

BMJ Open Understanding quit decisions in primary care: a qualitative study of older GPs

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ABSTRACT

Objective: To investigate the reasons behind intentions to quit direct patient care among experienced general practitioners (GPs) aged 50–60 years.

Design and setting: Qualitative study based on semistructured interviews with GPs in the South West region of England. Transcribed interviews were analysed thematically.

Participants: 23 GPs aged 50–60 years: 3 who had retired from direct patient care before age 60, and 20 who intended to quit direct patient care within the next 5 years.

Results: The analysis identified four key themes: early retirement is a viable option for many GPs; GPs have employment options other than undertaking direct patient care; GPs report feeling they are doing an (almost) undoable job; and GPs may have other aspirations that pull them away from practice. Findings from this study confirmed those from earlier research, with high workload, ageing and health, family and domestic life, and organisational change all influencing GPs' decisions about when to retire/quit direct patient care. However, in addition, GPs expressed feelings of insecurity and uncertainty regarding the future of general practice, low morale, and issues regarding accountability (appraisal and revalidation) and governance. Suggestions about how to help retain GPs within the active clinical workforce were offered, covering individual, practice and organisational levels.

Conclusions: This research highlights aspects of the current professional climate for GPs that are having an impact on retirement decisions. Any future changes to policy or practice to help retain experienced GPs will benefit from this informed understanding of GPs' views. Key factors to take into account include: making the GP workload more manageable; managing change sympathetically; paying attention to GPs' own health; improving confidence in the future of general practice; and improving GP morale.

Strengths and limitations of this study

- General practitioners (GPs) for interview were recruited from a larger scale survey, enabling inclusion of GPs from a variety of practice settings.
- There was limited success in recruiting GPs who were already retired, and also those currently working as salaried GPs, however, the final sample size was felt to adequately answer the research question.
- The use of thematic content analysis provided a timely overview of key issues to help inform current and future policy decisions.
- Interviews were conducted around the time of the 2015 general election: this may have influenced GPs' perceptions of some of the reported issues.

older reported a 'considerable' or 'high' likelihood of quitting direct patient care within 5 years.¹ Another survey of the future of general practice found that nearly two-thirds (63%) of those who had been GPs for more than 20 years stated they intended to retire within the next 5 years.² Our own recent survey of GPs in the South West region of England revealed that 64% of GPs aged 50–59 years intended to quit direct patient care within the next 5 years (Campbell *et al* (2015), unpublished data). As well as experienced GPs leaving, there are considerably fewer newly qualified doctors (around 20%) choosing a career in general practice than the Department of Health's target of 50%.³ There are also decreasing numbers in applications for GP training: there was a 15% fall from 2013 to 2014 across the UK⁴ with the General Medical Council arguing that burnout experienced within the existing workforce may be contributing to the fall in number of applications.⁵ Overall, there is slower growth of the GP workforce (on a full time equivalent (FTE) basis) in relation to population growth—the number of FTE GPs in England has fallen from its 2009 peak of 61.5–59.6/100 000



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INTRODUCTION

England faces a major and imminent problem in respect of general practitioner (GP) workforce capacity. A recent work-life survey identified that 54.1% of GPs aged 50 years and

of the population.⁶ In addition, a major restructuring of the National Health Service (NHS) primary care has taken place following implementation of the Health and Social Care Act 2012.⁷ This legislation, which heralded the creation of GP-led Clinical Commissioning Groups (CCGs), has had the potential to increase managerial and administrative workloads, particularly for (senior) established GPs. These changes may be resulting in new or additional factors influencing decisions made regarding intentions to quit direct patient care.

Previous research surveys conducted in the UK have identified a number of factors that may affect GPs' decisions to quit direct patient care or take early retirement. Frequently occurring factors included: high workload or associated work pressures (eg, long working hours),^{8–12} high patient expectations,⁹ a desire for more family or leisure time,⁸ reduced job satisfaction and disillusionment with the NHS,^{8 12 13} fear of deteriorating health and competence,⁸ and insufficient financial incentives to stay in work.⁸ Findings from other UK non-survey studies broadly concur with these and have also identified that problems in relation to partnership working arrangements may be contributing to a desire to leave general practice.¹⁴ Managing change (of role, workload, relations with secondary care and patients) has been identified as a further contributing factor.¹⁴ Findings from studies in Australia, Canada, The Netherlands and Finland indicate similar professional, personal health and psychosocial factors influencing GPs' decisions to quit.^{15–20} Although findings from each of these studies were generally consistent, they are now all over a decade old. Recently (2011), a British Medical Association national survey of GP opinion reported on a large-scale survey of 10 000 GPs.²¹ Reasons for retiring included: age; NHS reforms; revalidation; changes to pension, taxation and contributions; family commitments; and ill health. Another recent mixed-methods study identified the cumulative impact of work-related pressures, the changing and growing nature of the workload, and consequent practitioner stress as contributing to a GP's decisions to quit.²²

Given recent changes and developments in the structure and funding of primary care, and the concerns about GP shortages, it is timely to look in more depth at what factors currently influence GPs' decisions about when to retire/quit direct patient care. Recognising the critical and imminent depletion of the UK GP workforce, the National Institute of Health Research—Health Services Delivery strand—has recently commissioned a call for research into understanding and ameliorating these workforce issues.²³ Our qualitative study takes an important preliminary step in this regard, seeking to explore and understand an individual GP's current early retirement intentions, and the factors influencing these decisions.

METHOD

This qualitative study was carried out as part of a larger mixed-methods study exploring the challenges facing

the NHS in the light of workforce shortages. A questionnaire was sent to GPs from a random sample of 142 (46%) of the 306 practices in the South West region of England (who deliver services to approximately 1.03 million of the 2.25 million registered patients in the region).^{24–27} Practices were stratified by size, deprivation and setting. The final participating sample consisted of 48% of GPs (948/1981) from Somerset, Devon and Cornwall.

The questionnaire asked GPs to report the likelihood that they would be quitting direct patient care within the next 5 years (providing they had not already done so). GPs rated this likelihood on a five-point scale, provided demographic data, and indicated their willingness to be contacted for interview. An additional questionnaire was sent to practice managers asking for their help in contacting GPs who had quit within the last 2 years.

GPs who returned their questionnaire, indicated that they were aged 50–59 years, had a considerable or high likelihood of quitting direct patient care within the next 5 years, and were willing to be contacted for interview, were identified from the returns. Up to three attempts were made to schedule an interview with each of these GPs. GPs gave written, informed consent prior to interview.

The results from previous, relevant studies were used to develop an interview schedule, which was piloted with three non-participating GPs. The interviews sought to elicit GPs' views and experiences of the factors that influenced early retirement and/or quitting decisions, and to identify any factors that they felt might help to retain GPs in practice (see [box 1](#) for interview topics).

The semistructured telephone interviews with study participants were conducted by AS during January and February 2015. More interviews took place in May 2015 with additional GPs from the original sample. These GPs were purposively selected to increase the number of female participants and the number of those aged 50–55 years in the study.

All interviews were audio-recorded, transcribed verbatim and anonymised before being organised in NVivo 10 for thematic content analysis. An initial coding frame was independently constructed by two experienced qualitative researchers (AS and MC) based on the first five interviews. Following discussions, a consensus about the coding frame was reached. A revised coding frame was then developed and independently tested by AS and MC using a sixth transcript, and final modifications were made to reflect the outcome of this.

All transcripts were coded using this agreed frame, detailed project notes were kept regarding the further refinement of any existing codes and the addition of any new codes, and potential themes were discussed with the research team.

RESULTS

The original survey yielded a response rate of 56% (529/948). Of those who responded to the survey, 38%

Box 1 Key topics included in interviews with general practitioners (GPs; adapted to collect retrospective data from the GPs who had already retired)

Key topics for GP interviews

Current working situation: hours, role, type of geographical area covered (eg, urban, rural, inner city), key characteristics of population served by the practice (eg, large older population).

Year qualified as a GP

When likely to retire and age at that time. If this had always been the GP's intention/timing of this decision

Factors that have an influence on personal decisions about when to retire: work related or outside of work; any 'critical' or key events that influenced decisions or plans (Prompts taken from literature and prior interviews)

Any other factors they believe may have influenced GP colleagues' decisions about when to retire/quit direct patient care

Suggestions for strategies and policies to help retain GPs: examples of individual, practice or organisational level changes that have already been made (and detail of these); and changes that the GP would recommend/like to see made. GPs given the opportunity to describe what (if anything) would encourage/support them personally to stay in practice, and also what would be helpful to GPs 'in an ideal world' (Prompts taken from literature and prior interviews)

Anything else the GP would like to add on the topic

(203 GPs) were aged 50–59 years, and 64% of these (129 GPs) reported a considerable or high likelihood of quitting direct patient care within the next 5 years. Just over half (53%) of those aged 50–59 years, who had a considerable or high likelihood of quitting, agreed to be contacted for interview. Contact with 25 of these GPs (25/69) resulted in 14 interviews. Contact with eight GPs from the second, purposively selected sample (8/69) yielded six interviews, giving a total of 20 GPs intending to retire/quit direct patient care. In addition, the original survey and practice manager questionnaires identified 18 GPs who had quit direct patient care when aged between 50 and 59 years. Three of these GPs agreed to an interview.

Interviews lasted between 16 and 53 min (mean interview time: 32 min). Nine of the interviewees were women, and the mean age of interviewed GPs was 55 years (range: 51–60 years). Two of the GPs were currently working in a locum capacity. All the other 18 GPs who were still currently working were GP partners. The remaining three GPs had also been working as partners prior to retirement.

The three retired GPs had all retired due to ill health at age 55–56 years. Of those still working (n=20), intended retirement age ranged from 55 to 63 years, with 15 clearly stating that they aimed to retire by the age of 60 years or earlier, and two stating that they aimed to retire aged 62–63 years. Of the three GPs who did not have a specific retirement age in mind, one was already working as a locum, and another planned to become a salaried GP as an intermediate step before deciding on a retirement age.

Table 1 Characteristics of participating general practitioners (GPs) (n=23)

GP characteristics	Mean	Range
GP age	55	51–60
Actual retirement age (n=3)	55	55–56
Anticipated retirement age (n=17)	59	55–63
	N	Per cent
Gender		
Male	14	61
Female	9	39
Role in practice		
Partner	21	91
Locum	2	9
Practice size		
Small/medium (list size <3500–8000 patients)	8	35
Large (list size >8000 patients)	15	65
Practice location		
Urban (postcodes PL1, PL2, PL3, PL4, EX1, EX2, EX3, EX4, TA1)	8	35
Non-urban (all other postcodes in the region)	15	65
Practice deprivation		
Deprived (scores in deciles 1–5)	10	43
Not deprived (scores in deciles 6–10)	13	57

Table 1 shows the characteristics of the participating GPs.

What influences experienced GPs' decisions about when to retire/quit direct patient care?

The analysis identified four main themes:

- ▶ Early retirement is a viable option for many GPs.
- ▶ There are employment options available to GPs other than undertaking direct patient care.
- ▶ GPs feel that they are doing an (almost) 'undoable' job (related to: workload; change; NHS structures and systems; politics; partnership issues; concerns about the future of general practice; ageing and ill health; and reduced morale and emotional resilience).
- ▶ GPs may also have other aspirations that pull them away from direct patient care.

Early retirement is a viable option for many GPs

The 1995 section of the NHS Pension Scheme and 24 h retirement were cited by GPs as a way to trade-off ongoing, continuous working and full pension, with early retirement (and/or reducing hours) while still receiving an adequate income. Some had received financial advice to this effect, and many felt that it made sense to take advantage of this option. Long-term financial plans had been established to enable this to happen, and GPs felt reluctant to continue working knowing that they already had a 'full pension pot'.

There appeared to be a cultural norm (it is common among their peer group) that made it acceptable for

GPs to consider, and to take, early retirement. However, there was also a potential conflict between age, experience and perceived value to the profession: experienced GPs were valued but there was also fear of being ‘an old doctor’.

How can the country afford to let people with 30 years’ experience just go, just because they’ve had enough? It’s a tragedy. (GP21, Partner, female, age 57)

I will be eligible to retire at 60. I don’t want to be viewed as an old doctor, I don’t want to get out of touch and I worry that I wouldn’t be quite as up-to-date as I get older and that my memory won’t be quite so good, those kind of things. (GP22, Partner, female, age 55)

There are other options available to GPs

Four GPs were relatively happy with their current work situation and did not feel a need to change it at this time. The remaining GPs who were still working were considering or had already taken other options, including: 24 h retirement, reducing hours, becoming a locum or salaried GP, or changing career.

Two GPs wished to remain in a direct patient care setting but with a different role. Both GPs had trained in complementary therapies and both intended to stop being a GP in order to work as a complementary therapist (one full time, one part time). Three GPs maintaining a primary care role had reduced their working hours, and one planned to go from full time to half time hours once they were age 60 years.

I was full time until 58. I looked at the pension and the pension was very good and I thought well y’know it’s ridiculous carrying on killing yourself if I can do part time. I did 24 hour retirement and then went back which is what most GPs tend to do. (Interviewer: Did you have any thoughts at that time about just stopping patient care altogether?) No because I liked the patients. Part time seemed a nice compromise. (GP1, Partner, female, age 60)

Although reducing hours could benefit the individual, the knock-on effects of a GP reducing their hours and (by necessity) also list size, were noted as having consequences and potential difficulties for the practice including increasing the workload for existing GPs and/or requiring the appointment of additional staff.

Two GPs had changed from being GP partners to locum GPs. Becoming a locum was seen to offer far less involvement with the practice and potentially more time (and personal resources) to spend on the GP’s own areas of interest (professional and personal). However, there was also awareness that becoming a locum shifts that GP’s burdens of responsibility onto other members of the practice. Although individual decisions were considerate of the potential impact on the practice, there was tension between not wanting to shift the burden of responsibility onto colleagues, while also not wanting to

be the one left with the burden if other colleagues acted (retired or reduced hours) first.

Transferring their skills (eg, taking on roles as an appraiser, clinical commission lead, advisory committee member, pharmaceutical consultant or working for a medical school) was a further option that GPs identified: either having this role alongside direct patient care or as an alternative to it. A key attraction of transferring skills included feeling financially and professionally rewarded.

A medical degree is one of the most wide-ranging degrees there is: it’s about science, research, communication, empathy, organisation, management—we’re pretty skilled people... Other people want me to do other stuff now; they’ll pay me good money and treat me very differently to what is currently happening to GPs. (GP16, Locum, male, age 58)

GPs feel that they are doing an (almost) undoable job

By and large, the GPs reported that seeing patients was the part of the job they enjoyed the most, however, there were several factors that made the job ‘on the cusp of undoable at times’ (GP5, Partner, female, age 55 years), and these factors were all cited as influencing decisions about when to retire/quit direct patient care.

Key issues identified by the GPs were: workload; change; NHS structures and systems; concerns about the future of general practice; partnership issues; politics; the impact of ageing and ill health; and reduced morale and emotional resilience.

Workload

GPs worked long days, the pace of work was felt to be very difficult to maintain, and there was a general feeling that the work had become more complex in recent years.

Looking after patients is okay. It’s the rest of the massive amount of stuff that’s piled upon us that’s driving me out, like it’s driven everybody else out... lifestyle is zilch. (GP14, Partner, male, age 57)

The workload has increased such a lot that it’s hard to see how I can keep going at this pace, I don’t think I can. (GP22, Partner, female, age 55)

Two GPs noted that the demand for patient care was outstripping supply. Contributing factors included: unrealistic patient expectations; an increase in the number of patient contacts without a corresponding increase in the number of GPs; and additional workload from secondary care. Other demands in addition to contact with patients were felt to compound the problem, including: the need to meet targets, to stay up-to-date with new guidelines, and to prepare for Care Quality Commission (CQC) visits.

The demands of the job go up and up and, if that were to continue, that’s the sort of thing that might make me

say 'hold on, this is no fun, this is crazy'. I can't do a proper job working like this in these circumstances. (GP18, Partner, male, age 53)

(Being a GP is) the best job in the world but there's just too much of it. (GP15, Retired partner, male, age 58)

One GP felt strongly that managing non-specific and irrelevant emails (sent primarily from CCG colleagues and the health authority) added to workload. Several of the GPs noted that they looked at their work emails from home/in non-work time in order to try and keep up-to-date.

Seeing an inbox with 100 new emails...is enough for me to switch it off again and concentrate on patient care for a while. (GP11, Partner, male, age 54)

Change

Several GPs described the impact of the 'drip, drip' of accumulative change over their years of practice. Three GPs mentioned that it was difficult to see the value of organisational changes that had been introduced; two GPs discussed feeling a lack of control/influence regarding changes; and one GP described feeling that there was very limited organisational continuity.

Another reorganisation was one reorganisation too many. (GP12, Retired Partner, female, age 58)

You never feel that you've quite got your feet on solid ground and it's always constantly changing. (GP9, Partner, male, age 51)

We've been bombarded with change...and we're fatigued with it. (GP21, Partner, female, age 57)

Most of the examples given related to changes imposed from outside of the GP's practice. However, internal/practice-level changes (such as peers retiring), could also contribute to decisions to leave.

We've just had three more retirements so nearly all the people who were around when I started have now gone and been superseded by younger, different GPs...my work satisfaction is less and I think a large part of it is because of the changing style of work: the newer doctors work differently. I don't like the way they do it. (GP18, Partner, male, age 53)

NHS structures and systems

Several of the GPs felt they were chasing targets all the time and 'government interference' and micromanagement were seen by one GP as a lack of trust by the Government. One GP felt that the Quality Outcomes Framework (QOF) system was not as profitable as some (younger) GPs may believe, and there was a general sense that pursuing QOF points distracted from patient care.

You've come to me with a bad cough and a bad chest... I'm seeing you thinking: I need to listen to your chest, do you need antibiotics? And then I'm thinking: I'm going to lose my targets—do I know your weight...height... blood pressure...have you had your blood sugar done? Rather than dealing with you as a person, I'm thinking: heck we've missed a target on this one and it's going to cost the practice. (GP15, Partner, male, age 58)

A lot of things feel as if they are out of our control, things like the CQC, seven day service, appraisals, all the box ticking we have to do...a new project, a new prescribing thing, one after the other, they keep coming. And ultimately you decide: do we play the game or do we not play the game (GP18, Partner, male, age 53)

CQC checks were viewed as a burden of additional paperwork, bureaucracy and stress by many of the GPs, although it was acknowledged that many of the associated tasks were undertaken by practice managers.

Views about CCGs varied, however, one GP did express concerns that they were being used to scapegoat GPs.

I feel that primary care is going rapidly towards the precipice and the setting up of CCGs is to try and make damn sure that the politicians don't get the blame but we do... If they could get the GPs to be the cause of the crash of the NHS then that would be perfect because they could take the blame and not the political party in government. (GP14, Partner, male, age 57)

GPs felt that referral pathways had become more complex and time-consuming. They received more referrals and were required to do more follow-ups due to unrealistic expectations of patients, and hospital doctors lacking resources. There was also a complaint from one GP that GPs are working in 'a vacuum of information' owing to delays in communication from hospitals.

You can no longer make a referral on its own merits. (GP23, Partner, female, age 52)

GPs expressed mixed views about the appraisal and revalidation system. Some found appraisals helpful while others felt they were an additional burden and ineffective.

Every time I come for an appraisal I feel like I'm just repeating myself and I'm just ticking these boxes. But then when you get to sit down with another GP and talk, it's always very beneficial. (GP23, Partner, female, age 52)

...having this poor Herbert coming and policing me once a year I find utterly insulting and a waste of time 'cos it doesn't achieve anything whatsoever for me. Proves to them that I'm doing what I say I'm doing so it's just a policing exercise that I resent. (GP19, Partner, female, age 55)

Two GPs mentioned that they would schedule their retirement to avoid their next revalidation.

Politics

Six GPs described feeling that politicians were using the NHS for their own gain, and felt threatened by Government proposals and changes (eg, 7-day access to primary care).²⁸ This was experienced as stressful and demoralising.

The threats from politicians to change our working hours (are) so stressful and demoralising...we can't see how we can make that work without our work-life balance being fairly comprehensively stuffed...that is an instant turn-off and an instant major demoraliser for GPs who are already overworked and struggling. (GP3, Partner, male, age 57)

Partnership issues

Good working relationships with other partners in the practice were cited as helping to mitigate some of the difficulties around managing workload, change, etc.

It is certainly busy and I think the important thing is that we do have a good group here and that I work in a good partnership and a good practice. People are aware of other people's needs and we work together as a group and I think it is a very supportive practice... I don't think I'd still be in the NHS if I was working in another practice, I probably would have left years ago actually. (GP8, Partner, male, age 57)

However, where good relationships were lacking, and/or newer partners had opposing views about how the practice should be run (eg, whether to have personal lists or not), GPs experienced a lack of support and reduced loyalty to the practice, thus decreasing their likelihood of staying on.

Issues related to merging and sharing resources were also identified.

The big plan is to merge with a neighbouring practice and I think, if I was ten years younger, I'd be thinking 'that's great'. But now I'm thinking 'have I really got the energy to do that?' I don't know. And if that happens in the next six months, it may push me to go. (GP21, Partner, female, age 57)

Concerns about the future of general practice

There was a clear awareness (and often direct experience) of current issues related to difficulties in recruiting and retaining GPs. This was a concern of all the GPs: many anticipating that the situation would continue to deteriorate. Concerns about there being no one to replace them once they left general practice were noted as potentially impacting on decision-making.

One GP described the NHS as a 'failing brand', and highlighted how this could lead to his choosing to retire early.

I don't like being caught at present in a rather uncomfortable situation with patient demand as it is and a

shortage of GPs and if I'm honest I think that, if I felt more uncomfortable in the coming months, I might just retire early. I'm not prepared to try to flag up a failing NHS ...it's just the brand seems to be failing in the eyes of the public. (GP8, Partner, male, age 57)

Practise-based models were felt to be most responsive to local demand, but the current funding model made it difficult for practices to keep up with the increasing patient demand. Also, GP concern about the future of general practice meant they may be less likely to invest in buildings and make long-term commitments.

People are genuinely worried about the future of general practice...they seem to be getting very twitchy about buying into property, making long-term commitments to the service, which is a great sadness. (GP11, Partner, male, age 58)

Ageing and ill health

Eight of the GPs identified ageing as having an impact on their confidence and ability and, consequently, their perceived capacity to continue working in direct patient care.

There seems to be something that happens when you reach about 55: you start to get feelings of struggling with the work and 60 feels an awful long way away. (GP3, Partner, male, age 57)

The length and pace of the working day were felt to be exhausting, stamina decreased with age, and this was compounded for some female GPs who reported experiencing sleep disturbance which they attributed to the menopause.

Deteriorating cognitive (eg, memory) and physical (eg, eyesight) functioning led to fear, anxiety, loss of confidence and stress. GPs described the fear of 'unconscious incompetence'.

The constant feeling that you are driving at top speed and something's going to go wrong is unnerving. (GP12, retired Partner, female, age 58)

All the retired GPs had retired earlier than they originally intended to on account of continuing ill health. One of the GPs intending to retire had experienced severe health problems that resulted in a year out of practice and the decision to retire immediately should she become unwell again. Similar views were held by another GP who had been off work with stress-related illness.

If I ever had a recurrence of that stress-related illness, that would certainly be a signal to walk away. (GP18, Partner, male, age 53)

Looking after their own well-being was 'just one more thing to fit in', and GPs were reluctant to visit their own doctor due to not wanting to be a 'nuisance patient',

and an awareness that ‘they’re going through the same suffering as you are’ (GP12, retired Partner, female, age 58).

Uncertainty of future health also impacted on decisions about when to retire: GPs wanted to maximise their healthful years postretirement.

You don’t want to leave things too late and not be able to do some nice things before you start getting ill. (GP22, Partner, female, age 55)

Morale and emotional resilience

Morale was described as being very low among GPs, and key reasons for this included ‘media bashing’ and medicine/doctors being used for political gain.

It doesn’t do much for morale when your politicians and your press...are putting the boot in on people (whose) main motivation for going to work is to help patients. (GP3, Partner, male, age 57)

Other factors that contributed to low morale were: feeling worn down by change, and not feeling valued by patients and politicians.

Three GPs referred to experiencing ‘burnout’ as a result of the job. Another referred to ‘the attrition of your own resilience to keep going’ (GP11, Partner, male, age 54). Feelings of being overwhelmed, stressed and losing confidence were also mentioned by another two GPs.

‘Pull’ factors

In addition to the factors that GPs recognise as ‘pushing’ them out of practice, there were also several factors identified that were seen to be ‘pulling’ GPs away. These included: wanting to retire while still relatively young and healthy; having other things they want to do with their time and energy (including more time for social life and for other vocational roles); and wanting to have quality time with family—especially if their spouse was also retiring/had already retired.

What might help to retain experienced GPs in direct patient care?

The GPs were asked to describe anything that they had already identified and/or implemented to address any of the ‘push’ factors they experienced (‘actual solutions’), and also to outline any other suggestions they may have (‘hypothetical solutions’).

‘Actual solutions’ existed at practice, individual and organisational levels. The GPs recognised that retention was facilitated through good partnership working and being part of a supportive practice, as well as having an effective practice manager, reception staff and secretarial support. Examples of practice-level changes that had been successful in supporting GPs included: giving GPs dedicated time for administrative tasks; sharing workload with other practices; and introducing a GP buddy system

to help manage incoming queries if one GP was on annual leave or off sick.

Individual-level solutions included: restructuring role and working hours; and using stress-management techniques such as mindfulness. GPs also cited awareness and use of local clinical support and counselling services such as a GP Safe House.²⁹

In addition to these ‘actual solutions’, GPs also outlined a wish for more emotional, practical and organisational support. These ‘hypothetical solutions’ included: creating greater peer support among GPs; provision of mandatory study days to help GPs prioritise their own health and well-being; making it easier for GPs to reduce their hours and/or become a salaried or locum GP; improving access to information to help GPs stay up-to-date; giving GPs one email account solely for patient matters, and another account for all non-patient matters; improving the integration of health and social care to make it easier for GPs to access community beds for their patients (as an example); and either taking the NHS out of Government control or making it a cross-party issue with commitment to longer term planning to ensure greater consistency and less party-specific changes.

DISCUSSION

This study’s findings provide context for, and understanding of, the factors currently influencing GPs’ decisions about when to retire/quit direct patient care. In summary: early retirement is a viable option for many GPs; GPs have employment options other than direct patient care; GPs feel that they are doing an (almost) undoable job; and GPs may also have other aspirations that pull them away from practice. Although the relative influence of each of these factors may vary from GP to GP, our findings show that they consistently inform intentions to retire/quit direct patient care. Of key significance is the insight gained into how some GPs view their current role: as ‘on the cusp of undoable’. Pessimism about the future of general practice, change fatigue, and the financial viability of early retirement, only serve to exacerbate the feelings of GPs choosing to ‘jump before they are pushed (any further)’.

There were similarities between the findings of this study and previous UK research which looked at experienced GPs’ reasons for quitting direct patient care. Factors identified over a decade ago are still relevant to the current climate, namely: workload,^{8–12} patient expectations,⁹ a desire for more family or leisure time,⁸ reduced job satisfaction and disillusionment with the NHS,^{8, 12} fear of deteriorating health and competence,⁸ insufficient financial incentives to stay in work,⁸ partnership issues¹⁴ and change.¹⁴ Recent factors identified in 2011 and 2015 were also apparent in our research, namely, the impact of age, NHS reforms and revalidation,²¹ and the cumulative impact of workload factors on GP’s own health and well-being.²² In addition to

documenting the continued impact of all of these factors on GPs' decision-making, this study also highlights the changing context and the professional environment within which GPs operate. Issues relating to workload, ageing and health, and family and domestic life were all predictable—but interviewees also expressed considerable strength of feeling when reporting the sense of being part of a political football match, and standing on unsecure and uncertain professional ground.

A recent report for Health Education England from the Primary Care Workforce Commission aimed to identify solutions to meet the current and future needs of primary care.³⁰ Key solution areas identified included: a multidisciplinary workforce for primary care; making better use of technology; maintaining quality and safety in primary care; addressing population groups with particular needs; improved integration of care; working together in federations and networks of practices; and education and training. Our findings illustrate the willingness of current GPs to explore and implement solutions (including several of those identified in the report), the importance of including attention to personal and individual-level needs and, crucially, the need for sympathetic management of the introduction of any future changes to primary care. As cited in Health Education England's future of primary care report, 'care of the patient requires care of the provider'.^{30 31}

Policy implications

The four key findings from this study have direct relevance to current and future policy decisions. The GPs in this study cited the viability of early retirement based on the 1995 section of the NHS Pensions Scheme. Although there have already been subsequent changes to NHS pensions (2008 and 2015),³² it is important to recognise the implication of pension arrangements and pension policies as a contributing factor to GPs' quitting decisions, and to consider this for future pension planning. The GPs' awareness and uptake of other employment roles indicates that there is a need for recognition of the substantial skill base within the GP workforce. GPs need to be given opportunities to use their range of clinical, organisational and managerial skills, and to be appropriately rewarded—both in terms of financial remuneration and professional recognition. GPs' description of their job as 'on the cusp of undoable' illustrates the need to recognise the potential knock-on effects of political, structural and organisational changes, and the subsequent impact on the physical and mental well-being of the GP workforce. There is a need to ensure high-quality services—that can be easily accessed and without stigma—that target the health of the GP workforce. Finally, the powerful 'pull' of other life experiences and opportunities postretirement suggests a need for increased efforts to help GPs maintain their work-life balance throughout their careers, including, for example, more flexible working.

Strengths and limitations of the study

Use of the larger scale survey participants, and the two-stage sampling process enabled inclusion of GPs from a variety of settings (based on practice list size, deprivation and urban or non-urban setting), and a final sample size that indicated there were no further themes emerging from the data. Although consideration is advised when examining the sampling adequacy of qualitative research, our pragmatic and flexible approach was felt to answer the research question,³³ and we are confident that our findings are likely to be transferable to GPs across the South West, and may also be transferable to other regions in England. Conducting interviews by telephone (rather than face-to-face) was also a pragmatic decision that allowed for flexibility in the timing and duration of the interviews and, therefore, greater ease for the participating GPs. We used thematic content analysis with the aim of gaining a rapid overview of the current context in this key area of GP workforce shortages. Given our aim, we concentrated on exploring the 'at risk' group of early retirees, and did not try to compare these with GPs who did not intend to quit direct patient care or retire before the age of 60 years. We experienced limited success with recruiting retired GPs into the study, and all those who did participate in the interviews had been forced to retire due to ill health. Thus, we are unable to comment on the views and experiences of GPs who had taken early retirement without the pressure of ill health. Also, the GP interview sample consisted mainly of GP partners, with only two locum GPs, and no salaried GPs. Consequently, we are unable to comment on the experiences and views of salaried GPs. Most of the GP interviews were conducted shortly before the 2015 general election, with the remainder in the weeks immediately after. It is possible that the timing of interviews, close to an election, may have influenced GPs' perceptions of some of the reported factors.

CONCLUSION

This study has illuminated an important area of national concern. A significant number of experienced GPs are currently choosing to leave direct patient care and take early retirement rather than continue to work in situations that feel too difficult to manage and sustain. Given the shortage of GPs, it is important to explore what, if anything, might support and encourage these experienced GPs to remain in direct patient care beyond their intended early retirement age. However, given that one of the factors already identified by GPs as a negative influence is 'change', any further changes to policy and practice would benefit from being informed by current evidence. The findings from this study begin to provide that evidence, policy areas for consideration have been identified, and the topic has been further illuminated with first-hand understanding and examples from GPs who are 'at risk' of retiring early. Several issues have

been identified that may encourage GPs to delay retirement: making the workload more manageable; managing change sympathetically; paying attention to GPs' own health; improving confidence in the future of general practice; and supporting initiatives aimed at improving GP morale. Further research is required to explore potential strategies that could address these issues, and also to ensure that GPs are not subjected to further unnecessary or unhelpful change. It would also be helpful to find out how other GPs, who do not intend to retire early, manage in this current climate. By finding out more about what helps GPs (eg, supportive partnerships), a new model can be developed to reduce or eliminate the negative influences—factors that make GPs more 'at risk' of early retirement—and improve or increase positive drivers—factors that support experienced GPs to remain in direct patient care.

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Data sharing statement No additional data are available.

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REFERENCES

- Hann M, McDonald J, Checkland K, *et al*. Seventh National GP Worklife Survey. 2013.
- ICM Unlimited. British Medical Association National Survey of GPs: The future of General Practice 2015. 2015.
- Lambert T, Goldacre M. Trends in doctors' early career choices for general practice in the UK: longitudinal questionnaire surveys. *Br J Gen Pract* 2011;61:e397–403.
- Lacobucci G. GMC sees 15% fall in applications for GP training. *BMJ* 2014;349:g6139.
- General Medical Council. *The state of medical education and practice in the UK*. London: General Medical Council, 2014.
- Centre for Workforce Intelligence. *In-depth review of the general practitioner workforce: final report*. 2014.
- UK Government. Health and Social Care Act 2012 c.7. Secondary Health and Social Care Act 2012 c.7 2012. <http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted> (accessed Oct 2015).
- Davidson JM, Lambert TW, Parkhouse J, *et al*. Retirement intentions of doctors who qualified in the United Kingdom in 1974: postal questionnaire survey. *J Public Health Med* 2001;23:323–8.
- Leese B, Young R, Sibbald B. GP principals leaving practice in the UK. *Eur J Gen Pract* 2002;8:62–8.
- Evans J, Lambert T, Goldacre M. GP recruitment and retention: a qualitative analysis of doctors' comments about training for and working in general practice. *Occas Pap R Coll Gen Pract* 2002;83:iii–vi, 1–33.
- Kmietowicz Z. Quarter of GPs want to quit, BMA survey shows. *BMJ* 2001;323:887.
- Luce A, van Zwanenberg T, Firth-Cozens J, *et al*. What might encourage later retirement among general practitioners? *J Manag Med* 2002;16:303–10.
- Sibbald B, Bojke C, Gravelle H. National survey of job satisfaction and retirement intentions among general practitioners in England. *BMJ* 2003;326:22.
- Newton J, Luce A, van Zwanenberg T, *et al*. Job Dissatisfaction and early retirement: a qualitative study of general practitioners in the Northern Deanery. *Prim Health Care Res Dev* 2004;5:68–76.
- Gardiner M, Sexton R, Durbridge M, *et al*. The role of psychological well-being in retaining rural general practitioners. *Aust J Rural Health* 2005;13:149–55.
- Brett TD, Arnold-Reed DE, Hince DA, *et al*. Retirement intentions of general practitioners aged 45–65 years.[Erratum appears in Med J Aust. 2009 Sep 7;191(5):296]. *Med J Aust* 2009;191:75–7.
- Kelley ML, Kuluski K, Brownlee K, *et al*. Physician satisfaction and practice intentions in Northwestern Ontario. *Can J Rural Med* 2008;13:129–35.
- Pit SW, Hansen V. Factors influencing early retirement intentions in Australian rural general practitioners. *Occup Med (Lond)* 2014;64:297–304.
- Van Greuningen M, Heiligers PJ, Van der Velden LF. Motives for early retirement of self-employed GPs in the Netherlands: a comparison of two time periods. *BMC Health Serv Res* 2012;12:467.
- Heponiemi T, Kouvonen A, Vänskä J, *et al*. Health, psychosocial factors and retirement intentions among Finnish physicians. *Occup Med (Lond)* 2008;58:406–12.
- British Medical Association. National survey of GP Opinion 2011. London, UK: British Medical Association, 2011.
- Dale J, Potter R, Owen K, *et al*. Retaining the general practitioner workforce in England: what matters to GPs? A cross-sectional study. *BMC Fam Pract* 2015;16:140.
- National Institute for Health Research, NHS. Health Services and Delivery Research Programme, Commissioning brief 14/196, Organisation and management of general practice. 2014.
- South Devon and Torbay Clinical Commissioning Group Annual Report 2014/2015. <http://www.southdevonandtorbayccg.nhs.uk/about-us/Documents/annual-report-and-accounts-2014-2015.pdf> (accessed Oct 2015).
- North, East and West Devon Clinical Commissioning Group Prospectus 2015. <http://www.newdevonccg.nhs.uk/about-us/100069> (accessed Oct 2015).
- Somerset Clinical Commissioning Group Annual Report and Accounts 2014/15. <http://www.somersetccg.nhs.uk/publications/annual-report/> (accessed Oct 2015).
- NHS Kernow Annual Report and Accounts 2014–15. <http://policies.kernowccg.nhs.uk/DocumentsLibrary/KernowCCG/OurOrganisation/StrategicReportsAndPlans/AnnualReport.pdf> (accessed Oct 2015).
- Department of Health and Prime Minister's Office. Press release: Seven day, 1am–8pm, GP access for hardworking people. 2013. <https://www.gov.uk/government/news/seven-day-8am-8pm-gp-access-for-hard-working-people> (accessed Oct 2015).
- Somerset GP Safe House. <http://www.somersetssafehouse.co.uk/index.php> (accessed Oct 2015).
- Health Education England. The future of primary care: creating teams for tomorrow. <https://www.hee.nhs.uk/sites/default/files/documents/The%20Future%20of%20Primary%20Care%20report.pdf> (accessed 11 Feb 2016).
- Bodenheimer T, Sinsky C. From triple to quadruple aim: care of the patient requires care of the provider. *Ann Fam Med* 2014;12:573–6.
- British Medical Association. <http://bma.org.uk/support-at-work/pensions> (accessed Oct 2015).
- O'Reilly M, Parker N. 'Unsatisfactory saturation': a critical exploration of saturated sample sizes in qualitative research. *Qual Res* 2012;13:190–7.