

“Should I stay or should I go now?”: A qualitative study of why UK doctors retire

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Abstract

Background

Healthcare delivery and education face critical potential shortages in the foreseeable future in terms of retaining doctors nearing the time of retirement - doctors who have experience-based knowledge to pass onto the next generation. Retirement decisions are driven by a combination of macro-related, job and individual factors. This is a constantly shifting space; findings from earlier studies do not always help us understand the retirement decisions of contemporary cohorts of doctors. To address these issues, and identify new knowledge to inform approaches to retaining expertise, we aimed to identify and explore what may keep an older doctor in the workforce (“stay” factors) and (“go”) factors that might prompt retirement.

Method

We invited doctors aged 50 years or over from diverse areas of Scotland to participate in qualitative, semi-structured interviews. Initial analysis of interview transcripts was inductive. Mitchell et al.’s embeddedness theory, encompassing the dimensions of ‘link’, ‘fit’ and ‘sacrifice’, was used for subsequent theory-driven analysis.

Results

Forty respondents participated. In terms of ‘link’, retiring could feel like a loss when work links were positive, whereas the opposite was true when relationships were poor, or peers were retiring. Considering ‘fit’, intrinsic job satisfaction was high but respondents had less confidence in their own abilities as they grew older. However, the data foregrounded the inverse of Mitchell et al.’s notion of ‘sacrifice’; for UK doctors, staying in work can involve sacrifice because of tax penalties, work intensity and arduous demands.

Conclusion

Retirement stay/go factors seem enmeshed in the cultural, social and economic structures of healthcare organisations and countries. Systems-level interventions that address ultimate causes, such as sufficient staffing, supportive systems, non-punitive taxation regimes and good working conditions are likely to be most effective in encouraging doctors to continue to contribute their knowledge and skills to the benefit of patients and learners.

299 words

Keywords

Physician; Retirement; Employee retention; Job embeddedness; Qualitative research

Background

People are the backbone of healthcare^{1,2} and healthcare education delivery in the workplace.

However, many health systems face difficulties creating and maintaining an effective, efficient and motivated workforce.^{3,4} Much of the discussion on this topic has focused on workforce production (recruiting and training the next generation of healthcare professionals).^{1,2,5} However, a major factor in workforce planning is retaining experienced staff; those nearing the end of their careers who have tacit knowledge about patient care, education, leadership, research, and innovation which must be transferred to the next generation.⁶⁻⁸ The wider literature suggests that the loss of experience-based knowledge puts organisations at risk⁶ and, in the case of doctors, leaves healthcare services overstretched, jeopardises patient care, impacts on continuity of care, and brings about a shortage of experienced people to educate the next generations of medical students and doctors in training.

The risks to healthcare delivery and medical education posed by the loss of experienced clinicians through retirement is immediate in many countries. For example, in the United Kingdom (UK), two-thirds of doctors aged 55-64 are considering retiring within three years.⁹ Similarly, in the United States (US) there is a trend towards earlier retirement; the average retirement age of physicians decreased from 70 in 1980 to 65 in 2016.^{10,11} Paradoxically, this is against a backdrop of older populations of doctors in many countries, suggesting diverse patterns of behaviour in senior doctors.^{1,12-15} However, overall there is a global medical workforce shortage, and a growing and ageing population with greater health needs and demands.¹⁶ This “double whammy” means healthcare delivery and education face critical potential shortages in the foreseeable future due, at least in part, to skilled doctors retiring.¹⁷⁻²¹

Retirement decision-making is complex. Retirement decisions are made against a background of societal norms about retirement age, which are typically related to pensions eligibility,²² as well as

organisational and public policies about pensions provision.²³ Thereafter, influences on retirement decisions tend to be individual or job-related. Individual factors include, for example, poor health, the attraction of “doing something different” in retirement, or a spouse that has retired.²⁴⁻²⁷ In doctors, age-related deterioration may also be a driver,²⁸ reflected in more patient complaints about older doctors.²⁹ (Yet, nothing is simple. The effect of age on individual performance varies enormously^{7,8,30,31} and different specialties have different physical and cognitive demands.³²) Job-related factors which influence retirement decision-making include work autonomy, work flexibility, provision of rewards that older workers value (e.g. recognition and application of acquired knowledge), ongoing training and good interpersonal relations on the job.³³⁻³⁷

Many - predominately quantitative - studies have looked at doctor retirement decision making.^{8-11,18,21,38} The findings from these studies reflect the wider literature in that retirement decision-making is multi-faceted. However, this is a dynamic space where national and organisational policies and practices change constantly, and these macro-changes (e.g. pensions reforms) influence individual behaviour.²³ For example, Silver et al. reviewed 65 studies of doctor retirement planning published up to 2016, and including many UK studies. They concluded that doctors are likely to remain in practice beyond the traditional retirement age of 65.³⁸ That is no longer the case in the UK context.⁹ Moreover, there are limits to the literature. For example, the age range of participants in 65 studies included in Silver et al.’s review varied from aged 26 years to 94 years, suggesting that for many study participants, retirement was a distal event. To address these limitations, and acknowledging calls for more exploration and qualitative work on this topic,³⁹ our aim in this study is to understand retirement decision-making in a contemporary cohort of doctors, to understand what influences retirement decision-making. Our ultimate goal is to use this new knowledge to inform approaches to retaining expertise.

Method

Aim

We aimed to identify and explore both the embedding forces that may keep an older doctor in the workforce (“stay” factors) and (“go”) factors that might prompt retirement.

Design

In this qualitative study we used individual interviews to identify and explore multiple perspectives of the stay and go factors.^{40,41}

Context

The study was carried out in Scotland, UK, where most hospital doctors work mainly for the National Health Service (NHS). Most General Practitioners (GPs) are independent practitioners contracted to provide services to the NHS, or in salaried posts working directly for the NHS.

Our research focus was pertinent for these groups and the UK context. In relation to retirement, a recent (2018) survey showed that 60% of consultants intend to retire at or before the age of 60⁴² while other surveys have reported that over 40% of current GPs plan to retire in the next few years, with a large proportion of these doctors taking early retirement.^{19,20,43-45} These intentions to retire or leave are against a backdrop of an ageing GP⁴⁶ and consultant workforce,⁴⁷ and complex pension taxation systems where people saving for retirement benefit from tax relief, subject to annual and lifetime limits. These limits have reduced in recent years and pensions savings in excess of the limits face significant tax charges. The implications of this on doctor job satisfaction and retention have received much attention in both the popular and medical media in the UK, and were extremely topical at the time of carrying out this study.^{48,49}

Participants

We approached doctors from three career groups (GPs, Consultants, and Associate Specialist and Specialty (SAS) doctors), and from four of the 14 Scottish Health Board Areas (HBAs). We selected the four HBAs to represent a range of urban and rural, affluent and less affluent locations.⁵⁰ Doctors were emailed invitations and a Participant Information Sheet (PIS) on our behalf by the British Medical Association (BMA), a professional body and trade union for the medical profession, who supported this project. Potential participants were identified from existing membership lists, but the invitation indicated that the research team was independent of the BMA.

We wanted to interview doctors who were: aged between 50 and 80 years; registered with the UK's General Medical Council (GMC); and either practicing or recently retired from practice as a medical practitioner working mainly in Scotland. We chose 50 years of age as the cut-off as many studies define older workers as those aged 50 years and over.^{51,52} We also felt that retirement was a distal event for those under 50 years of age in the UK context, where at the time of data collection minimum eligibility for a state pension was age 65.

To ensure the most diverse group of participants, and therefore greater likelihood of different views and attitudes towards retirement, we purposively selected respondents who fulfilled our inclusion criteria and represented a range of the aforementioned characteristics. We aimed to recruit nine doctors from each HBA, three from each career group (GP, Consultant, SAS doctor; n=36). We followed up indications of interest in the study with an email or telephone call to arrange an interview.

Data collection

We developed a semi-structured interview schedule informed by the literature and discussions with representative doctors (Box 1). We tested and refined the schedule via four pilot interviews. No substantial changes were required to the schedule following piloting, so these data were incorporated into the main data set. TP conducted all interviews. The interview schedule ensured consistency but interviews were iterative and continued until the participant felt s/he had shared their experiences sufficiently. As far as possible, open questions guided the discussions, with prompts from the researcher to probe for deeper understanding of participants' views.

.....Box 1: Interview schedule

Data analysis

Interviews were digitally audio-recorded for later transcription and anonymised through the transcription process. Transcribed data were entered into qualitative data analysis software to facilitate data management and multi-analyst data coding.⁵³ We initially conducted a primary-level, thematic framework analysis to identify, extract and code themes and sub-themes relating to content.⁵⁴ After team discussion of preliminary codes and resolution of any coding disagreements, coding and interpretation occurred iteratively and inductively, focusing throughout on the research question.

After the themes emerged, and following further team discussion, we extended beyond simple thematic analysis to critically analyse doctors' views, attitudes and decisions about retirement using a job embeddedness lens.⁵⁵

Job embeddedness has a firm grounding, originating in Field theory.⁵⁶⁻⁵⁸ It comprises three dimensions: link, fit and sacrifice. Link refers to connections between a person and organisation,

and/or other people. Studies have demonstrated that social integration at work motivates people to stay in the workplace.^{55,59} Ng and Feldman⁶⁰ argue that older employees have less inclination to leave an organisation because, compared to younger employees, they tend to have stronger links with their colleagues and have more links between on-the-job and off-the-job factors. In terms of fit, an individual's personal values, career goals, and future plans must fit with the wider organisational culture and the demands of their immediate job (job knowledge, skills, and abilities). The better the fit,⁶¹ the higher the likelihood that an employee will feel professionally and personally tied to an organisation. This is related to the concept of perceived organisational support (POS); where employees perceive that the organisation values and supports them, they will be more likely to stay with that organisation.^{62,63} In terms of predicting retirement, fit also encompasses the demands of the job⁶⁴ and mechanisms to compensate for physical, cognitive and/or practical constraints (e.g. part-time working).⁶⁵ Sacrifice refers to material or psychological benefits that may be forfeited by leaving a job such as loss of intrinsically interesting work tasks, financial rewards and/or job stability.⁶⁶ Studies have found that the three dimensions of link, fit and sacrifice influence retirement decisions,^{67,68} both in respect to why employees want to leave their organisations and why they may remain.^{69,70}

Reflexivity

Qualitative research and analysis are dependent on the relationship between researcher and research process.⁷¹ We considered our positions and relationships with the data constantly and critically bearing in mind our different disciplinary backgrounds (psychology, health services research, health economics), research interests (e.g. different theoretical perspectives), personal life courses⁷² and cultural backgrounds, and how these might have shaped our co-construction of the data.

Ethics

Approvals for this study were obtained in advance of data collection from the College Ethics Review Board (CERB) at the University of Aberdeen.

Results

Responses to the emailed invitation were received from 188 doctors. Thirty-six doctors were purposively selected for interview in accordance with our sampling approach. Our four pilot interviews were also included in the analysis, giving 40 interviewees in total. Table 1 reports participant characteristics.

.....Table 1: Characteristics of interviewees

Amongst consultant and SAS doctors, the specialties represented included anaesthetics, endocrinology, ear nose and throat, emergency medicine, gastrointestinal medicine, general medicine, neurosurgery, obstetrics, oncology, paediatrics, psychiatry, radiology and respiratory medicine.

The median length of interview was 52 minutes (range: 16-72 minutes), and the total data represented approximately 35 hours of interview time.

We report verbatim quotes in italics, identifying participants by career grade (GP; Consultant (C); SAS), working status (working (W); retired and returned to clinical practice (RR); fully retired from

clinical practice(R)) and a numerical identifier. Where less relevant text has been cut out, this is indicated by the symbol <>. Any non-verbatim explanatory text is in [square brackets].

Sacrifice

In the theory of job embeddedness, sacrifice represents the perceived tangible (e.g. income) and intangible (e.g. feeling valued, support, loss of identity) costs of leaving a job.⁵⁵ In terms of retirement, this might encompass loss of support from colleagues (see also [Links](#)), feeling valued by the organisation,⁶² self-identity or financial rewards and benefits.⁶⁷

Comments suggesting feelings of loss or sacrifice of self-identity on retiring were not particularly prevalent in the data. While some participants speculated some anxiety about missing “being a doctor” (*I think, I suspect I will miss it, but I’m of a mind that we’ve made a plan, and we’re going to be doing things, so I will actively work to not miss it (C11,W)*), others had no such qualms (*I feel that when I retire, I’ve done my bit, and I’d be happy to draw a line under it (GP20,W)*).

Whilst Mitchell et al. primarily focus on sacrifices employees make when they leave a job,⁵⁵ our data point more compellingly to sacrifices that doctors could experience by **staying** in a job, rather than retiring. Most participants had plans for what they would do in their retirement and looked forward to having more time to pursue outside interests. Many cited the retirement of a spouse as an important influence on their own retirement; others simply wanted to have more time to spend with family. Those who anticipated a caring role in later life for elderly relatives or other dependents perceived that they needed more free time to devote to this. Put simply, staying in work was unattractive to many who wanted a better work-life balance:

I mean I could retire at 59. I may do that. I think it also depends on other things like what my wife does, what her retirement plans are, not to mention what our children do, and where our grandchildren situation is. (GP20,W)

Participants expressed fears of making mistakes linked to anxiety about possible age-related deterioration of performance (see also Fit). Concerns included both fears for patient safety and potential complaints:

You only need one disaster to kind of, to alter your view of things, and one legal case, one big complaint, or one death can ruin it, and all of a sudden it sours it forever (C10,W).

Awareness that registered UK practitioners over 50 are most likely to be subject to formal complaints⁷³ and a recent high profile legal case appeared to fuel such anxieties.⁷⁴ The general sense was that retiring would eliminate these risks, thus, staying in the job could be seen as sacrifice, rather than the reverse.

Participants discussed the financial implications of retiring or not in great detail. Relatively speaking, doctors in the UK have very good pension plans so, for most, the decrease of income that comes with retirement was not an issue or sacrifice. In fact, the complexity of recent pension changes sometimes meant the opposite; for some doctors it was financially advantageous to retire. Doctors whose pension pots were approaching or had reached the lifetime allowance (see [Context](#)) would seriously consider retiring early if that meant taking their pension at the most tax efficient time:

This guy [financial advisor] calculated my pension entitlements and the tax and all the rest of it <> essentially he said, "if you do not stop working at 60, or 60 and a few days, you're going to be penalised so much that it's just not worth it" (SAS40,W).

Similarly, some were finding that regular breaching of the annual allowance (see [Context](#)) on pension contributions was pushing them to consider retiring:

I'm stuffed for annual allowance. So I've got massive extra tax bills that I've been debating, you know, should I retire sooner? <> it's just financially crippling <> a lot of doctors will be hitting that just now, all my mates, you know, we've gone over our annual allowance, so that is precipitating a lot of them to say, "well rather than all that extra tax and stuff like that, it's not going to make an

awful lot of difference to me, but I haven't got the ready's for that, I'll just retire now", especially if they're feeling a bit weary about things (GP25,W).

Alternatively, one younger consultant, who was some way off the normal pension age, elected to work fewer hours:

The times when I took on another role, as head of service, you get a slight uplift in your salary, it's not huge, but it's there. That has a kind of 20-fold effect on the pension taxation. So you can find yourself paying huge amounts of tax, and the obvious solution is what most people are doing, is actually to reduce their hours (C9,W).

However, concerns about work intensity seemed just as important as financial considerations when contemplating retirement. Participants spoke of struggling with overly heavy, intense workloads, major upheavals (e.g. reorganisation, relocation), and myriad daily hassles such as insufficient administrative support, poor IT facilities and lack of staff parking (see also [Fit](#)). These issues were perceived as ever present but participants felt that they were not supported by the organisation (typically interpreted as the local NHS health board) in terms of managing challenges:

The health board, they, you know, there's this thing where people pretend to be supportive and actually they're not <> it's about "the whole" being valued, and the lack of control and people making these decisions but, you know, being unappreciated (GP24,W).

For some, the support and value they received from other quarters compensated for lack of organisational support (*I know my patients value me, my colleagues and the trainees here, we all value each other, so I don't actually need to be valued by management (C7,W)*: see further discussion below and [Links](#)), but for a few, lack of support from management led directly to them contemplating or, in the following case, actually taking earlier retirement:

I had a difficult job planning series of interviews with a manager, and it became really quite difficult <> I just put the line in the sand and thought, “no I’m not going to be doing that again, I’m going” (C13,W).

Participants talked about relationships with NHS managers, usually negatively; amongst some there was a general feeling that managers did not understand the needs of those working at ‘the coalface’ and were unprepared to listen. Managers appeared to be seen as representatives of the organisation (i.e. the NHS) and their actions/behaviour as reflecting the values of the organisation.^{75,76}

Links

Job embeddedness theory suggests that formal or informal connections, or “links”, between people play a role in retention.⁵⁵ Our data indicate that links/social enmeshment with workplace peers and the wider community provides support and creates workplace cohesion: *you wanted to do your best for the local folk around you (GP28,R)*. One participant who elected to return to work in the same department after taking so-called 24-hour retirement, described their workplace as: *a good, cohesive department, always functional, coped well with many challenges thrown at our way. It was, and is a good department to work in (C1,RR)*. Others phased their retirement to help their team: *I did agree to carry on doing a very small amount of clinical work because there a was a bit of gap in terms of succession (C15,R)*. The reverse was, however, apparent for others. One GP took earlier than planned retirement and explained: *Problems arose with a couple of members of staff. We went through a couple of practice managers <> but it all revolved round poor relationships amongst the partners (GP27,W)*.

Our participants viewed the rate at which their colleagues were retiring as “a signal device”⁶⁷ that they too should retire:

Right now, there is a whole cohort of people who are the people I have been working with for decades now, who are starting to retire. So there is that almost bereavement reaction, as each one of them leaves, and you don't hear that laughter in the corridor anymore, you don't hear the anecdotes about their children, and their grandchildren (SAS36,W).

In other words, if your peers are retiring, that is the norm and you may not wish to be “left behind”. This quote also illustrates the importance of colleagues in terms of support and assistance, and how knowledge of, and interest in, personal factors is part of the glue that binds people together in the workplace.

Fit

Mitchell et al.'s definition of 'fit' includes the degree to which a person's values and plans fit with job demands and organisational culture, and the extent to which a job has a manageable level of challenge.⁵⁵

Almost without exception, the doctors we interviewed highly valued their profession. Job satisfaction was high and, in particular, they enjoyed the variety, clinical work and patient contact: *what gets me out of bed in the morning is I look forward to looking after patients, and I still enjoy it, and that side of things is an enormous positive (C11,W)*. On a day-to-day basis, most participants also seemed generally satisfied with their levels of clinical autonomy, another facet of 'fit'.⁵⁵

However, participants referred to high levels of pressure because of demanding work schedules, busy environments, long working hours, insufficient staff, being *asked to do more and more and more (C14,W)*, pressure from increasing patient expectations, and feeling that the job was very different from the one they entered. These pressures were seen as detrimental to personal well-being and to patient care (*I mean it's a war zone in our ward at times. The number of children*

coming in that are unwell, the number of staff we have, and you know, mistakes do happen (C3,W)),
and were important factors in retirement decision-making.

Night on-call was discussed specifically as a work demand that was more difficult to manage with age. A number of participants had withdrawn from out-of-hours working or on-call, but this was not always possible:

...in a bigger hospital, at 50 you might be able to choose to not be on-call, or to be only on-call half as much, or to do, you know, maybe you'll do more clinics and less board work, whatever would actually suit you at the time, you might become a hospital manager and do less clinical activity, if you can do these things, but you don't really have that option [in this hospital](C12,W)

A more flexible work schedule seemed to be easier to achieve for GPs generally, possibly because of their different contractual and management structures (see [Method](#)). However, as was the case for consultants, this flexibility was less possible in smaller and/or more remote practices.

Within job embeddedness theory, 'fit' is also connected with how well an individual's skills match their job.⁵⁵ Many in this study had concerns not only about personal competence as they grew older (see earlier) but also confidence in their own abilities. For example, hospital doctors whose jobs rely on good eyesight (e.g. radiology) or fine motor skills (e.g. paediatric surgery) were conscious that these would inevitably deteriorate as they aged, and this could have implications for patient safety. Experience was seen as compensating for skills loss to some extent, but keeping up to date with new knowledge was seen as increasingly difficult:

I don't think I'd lose my skills, or my craft, but the... the extra stuff, the add on, to keep that stuff going up to date starts to become more than the job is worth (GP26,W).

...the hard drive is full, it really is (C14,W).

While reducing working hours was a popular option in relation to managing a work-life balance and extending working life (see earlier), retaining enough clinical work to maintain competence was seen as important: *I just think that it would be difficult to keep up to date unless you're doing it quite a lot* (GP19,W). Participants did not put a figure or amount on this threshold but believed that either they, their colleagues or managers would self-monitor/monitor and intervene if there were problems:

I think you're probably best at assessing. I mean obviously if there's a big problem you would hope that would be highlighted by your line manager or colleagues (SAS31).

These data suggest that the (informal) views of colleagues were important and useful in assessing continued “fit” in terms of skills and competence. On the other hand, national regulatory systems for ensuring doctors are competent/maintain competence were viewed negatively.⁷⁷ Mandatory revalidation was roundly criticised: *I doubt that it's going to prevent bad doctors* (SAS40); *I think it's a farce* (C7,W); *absolute waste of time* (C8,W). Views on appraisal⁷⁸ were more diverse. For some, it was a useful exercise in self-reflection, therapeutic, and/or a (positive) opportunity to get feedback from patients and colleagues. For many it appeared to be a necessary burden, and the degree of usefulness was dependent on the skills of the appraiser. Sceptics of the appraisal system were rather more negative: *appraisal is completely useless, it's a complete waste of time* (GP24,W).

Discussion

Our aim was to identify and explore the factors that might keep a doctor in the workforce and those that might prompt someone to retire. Using ‘job embeddedness’ as a theoretical lens, our data suggest that participants perceived their jobs to be meaningful and enjoyed certain aspects of working life, particularly patient contact and social links with colleagues. However, (overly) onerous workloads and age-related constraints (e.g. sensory deterioration, fatigue) appeared to be

associated with motivation to stop working. Our participants reflected on how burden of work, high intensity workloads and high demands⁷⁹ are harder to manage as one gets older. The pension taxation issues were, for some, the last straw in terms of pushing them towards retirement.

The data foregrounded a situation that appeared to be the inverse of Mitchell et al.'s notion of sacrifice; for high-earning, time-poor, stressed-out individuals (like many doctors),^{80,81} staying in work (even to the standard retiral age) can involve sacrifice because of tax penalties, perceived lack of organisational support and fear of error. Any or all of these factors may stimulate ideas of retiring on or before traditional retiral age. Figure 1 presents a summary of our findings and illustrates the interactions between various aspects of sacrifice, links and fit in the data.

..... **Figure 1 about here**

Our data suggest that the macro-level factor of pension taxation change is one of many factors that might push a UK doctor into retirement. Reflecting previous studies from other occupational groups,^{42,47,82-86} work burden and working hours are also important in retirement decision making as are relationships with peers⁸⁴ and being able to afford to retire.⁸⁷⁻⁸⁹ While appraisal and revalidation processes were viewed as burdens,⁹⁰ these seemed less influential when considering retirement than work pressures or pension savings limits.

Employers cannot influence individual antecedents of retiral intentions such as family issues or health concerns.⁹¹ What they can do is consider supporting older doctors by reducing hours, particularly out-of-hours and overnight working (to address diminishing stamina and guard against error), and ensuring professional development time (addressing fear of error and of not feeling up-to-date). Drawing on job embeddedness theory, these interventions may also ensure doctors feel

valued, increasing their commitment and loyalty to the organisation, which in turn could have tangible gains (keeping older doctors in the workforce/retaining expertise).^{92,93} Healthcare organisations may consider that different working arrangements for later-career doctors are impossible because of insufficient staffing levels and other constraining factors. We would argue that keeping an experienced doctor 50% of the time for a year or two longer is better than losing their skills and experience completely because they no longer feel capable of carrying on in the same role with the same responsibilities.

There is also an argument to consider other roles for doctors transitioning towards retirement, to harness their knowledge and experience for medical education and training.⁹⁴ This so-called “bridge employment”⁶⁵ would have the potential to retain older doctors and maintain their job satisfaction while, for example, also meeting the educational needs of medical students and younger doctors. Finally, processes for supporting older doctors in the workforce for longer may also be useful in terms of signals to others to stay, not go,⁶⁷ particularly in countries with a bulge of doctors nearing retirement age.

Rather than focusing on one specialty group (as has been the case in many previous studies in this area),³⁸ we sampled across specialties, hospital and community medicine, and different roles (GP, consultant, SAS doctor). We had a good balance of male and female participants. Our sample included doctors who were working, doctors who had retired, doctors who were on the point of retiring (meaning their retirement date had already been set) and some participants with no firm plans for retirement. Our recruitment of participants aged 50 years plus was aligned with many retirement studies,^{51,52} but may have excluded younger doctors who could have already been planning their retirement.⁹⁵ Interestingly 90% of our participants were aged under 62 years, reflecting recent figures on UK doctors’ retiral patterns.⁹⁶ Finally, this is a qualitative study, carried

out in one context, and our findings may not be transferable to other contexts with, for example, different pensions systems.⁹⁷

As with any voluntary study, there would have been an element of participant self-selection but we mitigated this by having a predetermined sampling framework. Of interest was the extremely positive response to our initial recruitment email, reflecting that this is a topic of interest and importance, in the UK at least. Recruitment was via a third party, the BMA, which represents more than half of doctors aged 50 year plus in Scotland: we have no way of knowing if BMA-registered doctors differ from their non-BMA counterparts.

Job embeddedness theory was developed and validated mainly in the US⁷⁰ and the bulk of research has taken place in high-turnover, industrial settings.⁶⁹ In contrast, our study was carried out in the UK with a low-turnover, highly-educated professional group, working directly or indirectly for the same public sector organisation. The notions of fit and links were mostly applicable but some aspects of sacrifice, particularly the economic aspect, were not applicable to this geo-social-cultural context. In other words, although we used embeddedness theory to highlight patterns and generate conceptual generalisability,^{98,99} there may be boundaries to embeddedness theory as applied to retirement, and there are populations, settings and points in time where this theory may be less effective.^{100,101} Further research is required. We also propose that an outstanding gap in the literature is determining what are the **most** important factors in retirement decision-making. To examine this requires the use of stated preference approaches, such as discrete choice experiments (DCE).¹⁰²⁻¹⁰⁴

Our focus on retirement was consistent with contemporary theorising of embeddedness theory.^{67,68} However, as with all theoretical or conceptual lenses, embeddedness illuminated certain aspects of

the data;¹⁰⁵ another lens may have emphasised different data, such as that related to identity threat (e.g. apprehension about clinical competence and loss of belonging as colleagues retired).^{106,107}

In conclusion, we suggest that retirement stay/go factors are enmeshed in the cultural, social, and economic structures of healthcare organisations and the countries in which they are situated.

Tailoring later-career jobs to individuals (micro-level interventions) may lead to doctors staying in the workforce for longer. However, macro- and systems-level interventions that address ultimate causes,¹⁰⁸ such as ensuring sufficient doctor numbers to manage workload, supportive systems, non-punitive taxation/pensions saving regimes and good working conditions are likely to be more effective in encouraging doctors to continue to contribute their knowledge and skills to the benefit of patients and the next generations of doctors.

Declarations

Ethics approval and consent to participate

Ethical permission was granted for this study from the College Ethics Review Board at the University of Aberdeen (CERB/2017/10/1521). All interviewees gave written informed consent for participation, including permission to: audio-record the interview; use anonymised data in dissemination materials; and re-contact.

Availability of data

We did not seek explicit consent from our interview subjects if they wished to share their data outside the research team, and so cannot share it in the public domain.

Competing Interests

The authors declare no competing interests.

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Authors' contributions

The funding for this project was obtained by JC. The study design was led by JC in collaboration with TP and DS. TP prepared the ethics application. TP and JC led on the literature review. The analysis was carried out by TP and OE, under supervision from JC. TP drafted an earlier version of this paper, with JC revising the paper. All authors reviewed the final draft and approved the paper. The study is guaranteed by the University of Aberdeen.

Collaborator Statement

This project was carried out in collaboration with the British Medical Association (BMA), Scotland

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Table 1: Characteristics of interviewees (N=40)

CHARACTERISTICS		n (%)
Sex	Male	19 (47.5)
	Female	21 (52.5)
Career group	Consultant	15 (32.5)
	GP	15 (32.5)
	SAS	10 (25.0)
Age	50-52	7 (17.5)
	53-55	9 (22.5)
	56-58	9 (22.5)
	59-61	11 (27.5)
	62+	4 (10.0)
Work pattern	At least 8 sessions/week (4 days/80% FTE)	22 (55.0)
	Fewer than 8 sessions/week	15 (37.5)
	Fully retired from clinical practice	3 (7.5)

Box 1: Interview schedule

1. Summary of current job
2. Have you given any consideration to when you might retire?/When did you retire?
3. Which aspects of your everyday work are likely to/did influence your retirement decisions (e.g. workload, job satisfaction)?
4. Are there any other professional factors that might/did influence your retirement decisions (e.g. relationships with management, revalidation/appraisal)?
5. Which aspects of your personal life are likely to/did influence your retirement decisions (e.g. health, family, finances)?
6. What would need to change for you to delay or bring forward your retirement plans (stay/go factors)?