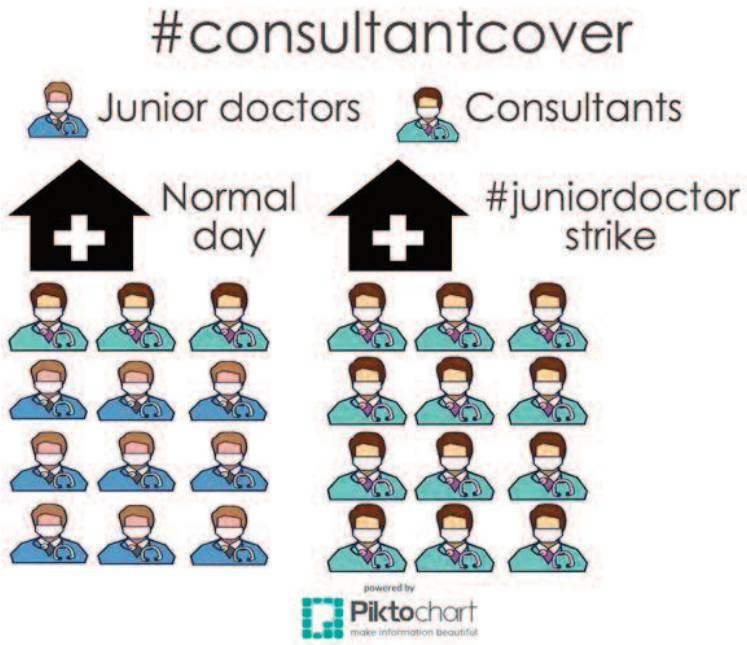
Since 2010 the number of junior doctors continuing to specialist training has been decreasing year on year. In August, when the new contract is due to come in, it is going to be more difficult than ever before to staff our hospitals appropriately with junior doctors.

The contract removes the monitoring system, which included heavy fines for trusts who overworked their juniors, and replaces it with payments based on the individual doctor overworked.

Despite a heavy cut in locum pay contained within the contract, it will still be cheaper under the new contract to overwork a junior doctor and pay the individual fine, rather than find another doctor to work that shift.

Under the new contract, it will be in hospital management's best interest to:

* Strong-arm junior doctors into opting out of the European Working Time Directive.



* Overwork their junior doctors and pay the fine, rather than trying to find more doctors.
* Encourage junior doctors to take last minute internal locum shifts, rather than getting the enhanced rate payment they are entitled to for overworking.

Without collective monitoring, and with individual work scheduling, it will be up to each individual junior doctor to ensure that she or he is paid fairly.

The outcome for patients will be overworked doctors who simultaneously are fighting with hospital management for recognition of the hours they are working.

This contract will be unsafe for patients. We must stop the government imposing it.

• Full details at: tinyurl.com/j6ce84u

Read more about the junior doctors' dispute and the fight to save the NHS on Pete's blog. https://ahealthy-blog.svbtle.com