HDU Submission

Evidence to the Review Body on Doctors' and Dentists' Remuneration 2027/28

Hospital Doctors Union

September 2026

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1 Introduction

1.1 Hospital doctors are clear that a fair settlement on pay is required if the health service is to see an end to industrial action. The 2026/27 DDRB recommendation of a 3.5% award came as a disappointment to the medical profession and represented, at best, a case of "treading water". The DDRB has an opportunity with the 2027/28 pay round to recommend a significant above-inflation award that reverses the historic real-terms erosion of doctors' pay since 2008/09. This would protect the sustainability of the medical workforce and address the ongoing crisis in recruitment and retention.

1.2 The Hospital Doctors Union's (HDU) annual survey, *Hospital Doctors at Work 2026: Building the case for change,* surveyed 769 doctors across the UK. It reveals little or no improvement in doctors' wellbeing or morale in the last 12 months. Almost two-thirds of survey respondents said morale in their workplace was 'low' or 'very low', and six in 10 (60%) said they felt unreasonably stressed more than half the time, up from 57.5% in last year's survey.[1] Just 55% of respondents said they would recommend medicine as a career to others, down from 58% in 2025.[2] This continues an almost year-on-year downward trend since 2021.[3]

1.3 Almost half of respondents to HDU's survey said they were dissatisfied or very dissatisfied with the most recent pay award, and more than six in 10 said restoring doctors' pay to 2008/09 levels was important or very important. When asked what would make the biggest difference to recruitment and retention, respondents most often said higher basic wages.[4] Doctors of all grades have once again sent a clear message that a significant pay award and a roadmap to pay restoration are vital to ending ongoing industrial action.

1.4 Hospital doctors faced unprecedented challenges in 2026. This year saw record levels of demand in accident and emergency (A&E) departments. Soaring temperatures

[1] HDU, Hospital Doctors at Work 2026: Building the case for change, annual survey of hospital doctors (2026)
[2] Ibid
[3] HCSA, Hospital doctors at work: Help build the case for change (2021); HCSA, Hospital doctors at work: Help build the case for change (2023); HCSA, Hospital doctors at work: Help build the case for change (2024); HCSA, Hospital doctors at work: Help build the case for change (2025)
[4] HDU, Hospital Doctors at Work 2026

led to significant spikes in demand across the UK, with hospital staff working in often intolerable conditions in buildings not adapted to the heat. In England, emergency departments (EDs) saw 3.2 million more attendances and major (type 1) A&E departments saw 1.3 million more admissions than in 2010/11 (when the current 4-hour A&E target was introduced). In July, more than 150,000 patients waited more than 12 hours in type 1 EDs, making it the worst July on record for 12-hour waits.[5] These pressures are expected to become the norm for doctors, with summer pressures expected to match winter for surges in demand, creating annual "twin crises".[6]

1.5 In Wales, around one in six patients attending a type 1 ED in June also waited more than 12 hours to be discharged.[7] In Northern Ireland, the Royal College of Emergency Medicine (RCEM) said 2026 ED figures were "the worst they have ever been" and described the state of EDs in Northern Ireland as "utterly horrifying".[8] Scotland also struggled to meet ever-growing demand, with the RCEM highlighting almost 900 excess deaths because of delayed discharges.[9]

1.6 In June, the first data on corridor care was published by NHS England. It revealed that a total of 90,201, or 2,910 patients a day, received care in inappropriate places such as corridors or temporary spaces.[10] NHS Scotland is now considering publishing its own data. On corridor care, HDU's survey paints a stark picture: almost half of respondents reported delivering care in temporary or non-clinical spaces at least sometimes, and three-quarters said it reduced their job satisfaction. On the impact of corridor care, one doctor said: "*The service that I work for has collapsed"*; another said: "*I feel ashamed that I work in such a broken system";* while a further doctor responded: "*I resigned and am retiring early."*[11]

[5] NHS England, A&E Attendances and Emergency Admissions (July 2026)
[6] NHS Alliance, The NHS Alliance response to the latest NHS performance figures (September 2026)
[7] NHS Performance for Welsh Local Health Boards (June 2026)
[8] Royal College of Emergency Medicine (RCEM), 'Utterly horrifying state of Northern Ireland A&Es…' (April 2026)
[9] RCEM, 'Almost 900 excess deaths from long A&E waits in Scotland…' (March 2026)
[10] NHS England, Corridor Care – Urgent and Emergency Care Daily Situation Reports (June 2026)
[11] HDU, Hospital Doctors at Work (2026)

1.7 Since the last DDRB round, the Medical Training (Prioritisation) Act was passed. The Act has made a positive difference to many doctors applying for foundation and specialty training programmes.[12] Phase two of the Medical Training Review is also underway. We await further detail on the regulations of the Medical Training (Prioritisation) Act, especially on the length of NHS experience required for eligibility, as well as the findings of the Training Review. However, we will support all steps that improve the working lives and career opportunities of resident doctors.

1.8 HDU is dismayed that the Long-Term Workforce Plan remains undelivered. The plan is now several months overdue, following its latest delay. Hospital doctors in England are expected to deliver the *10 Year Health Plan*. However, the government has yet to set out how it plans to meet the ever-growing demands faced by hospital doctors. We look forward to the government setting out how it will support the medical workforce to deliver its plans for the health service.

2 Reflections on the previous round

2.1 For the 2026/27 round, HDU put forward a pay claim that sought: *"A good-faith multi-year agreement to restore the value of resident doctor pay through a series of above-inflation annual pay rises and a future commitment to maintain pay at least level with inflation after that. A significant real-terms pay rise for all hospital doctors across the UK, accompanied by a roadmap for reversing pay erosion."*[13]

2.2 The DDRB's recommendation of a 3.5% uplift, therefore, came as a disappointment. In the 12 months up to March 2026 (the end of the financial year), CPIH (Consumer Prices Index including owner-occupiers' housing costs) was 3.4%. Doctors therefore received a real-terms pay rise of around 0.1%. The award did not deliver our ask of a *'significant real-terms pay rise for all doctors'* nor a *'roadmap to reversing pay erosion'* and did little to address the crisis in morale, recruitment, and retention facing the NHS.

[12] Medical Training (Prioritisation) Act (2026)
[13] HCSA, Evidence to the Review Body on Doctors' and Dentists' Remuneration 2026/27 (December 2025)

2.3 HDU welcomes the fact that the timing of this year's round has been brought forward. We are hopeful that future pay awards will be implemented on time before the new financial year, providing certainty for our members and avoiding the delays, need for back pay, and challenges around NHS pension contributions seen in previous rounds.

3 Economic outlook

3.1 UK inflation remains above the Bank of England's 2% target. The CPIH measure of inflation rose by 3.1% in the 12 months up to July 2026, up from 2.8% in June.[14] This is down from 3.6% in December 2025, when HDU last submitted evidence to the DDRB.[15]

3.2 In its 2026 report, the DDRB stated that CPI inflation was forecast to fall close to 2% over 2026-27.[16] The Bank of England's July 2026 Monetary Policy Report, however, forecasts CPI inflation to rise to 3.2% in the final quarter of 2026.[17] Its survey of market participants also showed an expectation of 3.2% in Q4 2026 and 3% in the first quarter of 2027.[18]

3.3 Despite relatively strong earnings growth across the economy as a whole, this has been substantially weaker for hospital doctors. Office for National Statistics (ONS) data for January to March 2026 shows that annual growth in employees' average earnings (including bonuses) was 4.1%.[19] Earnings growth for public sector workers was stronger, with regular pay increasing by 4.8%.[20] The DDRB's own analysis found that average consultant earnings in England increased by just 0.8% in the year to November 2025.[21]

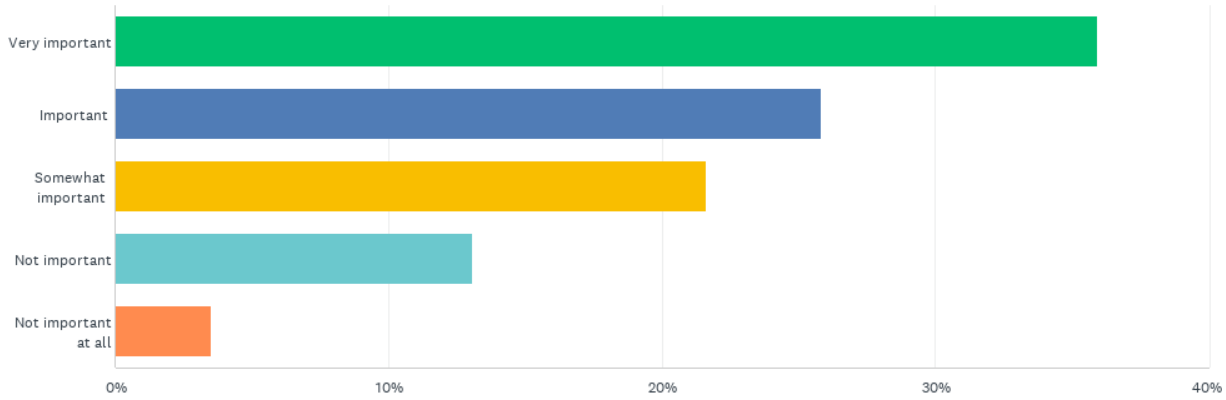
3.4 Rising inflation continues to disproportionately affect resident doctors. Increasing costs in housing, student loan repayments, travel expenses from rotational training, childcare and utilities all have an outsized impact. We ask that the DDRB consider these costs when it makes its decision on the 2027/28 award.

[14] Office for National Statistics (ONS), Consumer price inflation, UK: July 2026 (August 2026)
[15] ONS, Consumer Price Inflation, UK: December 2025 (January 2026)
[16] Review Body on Doctors' and Dentists' Remuneration (DDRB), Fifty-Fourth Report 2026 (March 2026)
[17] Bank of England (BoE), Monetary Policy Report - July 2026 (30 July 2026)
[18] BoE, Market Participants Survey results - July 2026 (31 July 2026)
[19] ONS, Average weekly earnings in Great Britain (May 2026)
[20] ONS, public-sector regular pay growth, January–March 2026 (May 2026)
[21] DDRB, Fifty-Fourth Report (2026)

4 Pay

4.1 Medical pay has experienced sustained erosion over several years. While recent awards have made some progress, last year's 3.5% award did not meaningfully reverse doctors' real-terms losses. When asked how important achieving pay restoration to 2008/09 levels was, 36% of respondents to HDU's survey said it was very important, 26% said it was important, and 22% said it was somewhat important.[22]

Figure 1: How important is achieving pay restoration to 2008/09 levels to you?



4.2 The failure to secure a lasting settlement on pay threatens the sustainability of the medical workforce. The GMC's 2025 barometer survey found that more than 20% of doctors said leaving the UK profession was the career change they were most likely to make, with 15% saying moving abroad was their most likely career change, up from 12% a year earlier.[23]

[22] HDU, Hospital Doctors at Work (2026)
[23] General Medical Council (GMC), The State of Medical Education and Practice in the UK: Workplace Experiences 2026 (August 2026)

4.3 HDU's survey data highlights the scale of the problem facing the health service. Almost a third of respondents said they had made definite plans to leave the NHS, unchanged from last year. Of those planning to leave, four in 10 cited pay erosion, six in 10 cited workplace stress or burnout, and more than half said they did not feel valued in the NHS.[24]

4.4 The ongoing failure to address doctors' pay represents a real and growing threat to the sustainability of the medical workforce. The UK government and devolved administrations' ability to deliver a functioning health service depends on retaining a medical workforce that feels valued. HDU urges the DDRB to recommend a pay award that recognises this.

5 Consultants

5.1 NHS consultants have experienced significant real-terms pay erosion over several years. Analysis from the Nuffield Trust reported that between 2010/11 and 2024/25, consultants' average earnings fell by 10% (measured using CPI), while private sector average earnings grew by at least 3.3% by the same measure over the period.[25] In its 2026/27 report, the DDRB itself showed that, after adjusting for inflation, average earnings for consultants decreased from £111,530 in September 2010 to £93,780 in November 2025, a reduction of 15.9%.[26]

5.2 Consultant pay varies significantly across the UK. A consultant working in England can expect to earn £113,565 in basic pay, rising to £150,569.[27] In Wales, consultants start on £114,099 and can earn up to £166,585, more than £16,000 higher than their counterparts in England.[28] In Scotland, consultants will earn £115,331 and can reach £153,247.[29] Consultants in Northern Ireland remain on the 2025/26 pay scale. We believe that achieving greater balance in consultant salaries across the UK would improve retention, stabilise workforces and reduce the frequency of industrial action.

[24] HDU, Hospital Doctors at Work (2026)
[25] Nuffield Trust, How do NHS staff earnings compare to 15 years ago? (2026)
[26] DDRB, Fifty-Fourth Report (2026)
[27] NHS Employers, Pay and Conditions Circular (M&D) 1/2026
[28] Welsh Government, Pay Circular M&D (April 2026)
[29] Management Steering Group, Consultant Key Documents, NHS Scotland (2026)

5.3 Alongside delivering clinical care, consultants are expected to take on many additional duties. Consultants take on leadership positions, shape clinical pathways, ensure robust clinical governance, mentor multi-disciplinary teams and maintain standards of care. Ensuring consultants receive adequate Supporting Professional Activities (SPA) time is therefore vital. HDU data, however, shows that consultants either do not receive the contractual standard 2.5 SPAs (3 SPAs are recommended for contracts in Wales), or their employers do not recognise the additional duties they perform as SPA time.[30]

5.4 More than half (57%) of respondents to HDU's annual survey reported not being allocated enough SPA time, with 207 respondents sharing examples of work their employer did not recognise. One said, "*Additional roles such as clinical governance and leads are given insufficient SPA allocations for what the job actually involves*"; another said: "*I do not get any SPA time, so everything*"; and a further doctor said: "*It used to be 7.5 DCC, 2.5 SPA for a 10 PA job. Now you get 1 SPA and have to fight for every scrap more (unlikely you can get to 2.5*)." This failure has consequences. Almost 1 in 5 respondents to our survey said that receiving additional SPA time would improve recruitment and retention.[31]

5.5 Changes to awards schemes have further disincentivised consultants from working more or staying in work. The removal of Local Clinical Excellence Awards (LCEAs) and the introduction of National Clinical Impact Awards (NCIA) have resulted in the loss of significant earnings for many senior doctors. Almost half of respondents to our survey who held a clinical impact award said changes to the award system had made them less or significantly less motivated, while fewer than 1% said the changes had increased their motivation.

5.6 When asked to give an example, one doctor said: *"No longer a financial incentive for all the extra unpaid work done".* Another said of the newer NCIA*: "Not really an excellence award, at a significantly lower rate and not pensionable".* A further doctor said:

[30] HDU, Hospital Doctors at Work (2026)
[31] HDU, Hospital Doctors at Work (2026)

"Other than a sense of pride, there is little incentive to go the extra mile in a system that is already under pressure and stressed."[32]

6 SAS doctors

6.1 Specialty, Associate Specialist, and Specialist (SAS) doctors are essential to the functioning of the health service. They work in every specialty and setting and are a vital part of the workforce. Many SAS doctors, however, face barriers to career development, progression and contracts.

6.2 Opportunities for SAS doctors vary significantly across the UK. Scotland and Wales, for example, have established a clear mechanism for SAS doctors looking to progress to the Specialist grade. In its report last year, the DDRB set out the pathway for regrading in Wales and highlighted that the number of Welsh Specialist doctors rose from 37 in May 2023 to 93 in May 2025.[33] NHS England, however, has not implemented a formal regrading mechanism. In March 2026, the government was asked a parliamentary question on whether England would introduce a regrading policy similar to that in Scotland and Wales. Secondary Care Minister Karin Smyth said: *"There are no specific plans to introduce a separate regrading policy similar to those in Scotland or Wales at this time."*[34]

6.3 HDU's latest survey reveals that many SAS doctors have not seen opportunities to progress to senior roles. When asked about their career plans, more than a third (34%) of respondents said they wanted to progress to the Specialist grade. However, more than half (56%) reported a lack of Specialist posts as a barrier, and more than six in 10 (62.5%) cited insufficient professional-development support.[35]

6.4 Issues with contracts also remain a significant challenge for many SAS doctors. The 2021 SAS contract reforms (and the 2022 reforms in Scotland) were intended to address outstanding barriers to progression and deliver more modern contracts with

[32] HDU, Hospital Doctors at Work (2026)
[33] DDRB, Fifty-Fourth Report (2026)
[34] UK Parliament, 'Doctors: Career Development', Written Question 12164 (March 2026)
[35] HDU, Hospital Doctors at Work (2026)

improved terms and conditions.[36] However, five years after the reforms were introduced, respondents to our survey highlight ongoing issues and concerns. One respondent said: *"overall pay is still better on 2008 contract", while* another commented: *"I don't want to lose the protection of the 2008 contract - I don't want to work unsocial hours and not be paid for it"*. On trying to transfer contracts, one doctor said: *"Trust has not done so despite request".* Clearly, these reforms have not meant improved pay or opportunities for many doctors.[37]

6.5 HDU supports the SAS Six reforms set out by the SAS Collective. The measures they recommend would deliver material improvements to the working lives, opportunities and careers of SAS doctors.[38]

7 Resident doctors

7.1 Resident doctors continue to face significant pressures on pay, working conditions and wellbeing. Rotational training often forces them to relocate at short notice or for short placements, creating additional costs and pressures, particularly for those with families. Recent reforms have made some progress, but substantial recruitment and retention challenges remain.

7.2 In its report last year, the DDRB stated that: "*doctors and dentists working in secondary care typically experience very strong in-role pay progression and structured pathways for promotion over their career*".[39] This does not accurately describe the situation facing resident doctors in 2026. Six in 10 residents who responded to our annual survey, for example, said their employer did not prioritise their training.[40] The UK government recently legislated to address the crisis in competition ratios for specialty training, acknowledging that the situation was "totally unacceptable".[41] We ask that this year's report properly acknowledges the challenges facing resident doctors.

[36] NHS Employers, SAS Contract 2021 (2021); NHS Scotland, Specialty Doctor and Specialist Grade Contract (2022)
[37] HDU, Hospital Doctors at Work (2026)
[38] SAS Collective, The SAS Six: Six Actions to Improve the Working Lives and Careers of SAS Doctors
[39] DDRB, Fifty-Fourth Report (2026)
[40] HDU, Hospital Doctors at Work (2026)
[41] Hansard, Medical Training (Prioritisation) Bill (Second Reading)

7.3 Last year NHS England published the 10-point plan to improve resident doctors' lives. The plan required NHS organisations to act across all 10 areas within 12 weeks.[42] Data from NHS England, however, shows that many areas remain unresolved. One area the plan sought to address was payroll errors, aiming to reduce errors by at least 90% by March 2026. NHS England data, however, shows just a 51.5% reduction.[43]

7.4 A respondent to our survey said: "*I have been paid incorrectly for 5 consecutive months following rotation to my current hospital. In 13 years, I have been paid correctly by trusts a fraction of the time. This is not captured in any way, never reported and happens frequently to my colleagues".*[44]

7.5 The plan also established an ambition to address outstanding rota issues. It required trusts to provide residents' work schedules at least eight weeks in advance and rotas no later than six weeks before a rotation. Eleven percent of respondents to our survey said they had missed a major life event in the previous 12 months because they couldn't get leave approved.[45] The 2025 GMC training survey shows that more than a quarter of doctors in training (26%) said rota gaps were not dealt with appropriately.[46]

7.6 More than half (55%) of respondents to our survey reported that they had seen no improvements as a result of the plan to improve resident doctors' lives, while 18% were not aware of the plan. No respondents reported significant improvements. In addition, 50% of respondents in Scotland, Wales and Northern Ireland reported no improvements from initiatives and 50% said they were not aware of initiatives to improve their working lives.[47]

7.7 The final area the DDRB should consider with regard to resident doctors is the ongoing impact of student loans. Residents in 2026 are saddled with high levels of debt

[42] NHS England, 10 Point Plan to Improve Resident Doctors' Working Lives (August 2025)
[43] NHS England, Spring Update: Progress Made on 10 Point Plan to Improve Resident Doctors' Working Lives (April 2026)
[44] HDU, Hospital Doctors at Work (2026)
[45] Ibid
[46] GMC, National Training Survey Results (2025)
[47] HDU, Hospital Doctors at Work (2026)

due to expensive tuition fees and student loan interest. Tuition fees often exceed £9,000, and graduates can leave university with debts of up to £60,000 to £70,000. Doctors in England and Wales with Plan 2 student loans will pay interest rates of up to 6% in 2026/27. Some residents with larger loans do not begin repaying the capital for many years after starting work, paying only the accruing interest.[48]

7.8 These loans effectively function as a graduate tax. Low starting salaries and high interest rates mean they can take decades to repay. The interest on these loans is also tied to RPI inflation, causing the debt to grow faster.[49] The UK government refuses, however, to measure doctors' pay erosion using that same index. This is one of the more egregious injustices facing resident doctors. We reiterate that this must be addressed urgently.

7.9 The 2026 resident-doctor deal in England introduced significant reforms, including to pay structure, nodal points and progression. The government explicitly agreed that the deal was separate from the DDRB process and not a substitute for future awards.[50] HDU expects this commitment to be reflected in the DDRB recommendation for 2027/28.

7.10 Last year, the HDU's resident doctors' committee set out a list of actions to restore dignity to resident doctors and improve attrition rates.[51] We restate our position that these measures, if introduced, would go a long way in improving residents' working lives. The many issues affecting resident doctors set out above are increasingly pushing them to leave the NHS. If the health service is to retain the consultants of the future, it must secure a lasting settlement on pay and truly improve resident doctors' working lives.

8 Locally employed doctors

[48] Student Loans Company (SLC), Student Loans in England (2026); Student Loans in Wales: Financial Year 2025–26
[49] SLC, How Interest is Calculated - Plan 2 (April 2026)
[50] Department of Health and Social Care, *Offer to BMA UK Resident Doctors Committee* (June 2026)
[51] HCSA, Evidence to the Review Body on Doctors' and Dentists' Remuneration 2026/27 (December 2025)

8.1 Locally employed doctors (LEDs) are a vital but often under-recognised part of the medical workforce. LEDs play an increasingly important role but face many unique challenges related to contracts, progression, and recognition.

8.2 HDU is concerned about the growing reliance on LEDs and the variation in the pay, terms, and conditions these doctors receive. Most LEDs perform roles similar to resident doctors in core or specialty training but are often employed on contracts without the same protections as national contracts.[52] This disparity has created concerns about a two-tier resident-doctor workforce. The absence of standardised national contract arrangements for LEDs means they are more vulnerable to local variation in terms and conditions and often experience more precarious employment.

8.3 Three-quarters (75%) of the LEDs who responded to our survey said they would accept a national contract if offered and 16% said they were dissatisfied with their current contract.[53] HDU therefore welcomes that LEDs in England can now apply for a SAS grade post, following the opening of applications to the Eligibility Permanency Framework (EPF).[54] HDU will monitor progress closely. However, this development has the potential to offer enhanced protection and stability for many doctors.

8.4 There is growing concern that the rise in LED posts has been in response to gaps in rotas and increasing vacancies. HDU shares concerns that some employers are hiring LEDs to fill rota gaps as a shortcut due to insufficient national training posts. LEDs employed in trusts with greater pressures often do not receive the same development opportunities as those in national training posts. Three-quarters (75%) of the LEDs that responded to our survey, for example, said they did not feel they receive the same opportunities for training and professional development as other doctors.[55]

8.5 When asked to share their experiences, one locally employed doctor said: "*No career and pay progression after 10 years of clinical and educational experience in the same trust*". Another doctor said: "*They haven't given me a permanent contract yet*", while

[52] BMA, Locally Employed Doctors (LEDs), pay and contracts in England (2026)
[53] HDU, Hospital Doctors at Work (2026)
[54] NHS Employers, SAS Eligibility and Permanency Framework (July 2026)
[55] HDU, Hospital Doctors at Work (2026)

a third said: "*I stopped working full time because I refuse to work that contract, I sacrificed training opportunity to have some autonomy over my time and earn enough to continue as a doctor*".[56] HDU is clear that LEDs should not be used as a cheaper solution to vacancies or a substitute for national training posts.

8.6 The 2026 resident-doctor deal included locally employed doctors for the first time. The deal includes enhanced appraisal arrangements from October 2026 and the promise of a national model contract.[57] This is a significant and welcome development. We reiterate our support for the SAS Collective's recommendations on LEDs[58] and on the need for action to address the systemic issues affecting these doctors.

9 Scotland

9.1 Since the last round, hospital doctors in Scotland have seen some positive developments. Resident doctors agreed a deal that delivered improved pay and commitments on contract reform.[59] In August, the Scottish Government announced it had accepted the DDRB award of 3.5% for the 2026/27 pay round for consultants and SAS doctors.[60] HDU reiterates its stance that more will be needed to address the pay erosion doctors have experienced in Scotland.

9.2 In December 2025, the Scottish Government published the first findings of its *Future Medical Workforce Project*. The project was informed by the views of over 2,000 doctors and highlighted increasing workloads, limited resources, and ongoing challenges with training and progression. It showed that despite increased capacity, bottlenecks in training programmes remain a key issue. The report said that Scotland would need at least 400 new training places by 2033 to meet growing demand.[61]

9.3 The environment in which hospital doctors work in Scotland is also a concern for HDU. The Scottish Government recently stated that over a third of the NHS estate had

[56] HDU, Hospital Doctors at Work (2026)
[57] Department of Health and Social Care, Offer to BMA UK Resident Doctors Committee (June 2026)
[58] SAS Collective, The SAS Six
[59] Scottish Government, Resident Doctors Strike Action Averted (February 2026)
[60] Scottish Government, NHS Pay Awards (August 2026)
[61] Scottish Government, Future Medical Workforce Project: Phase 1 Report (December 2025)

"major defects," and NHS Scotland faced a substantial maintenance backlog estimated at over £1.3 billion.[62] The GMC's 2025 Workforce Report revealed that 73% of Scotland's doctors feel that inadequate resources and staffing negatively impact patient care, and 46% reported witnessing direct risks to patient safety at work, higher than the UK average.[63]

9.4 It is estimated the NHS in Scotland will require 3,500 additional hospital beds by 2040, or the equivalent of a new hospital every 2.5 years to meet growing demand.[64] Plans to restructure the health service in Scotland, therefore, must not lead to service cuts or increase the already significant demands faced by hospital doctors.

9.5 In July, the Scottish Government announced £90 million of additional investment in planned care to improve capacity and reduce waiting lists.[65] This investment is welcome. However, a proper plan for investment in the workforce and infrastructure will be necessary to protect patient safety and avoid the unacceptable workloads faced by hospital doctors in Scotland.

10 Wales

10.1 Despite the Welsh Government agreeing to the principle of pay restoration, doctors' pay in Wales remains below 2008/09 levels.[66] Since the last round, the Welsh Government accepted the 3.5% DDRB recommendation[67] and resident doctors agreed to a deal that included a reformed pay structure and improved terms and conditions.[68] These steps are welcome, but more is needed to restore doctors' pay in Wales.

10.2 Hospital doctors in Wales experienced significant pressures in 2026. In June, the Welsh Government reported that waiting times had increased after 10 months of

[62] Audit Scotland, NHS in Scotland 2025: Finance and Performance (December 2025)
[63] GMC, The State of Medical Education and Practice in the UK: Workplace Experiences 2026 (August 2026)
[64] Our Scottish Future, Scotland's Unsustainable Health Service (December 2023)
[65] Scottish Government, Extra Funding to Reduce Long Waits for Treatment (28 July 2026)
[66] BMA Cymru, Pay Restoration and Jobs for Resident Doctors in Wales (2026)
[67] Welsh Government, Written Statement: Responding to the 54th Doctors and Dentists Review Body (March 2026).
[68] Welsh Government, Written Statement: Resident Doctor and Dentist Contract Reform (December 2025)

progress.[69] This increased demand was also evident in EDs. In June 2026, only around two-thirds of patients attending Welsh emergency departments were admitted, transferred or discharged within four hours, well below the Welsh Government's 95% target.[70] The largest health board, Betsi Cadwaladr, remains under special measures, and reported that the number of never events at the board more than doubled in the last year.[71]

10.3 These conditions are contributing to burnout and growing challenges around retention. The Royal College of Physicians highlighted that 81% of doctors in Wales said NHS staffing was inadequate (compared with 72% across the UK), and 37% reported being unable to cope with their workload at least weekly.[72] Health Education and Improvement Wales (HEIW) showed that average retention in Wales after completing postgraduate medical training was between 75% and 80%, falling to around 60% in some specialties.[73] These challenges are even worse in remote and rural areas. HDU's 2026 survey found that almost eight in 10 (79%) of doctors working in remote and rural areas had witnessed difficulty filling vacancies in the previous 12 months.[74]

10.4 HDU welcomes the progress the Welsh Government has made in resolving longstanding disputes, especially for resident doctors. However, more will be required to resolve the challenges our members in Wales face.

11 Northern Ireland

11.1 Hospital doctors in Northern Ireland continue to work under exceptional pressures. Waiting lists in Northern Ireland are the highest in the UK. In June, the median time spent in a Type 1 emergency department for patients subsequently admitted was

[69] Welsh Government, Action to Bring Down NHS Treatment Waits (June 2026)
[70] Digital Health and Care Wales, Emergency Department Data Set: Attendances and Waiting Times (July 2026)
[71] Welsh Government, Betsi Cadwaladr University Health Board Special Measures (Level 5): Year 3 Progress Report (March 2026)
[72] Royal College of Physicians, The Road to Recovery: An RCP Manifesto for the 2026 Senedd Election (September 2025)
[73] Health Education and Improvement Wales, Public Accountability Meeting Evidence Paper (February 2026)
[74] HDU, Hospital Doctors at Work (2026)

more than 13 hours. At Altnagelvin Hospital, the median wait was over 19 hours from arrival to admission.[75]

11.2 These service pressures are accompanied by significant financial pressures. In August, the Department of Health published details of its 2026/27 Reset and Recovery programme. It sets out how Health and Social Care (HSC) will secure savings of up to 4% of current spending, equivalent to around £350 million.[76] It says it will achieve this through efficiency savings, including vacancy controls, reductions in temporary staffing, and changes to hospital capacity. These reforms are accompanied by a reconfiguration of the hospital network.[77] HDU is concerned that these plans will place additional pressure on hospital doctors, including rota pressure and increased on-call demands as services change.

11.3 The situation for senior doctors in Northern Ireland is made worse by the absence of clinical award schemes. The suspension of these awards has reduced consultants' pay and pensionable income and has removed an important incentive for consultants to stay in work. One doctor who responded to our survey said: *"There have been no such new awards in NI - we feel fourth class doctors in the UK."*[78]

11.4 Recruitment and retention issues are further exacerbated by competition from the Republic of Ireland, where doctors are paid substantially more than in Northern Ireland. Consultants in the RoI can expect to earn €238,221 to €286,151 in basic pay[79], plus on-call allowances, compared with £110,681 to £145,517 for their counterparts in Northern Ireland.[80]

11.5 These issues are driving a recruitment and retention crisis across the health service. The Royal College of Surgeons' Northern Ireland workforce census found that

[75] Department of Health (Northern Ireland), Emergency Care Waiting Time Statistics: April–June 2026 (August 2026)
[76] Department of Health (Northern Ireland), Department of Health Statement on Reset and Recovery Plan (August 2026)
[77] Department of Health (Northern Ireland), Hospitals – Creating a Network for Better Outcomes (October 2024)
[78] HDU, Hospital Doctors at Work (2026)
[79] Health Service Executive, Consolidated Salary Scales (June 2026)
[80] DDRB, Fifty-Fourth Report (2026)

53% of surgeons had considered leaving the workforce, while 91% of those aged 55–64 intended to retire within four years.[81] BMA's Northern Ireland Medical Students Committee also found that 54% of final-year and penultimate-year medical students did not plan to stay and work in Northern Ireland.[82] We call on the Executive to deliver more investment in the workforce, not less, to tackle this crisis.

11.6 Hospital doctors in Northern Ireland increasingly experience burnout and fatigue as they try to maintain services amid cuts and increased pressures. We ask that the DDRB recommend a meaningful pay rise for clinicians in Northern Ireland that recognises the growing challenges and worsening retention crisis.

12 Working conditions

12.1 Corridor care

12.1.1 One of the major developments over the past several years, which has continued into 2026, has been the growing prevalence of corridor care. Almost half (48%) of respondents to our annual survey reported delivering care in a corridor or other temporary or non-clinical settings at least some of the time. Almost a quarter (23%) reported doing so daily or weekly.[83] Corridor care endangers patients and doctors and is increasingly responsible for a growing crisis of moral injury and low morale.

12.1.2 Seventy-five percent of the respondents to our survey who reported delivering corridor care said it reduced their job satisfaction. Almost one in 10 (9%) said they had considered leaving the NHS as a result. Details of the impact of corridor care were shared by 110 doctors. We cannot share every example, but their testimony is devastating. One doctor said: *"Every day is demoralising and makes you feel like a failure. The moral injury is significant"*. Another said: *"I frequently consider leaving the NHS".* One highlighted the impact of corridor care, saying: "*Low morale, high stress, poorer patient*

[81] Royal College of Surgeons of England, Advancing the Surgical Workforce: 2023 UK Surgical Workforce Census Report (2024)
[82] BMA Northern Ireland, Many Medical Students Planning for Careers Outside of Northern Ireland Due to Doctors' Pay and Conditions (May 2025)
[83] HDU, Hospital Doctors at Work (2026)

outcomes, higher clinician burnout, depression amongst medical professionals". Another said: "*The moral injury is appalling".*[84]

12.1.3 This situation is untenable. These testimonies are an indictment and exemplify a long-term failure to properly invest in the health service and its workforce. Corridor care is one of many exceptional challenges hospital doctors face in 2026. The intensity of demands placed on hospital doctors is unsustainable and, if left unaddressed, threatens the sustainability of the workforce.

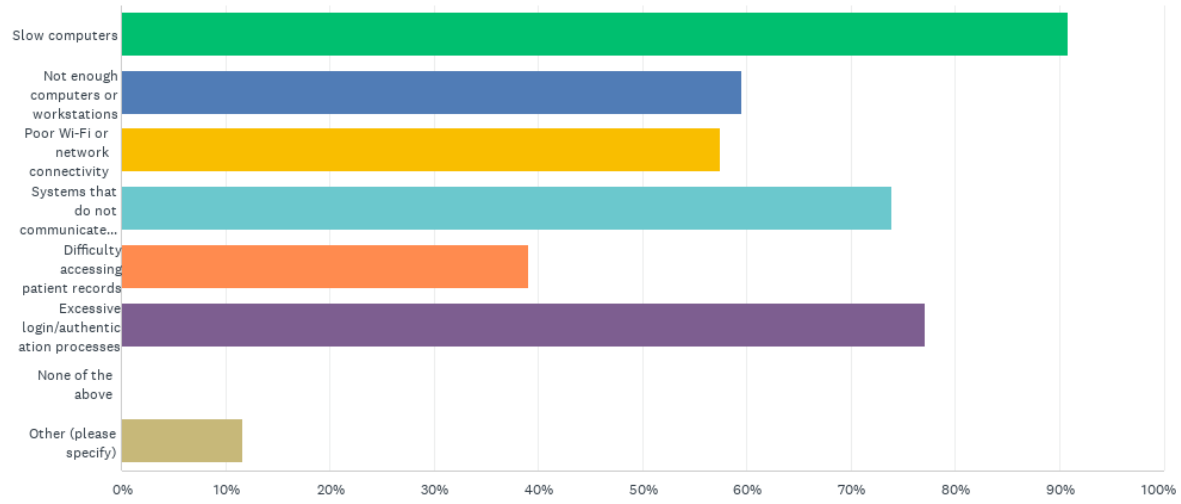
12.2 Artificial intelligence and digital infrastructure

12.2.1 The rollout of artificial intelligence (AI) and the increasing reliance on digital infrastructure form the backdrop to this pay round and will change doctors' working lives. The 10-year plan for the NHS set out an ambition to transform the NHS in England from "analogue to digital."[85] In July, NHS England announced an accelerated AI rollout "to cut waiting times and improve care for millions."[86] In March, NHS Scotland published its own AI strategy[87] and Wales and Northern Ireland have expanded the use of AI tools, including scribe technology and imaging analysis.[88]

12.2.2 However, there appears to be a considerable gulf between these ambitions and the realities on the ground. When asked about the IT they use at work, respondents to our survey reported several issues. Just 26% said they always had access to the IT equipment and systems needed to do their job. Twenty-seven percent said they had access only sometimes, rarely or never, and under half (47%) said they usually had the required IT. The graph below shows the most common issues respondents faced: 91% of respondents reported slow computers, and six in 10 reported not enough computers or workstations.[89]

Figure 2: Which of the following IT issues do you experience regularly?

[84] Ibid
[85] Department of Health and Social Care, Fit for the Future: 10 Year Health Plan for England (3 July 2025)
[86] NHS England, NHS Accelerates Artificial Intelligence Rollout to Cut Waiting Times and Improve Care for Millions (July 2026)
[87] Scottish Government, Scotland's Artificial Intelligence strategy, 2026-2031 (2026)
[88] Welsh Government, AI Cymru: Shaping a Smarter, Fairer, More Prosperous Wales (2026); Department of Health, AI Project Delivering Real Time Benefits to Patients in Northern Ireland (November 2025)
[89] HDU, Hospital Doctors at Work (2026)



12.2.3 NHS England has promised £10 billion of investment in technology, digital and data systems over three years, including in AI.[90] Our data suggests that this investment should first upgrade existing infrastructure. A recent Royal College of Physicians (RCP) survey on the use of AI and IT found that while 70% of physicians supported widespread AI implementation, 68% said the NHS currently lacks the digital infrastructure required to deploy it effectively.[91]

12.2.4 Several doctors responded to our survey and shared their experiences. One doctor said: *"IT is the single biggest challenge that I face, unfortunately on a daily basis*"; another reported: "*We work in one paediatric department across 2 Trusts in the same area: our IT systems do not connect*". A further doctor said: "*Our EPR (Maxims) is not fit for purpose and is dangerous. Now they are tacking AI to it without testing or plans*."[92]

12.2.5 These issues have implications for recruitment and retention. NHS England's 2024 Electronic Patient Record (EPR) Usability Survey showed a "clear positive correlation" between the quality of digital tools and staff's desire to remain in post. It also showed that among staff experiencing feelings of burnout, 47% said their EPR reduced

[90] NHS England, NHS Accelerates Artificial Intelligence Rollout to Cut Waiting Times and Improve Care for Millions (July 2026)
[91] Royal College of Physicians, The RCP View on Digital and AI (January 2026)
[92] HDU, Hospital Doctors at Work (2026)

efficiency, and 43% said it got in the way of quality of care.[93] At present, we have yet to see sufficient evidence of AI improving productivity in the health service or enabling doctors to focus on clinical care. HDU is clear that the solution to tackling waiting lists is investment in a supported, well-resourced medical workforce.

13 Vacancies

13.1 Inadequate staffing and vacancies are increasingly common across the health service. The GMC's Workplace Experiences 2026 report found that 41% of doctors reported difficulty providing patients with sufficient care each week. This figure was even higher among doctors in Wales (47%) and Scotland (46%).[94]

13.2 There is growing concern that vacancies are also underreported across the health service. NHS England data from June 2026 showed 9,390 medical vacancies, or 5.6% of the workforce. This was an improvement compared with the 2025 figure, which recorded 10,282 vacancies, or a 6.3% vacancy rate.[95]

13.3 The latest NHS Staff survey from March 2026 presents a different picture. The survey, based on responses from more than 760,000 NHS staff, found that only 32.8% agreed there were enough staff in their organisation to do their job properly, down from 34% in 2024.[96] HDU survey data shows 68% of respondents said their department had unfilled doctor vacancies, up from 64% last year. In addition, more than one in three respondents (35%) said No when asked whether their employer recognised all vacancies in their department, and another 32% said they didn't know.[97] NHS England itself cautions that vacancy statistics do not show how many posts are filled by temporary staff, and data may understate the scale of workforce shortages.[98]

[93] NHS England, 2024 Electronic Patient Record (EPR) Usability Survey for Secondary Care - Key Findings (2025)
[94] GMC, The State of Medical Education and Practice in the UK: Workplace Experiences 2026 (August 2026)
[95] NHS England, NHS Vacancy Statistics, England, April 2015–June 2026: Experimental Statistics (August 2026).
[96] NHS Staff Survey 2025 (March 2026).
[97] HDU, Hospital Doctors at Work (2026)
[98] NHS England, NHS Vacancy Statistics (August 2026)

13.4 Analysis from the BMJ revealed one in three consultant posts in some parts of the UK were vacant, with recruitment taking up to a year in 2024/25. It estimated this cost the NHS £670 million in locums.[99] When asked what would improve recruitment and retention of doctors, almost a quarter (24%) of respondents to our annual survey identified filling permanent vacancies, while 21% selected expanding the number of permanent posts.[100]

14 Wellbeing and morale

14.1 Hospital doctors' morale in 2026 is in crisis. Ongoing issues around pay, working conditions and increasing demands mean many staff are experiencing burnout, fatigue and moral injury. A recent YouGov survey found that nearly nine in 10 (87%) NHS staff described the health service as being in a weak state.[101]

14.2 Almost two-thirds (64%) of respondents to HDU's survey said that morale in their workplace was 'low' or 'very low'. Sixty percent said they experienced unreasonable stress at least half the time, and 44% said they had struggled with their mental health during the previous 12 months. When asked if they had experienced any of the following in the last 12 months, more than half of respondents (55%) reported fatigue, 48% said they experienced burnout, and 42% cited feelings of anxiety.[102]

14.3 The GMC's *Workplace Experiences 2026* report revealed that satisfaction with day-to-day work fell from 59% the previous year to 55%, high burnout risk increased from 18% to 20%, and the proportion unable to cope with workload at least weekly increased from 33% to 36%.[103] More than one in 10 (12%) respondents to our survey reported taking sickness absence for their mental health in the last year.[104]

[99] Adrian O'Dowd, Third of Consultant Posts Are Lying Vacant in Some UK Areas and Costing NHS Millions, Investigation Finds, BMJ (2025)
[100] HDU, Hospital Doctors at Work (2026)
[101] YouGov, How Do Healthcare Workers Feel About the NHS, Spring 2026 (May 2026)
[102] HDU, Hospital Doctors at Work (2026)
[103] GMC, The State of Medical Education and Practice in the UK: Workplace Experiences 2026 (August 2026)
[104] HDU, Hospital Doctors at Work (2026)

14.4 HDU survey data reveals that of those making definite plans to leave the NHS:

- 61% cited stress/burnout
- 59% said they did not feel valued
- 52% cited poor work-life balance
- 43% cited pay erosion.[105]

14.5 Sixty-two percent of respondents to HDU's annual survey said Yes when asked whether they would work fewer hours if the option was available. When asked the main reason, 61% cited work-life balance. Our survey found that of those planning to leave the NHS, 47% planned to retire, 20% would work in private practice, and 15% planned to move abroad.[106]

14.6 Violence and abuse continue to affect hospital doctors at work. The 2025 NHS Staff Survey found that 14.47% of staff reported experiencing at least one incident of physical violence from patients, service users, or members of the public, up from 14.38% in 2024. In addition, 3.51% of staff reported they had been a target of unwanted behaviour of a sexual nature in the workplace from staff or colleagues. This was a slight improvement from 3.67% in 2024.[107] It remains clear, however, that more is needed to ensure all NHS staff, including hospital doctors, are free from harassment, abuse and violence at work.

14.7 These challenges pose ongoing risks to workforce capacity. The retention crisis in the NHS should not be measured solely by doctors leaving the service, but also by doctors reducing their hours due to unsustainable pressures. Retaining a medical workforce able to meet increasing demands will depend on ensuring doctors feel safe at work and protecting doctors' wellbeing and morale.

15 Pensions

[105] Ibid
[106] HDU, Hospital Doctors at Work (2026)
[107] NHS Staff Survey 2025 (March 2026)

15.1 Hospital doctors are increasingly choosing to work fewer hours, retire early, or explore partial retirement. More than one in five (21.06%) respondents to HDU's survey said they had explored or discussed partial retirement with their employer. Among those exploring partial retirement, 66% cited improving work-life balance, 57% cited reducing their working hours and 34% cited health and wellbeing reasons.[108] The 2025 NHS Staff Survey shows that the number of staff working additional hours continues to decline. Last year, only 31% reported working additional hours, compared with a high of 38% in 2022.[109]

15.2 HDU remains deeply concerned about the impact of pensions on recruitment and retention rates for clinicians. Pension tax rules, particularly around annual allowance and tapered thresholds, mean that many doctors are unwilling to take on additional duties or are retiring early to avoid unexpected tax penalties. At the other end of the financial spectrum, evidence shows many younger resident doctors opting out of the NHS Pension Scheme, raising concerns about its affordability for doctors facing significant cost-of-living pressures.[110]

15.3 In this year's HDU survey, 43% of respondents who said they were making definite plans to leave the NHS cited pension taxation as a factor. In addition, more than 40% identified pension tax reform as a measure that would improve recruitment and retention. Pension taxation was also cited by 45% of those considering retire and return. Two-thirds of respondents who said they had considered retire and return said they wanted to access their pension while continuing to work, and more than half wanted to reduce their working hours.[111]

15.4 In recent years, many senior doctors have explored changes to working patterns, including moving to less than full-time (LTFT) or exploring partial retirement. HDU survey data reveals that almost two-thirds of doctors who pursued partial retirement cited improved work-life balance as the main reason, and 50% cited pension-tax

[108] HDU, Hospital Doctors at Work (2026)
[109] NHS Staff Survey 2025 (March 2026)
[110] NHS Business Services Authority (NHSBSA), *NHS Pensions Opt-out data* (2026)
[111] HDU, Hospital Doctors at Work (2026)

considerations.[112] HDU remains concerned by the variation in employer responses to flexible working requests, including partial retirement. The unwillingness of some employers to facilitate these requests is pushing more consultants to retire early or reduce their hours.

15.5 A respondent to our survey said, "*The tax cliffs are making it very difficult for me to encourage people to do extra work to help the department cover for various leaves. It currently encourages consultants to go LTFT*." Another said: "*Financial and Pension issues are the sole reason I will take partial retirement at 60 and then leave the NHS completely shortly after*". Another said: "*The tax and pension issue stop me from doing any extra work and have resulted in me reducing my hours by 20%*".[113]

15.6 Pension tax issues continue to be a major push factor for clinicians leaving the health service. We reiterate our position that resolving outstanding pension tax issues will be key to retaining the senior doctors needed for an effective and functioning health service.

16 Training

16.1 The Medical Training (Prioritisation) Act has been a positive development in addressing the crisis in postgraduate medical training. NHS England data shows competition ratios roughly halved for some applicants, with priority candidates filling 98% of posts, compared with 72% in 2025.[114] HDU welcomes this progress. The legacy of the crisis in specialty training, however, means a significant number of doctors are now re-entering the training pipeline. HDU is concerned that this influx will create new bottlenecks and issues at other stages of training. We await further details on how this will be addressed.

16.2 Despite progress in competition ratios, many issues with core and specialty training remain unresolved. Six in 10 respondents to our survey this year said their

[112] HDU, Hospital Doctors at Work (2026)
[113] HDU, Hospital Doctors at Work (2026)
[114] NHS England, Impact of Medical Training Prioritisation Act on Specialty Training Recruitment (June 2026)

employer did not prioritise their training, and only 9% reported receiving training daily. One in five reported they received training monthly, less than monthly, or never.[115] The 2025 GMC training survey found that only 52% of trainers were able to use their allocated training time as intended.[116]

16.3 Respondents to our survey also highlighted the costs and challenges associated with rotations and training. One doctor explained: "*It's exhausting finding your feet in a new job every 6 months, juggling childcare around rotas that aren't released until late*". Another said: *"I have had to rent for so long because of moving around I'm completely fed up with it. It also means my housing costs are a lot higher than they would have been if I could have stayed in the same area." A further doctor said: "Unable to plan for the months around induction due to changing rotas/ departments and makes leave very difficult at this time; long and unpredictable commutes worsen work-life balance and ability to plan childcare, etc."*[117]

16.4 The ongoing challenges with training mean many residents leave the health service after years of training and significant investment in their development. More than a third (36%) of respondents to HDU's survey said they planned to take time out of training. Of those taking time out, one in five said a place in their chosen specialty was unavailable, and almost one in five (19%) cited workplace stress.[118] Resolving these issues will be key to ensuring doctors are able to train and develop within the NHS.

17 Equality and diversity

17.1 Discrimination and inequality continue to affect hospital doctors at work. The most recent NHS Staff Survey revealed that one in five black and minority ethnic staff reported discrimination from patients or the public last year, compared with just 5% of white staff. Another 14% said they had experienced similar behaviour from colleagues, managers or team leaders, double the rate reported by their white colleagues.[119] HDU

[115] HDU, Hospital Doctors at Work (2026)
[116] GMC, National Training Survey Results (2025)
[117] HDU, Hospital Doctors at Work (2026)
[118] Ibid
[119] NHS Staff Survey 2025 (March 2026)

data shows that a third (33%) of survey respondents who identified as minority ethnic said they had witnessed a racist incident in the last year and more than a quarter (27%) said they had considered leaving their job as a result.[120]

17.2 Hospital doctors also face discrimination impacting their career progression. Almost half (45%) of respondents to our survey who reported belonging to an ethnic minority group said they thought it impacted their career progression, and over half (54%) said they felt unable to report incidents of racism.[121] The NHS Workforce Race Equality Standard (WRES), published in June 2025, showed that just 49% of ethnic-minority staff believed their trust provided equal opportunities for career progression or promotion, compared with 59% of white staff. For black staff, the figure was 42%. It also showed that in 80% of NHS trusts, white applicants were significantly more likely than ethnic-minority applicants to be appointed after shortlisting.[122]

17.3 Research from University College London (UCL) showed that this discrimination is leading to worsening retention rates for ethnic minority staff. The researchers found that NHS staff from ethnic minority groups (either UK or overseas nationals) were at greater risk of leaving the NHS compared to white UK nationals.[123] HDU's survey asked respondents from ethnic minority groups what would make the biggest difference in addressing discrimination affecting their careers. The most selected measures were transparent recruitment processes (57%), zero tolerance of racism by employers (57%), action on bullying and harassment (54%), and a review of the ethnicity pay gap (38%).[124]

17.4 Disability discrimination also continues to have a significant impact on many hospital doctors. Almost half of respondents (46%) to our survey who reported having a disability said they had experienced discrimination as a result. Four in 10 also said they were somewhat dissatisfied or dissatisfied with the support or adjustments they

[120] HDU, Hospital Doctors at Work (2026)
[121] HDU, Hospital Doctors at Work (2026)
[122] NHS England, NHS Workforce Race Equality Standard 2024: Data Analysis Report for NHS Trusts (June 2025)
[123] University College London, UCL Researchers Take Part in Parliamentary Roundtable on NHS Staff Retention (December 2025)
[124] HDU, Hospital Doctors at Work (2026)

received for their disability.[125] Research from the Royal College of Psychiatrists in 2025 highlighted persistent failures across NHS employers to provide reasonable adjustments for staff and noted this had implications for wellbeing and retention.[126]

17.5 More than a third of respondents to our survey (34%) who reported having a disability said they did not believe they received equal access to career progression, training and development opportunities compared with other doctors. One doctor said: "*Reasonable adjustments recommended 17 months ago and these have still not been put in place. The barriers are ridiculous to getting these implemented that makes you feel very undervalued*". Another said: "*Reasonable adjustments agreed in principle but in practice have been excluded/marginalised without adaptations*", while a further doctor said: "*I have asked for adaptations. Nothing was done*."[127]

17.6 Racism and inequality remain persistent challenges in the NHS. Addressing the prejudice and discrimination that continue to affect many doctors is imperative. Tackling these issues will require systemic action. However, failure to act will result in the loss of more staff essential to the operation of the health service.

17.7 HDU recommends that the actions set out above regarding career discrimination and measures to improve access to reasonable adjustments are introduced as a matter of urgency. HDU will continue to advocate for all doctors' rights to work in a health service free from discrimination and abuse.

18 Pay claim

18.1 In light of the severe challenges hospital doctors continue to face, and the impact of these challenges on recruitment, retention and morale, HDU is lodging the following pay claim:

[125] HDU, Hospital Doctors at Work (2026)
[126] Royal College of Psychiatrists, Providing Reasonable Adjustments: Essential Guidance for Mental Health Employers (August 2025)
[127] HDU, Hospital Doctors at Work (2026)

A significant above-inflation award that delivers a real-terms pay increase in 2027/28, alongside agreement on a multi-year roadmap to restore the value of doctors' pay.

18.2 This would begin to reverse pay erosion, support recruitment and retention, stabilise the medical workforce and reduce industrial action.

18.3 HDU calls on all UK administrations to engage constructively on a multi-year settlement and roadmap to pay restoration. This is necessary to protect the sustainability of the medical workforce.

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