

Exploring reasons behind UK doctors leaving the medical profession

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BMJ Open Exploring reasons behind UK doctors leaving the medical profession: a series of qualitative interviews with former UK doctors

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ABSTRACT

Background The retention of doctors is an important issue for the National Health Service; yet evidence suggests that the proportion of doctors wanting to leave UK medicine is increasing. Some of these doctors chose to continue their medical careers in other countries, however, some decided to leave the profession entirely.

Objectives This was the first study to interview a cohort of UK doctors who have left the medical profession to embark on alternative careers. Participants were asked about the reasoning behind their decision to leave medicine.

Design Qualitative study using one-to-one, semi-structured virtual interviews.

Participants 17 participants, recruited via purposive sampling.

Setting Zoom interviews with 17 former UK doctors who had left medicine to pursue alternative careers were conducted between February and July 2021.

Findings Data were analysed using thematic analysis and the theory of work adjustment was applied to findings. The most frequently discussed reasons for leaving were associated with factors preventing participants from providing a desired level of patient care, work-life balance, a lack of support, a lack of control over working lives and the pull of alternative careers. While reasons for leaving varied between participants, all participants reported greater satisfaction in their new careers.

Conclusion New careers were able to address many of the issues that caused participants to leave UK medicine. Consequently, it is important that some of the key issues raised in this study are addressed to retain more doctors in the UK medical workforce.

INTRODUCTION

The retention of staff is vital for any workforce, and this is particularly true for the National Health Service (NHS), which has a highly specialised workforce.¹ Doctors trained in the UK must spend a minimum of 4 years at medical school,² and this involves significant investment on the part of the UK government, who have reported an average cost of £230 000 to train a single doctor.³ As of 2019, there were 2.8 doctors per 1000 population

STRENGTHS AND LIMITATIONS OF THIS STUDY

- ⇒ The sample was diverse and included a mixture of males and females, doctors who had left medicine at different stages of their careers, and a mixture of doctors who had worked in primary and secondary care.
- ⇒ The theory of work adjustment was employed to contextualise the findings of the study, providing a theoretical framework for the results.
- ⇒ The semi-structured interview format allowed for a high extent of flexibility in each interview, allowing individual circumstances behind leaving medicine to be thoroughly explored.
- ⇒ Snowball sampling can lead to sampling bias, which increases the possibility of participants sharing similar characteristics and viewpoints, meaning the results are not generalisable.
- ⇒ The interviews and transcript coding were conducted by a single researcher.

in the UK, the fourth lowest proportion in Europe.⁴ Vacancies and understaffing are major problems for the NHS, and as demand for NHS services increases, the well-being of those doctors who remain in the system will become more important.⁵

When doctors decide to leave UK medicine, they have two choices: either continue to work as a doctor abroad or leave the profession entirely.⁶ The proportion of doctors wishing to leave UK medicine has been increasing since the 1970s.⁷ Lambert *et al* found that the dominant reason for doctors considering leaving medicine 3 years after graduation, cited by 48.5% of respondents, was due to 'NHS culture/state/politics'.⁸ Other common reasons given were associated with poor work-life balance, feelings of underappreciation, wanting to take a career break and the workload of the job.

'Dissatisfaction with the role/place of work/NHS culture' was also the most



frequently cited reason that doctors gave for leaving UK practice in a General Medical Council survey of 13 158 doctors who had previously worked in UK medicine.⁹ This is currently the largest survey of former UK doctors and it has provided unique insight into the demographics of UK doctors who have left medicine. Interestingly being male or disabled were the two most noteworthy risk factors for leaving UK medicine. The report also found that doctors were leaving at all stages of their career, with 32% leaving as 'specialists', 25% leaving as general practitioners (GPs) and the remaining 43% leaving as 'trainees or other'.

Smith *et al* interviewed Foundation Year 2 (FY2) doctors who were planning to leave UK medicine and continue their medical careers abroad.¹⁰ The study found that strict training structures, the pressure to make an immediate career decision and a bullying culture at work were all driving factors away from UK medicine. Thus the literature illustrates the pressures associated with working in UK medicine that contribute to dissatisfaction, and as doctors have similar motivational factors to other professionals for wanting to change careers, many will inevitably consider their options if dissatisfied.^{8 10-12}

The more popular option is for doctors who leave UK medicine to remain in the profession, but work abroad.⁸ Thus this group is much more extensively researched.¹³⁻¹⁵ There is no published study that has exclusively interviewed a population of doctors who have left UK medicine and embarked on new careers. This study draws on the theory of work adjustment (TWA) to explore the reasons behind participants' decision to leave medicine, addressing a significant gap in the literature. The theory was applied retrospectively to the data after inductive coding. This process is described in level 4 of Bradbury-Jones *et al*'s typology of how 'theory is used and articulated in qualitative research'.¹⁶

THEORY OF WORK ADJUSTMENT

The TWA was developed from vocational rehabilitation in 1964,¹⁷ and continues to be developed.¹⁸ It is regarded to be the most prominent vocational theory specifically related to job change.¹⁹ TWA was created with the intention of understanding the reasons why individuals change jobs,²⁰ and has previously been used in a similar manner to this study as a theoretical framework to explain why female engineers decided to leave their jobs.²¹

TWA contains two models: a predictive model and a process model.¹⁸ The predictive model focuses on the relationship between a person and their employer and illustrates how people and employers have requirements of each other. TWA proposes that when a person and employer are satisfied by each other, there is correspondence between person and employer. This means that the person is satisfied with their job and the employer is satisfied with the way the person is performing, resulting in a state of harmony or correspondence between the two.

Where this is not the case, when either the person is dissatisfied with the employer, or the employer regards

the person as unsatisfactory, then adjustment is required. Where adjustment is required, person or employer can seek to change the other party or change themselves. Adjustment may result in a person leaving a role or an employer dismissing a person.

The theory suggests that individuals' needs are underpinned by six core values that have a set of reinforcers which are features of an employer. Values and reinforcers are shown in [table 1](#). Identifying values and reinforcers helps to predict the factors that cause dissatisfaction (of a person) and may lead to attempts to achieve work adjustment.

The process model of TWA focuses on how work adjustment occurs.¹⁸ Different people and employers have different adjustment styles that lead to them reacting differently to discordance (dissatisfaction). Adjustment style is made up of four separate variables: flexibility, active adjustment, reactive adjustment, and perseverance. These variables are outlined in [table 2](#).

In exploring why doctors choose to leave the medical profession, we are concentrating on extreme forms of adjustment, where doctors have chosen to leave not only a specific role or employment, but the profession itself.

RESEARCH AIM

The study aimed to explore key reasons behind UK doctors deciding to leave the medical profession and pursue alternative careers.

METHODS

Study design

Due to the exploratory nature of the study, a qualitative study design was chosen over quantitative methods.^{22 23} We conducted 17 semi-structured interviews with doctors who had left the medical profession. All interviews were based on the same interview topic guide (online supplemental file 1) and were conducted by the first author. The semi-structured format gave a high degree of flexibility,²⁴ allowing participants to raise any issues that they deemed appropriate. All interviews took place virtually using the video conferencing application Zoom, between February and July 2021. The length of interviews ranged between 23 and 62 min, with an average interview length time of 41 min. Interviews were conducted and recorded using the video conferencing application Zoom. Full transcriptions were made by editing the Zoom recordings.

Recruitment

The recruitment strategy consisted of two main approaches: internet-based recruitment using social media platforms and snowball sampling. The study was advertised on the researchers' personal social media platforms LinkedIn, Facebook and Twitter. Snowball sampling allowed us to increase the sample by using the contacts of already recruited participants.²⁵ Thirteen participants were recruited through social media advertising and

Table 1 Core values and reinforcers

Value	Reinforcers	Meaning
Achievement	Ability usage, achievement	<p>Conditions that allow an individual to use their abilities to achieve success.</p> <p>For example, a person being able to use their communication skills to make a sale.</p>
Autonomy	Creativity, responsibility	<p>Conditions that enable individuals to have control over their work environment and allow them to use their individual creativity in their job.</p> <p>For example, a person being able to choose the location of their work.</p>
Status	Advancement, recognition, authority, social status	<p>Conditions that allow individuals to receive recognition.</p> <p>For example, a person being able to receive a promotion.</p>
Altruism	Coworker relations, social service, moral values	<p>Conditions allowing individuals to work in harmony, and to provide a service for others.</p> <p>For example, a person who feels that their job has a positive influence on society.</p>
Comfort	Activity, independence, variety, compensation, security, working conditions	<p>Conditions that decrease stress and unwanted pressures on individuals.</p> <p>For example, a person who is able to have a protected lunch break at work.</p>
Safety	Company policies, supervision—human relations, supervision—technical	<p>Conditions that give individuals stability.</p> <p>For example, a company policy where seniors must supervise their staff by meeting with them regularly to discuss performance and well-being.</p>

four via snowball sampling. Recruitment occurred from January to July 2021, and ceased once code saturation had been achieved.²⁶ The final two interviews yielded no new codes. Participants were not compensated for their time.

Participants were required to have graduated from a UK medical school, have completed the first year of foundation training (FY1), and to have left the profession between 2010 and 2020. Thus, all participants had left the profession more than a year before being interviewed and all had left the NHS before the beginning of the COVID-19 pandemic. This meant that pressures caused by the NHS response had not been experienced. Individuals working for either the NHS or UK universities in non-clinical roles, were not eligible, and neither were retired doctors.

Data analysis

The data analysis process began after completion of the first interview. Data was analysed in NVIVO V.12 using

Braun and Clarke's six-step guide for thematic analysis. One interview was coded by both authors and differences resolved through discussion. The final codes were determined by the first author who coded all other interviews, and also conducted the interviews.²⁷ Codes were identified inductively before mapping them on the six values of TWA or to one of the four adjustment style variables.¹⁸ This process was undertaken by both researchers.

Patient and public involvement

No patients or members of the public were involved in the design, or conduct, or reporting, or dissemination plans of this research.

RESULTS

Participant demographics

Of the 17 participants, 10 were female and 7 were male. Seven participants left medicine after becoming consultants or GPs and 10 participants left while still junior

Table 2 Adjustment styles variables

Adjustment style variable	Meaning
Flexibility	<p>The amount of dissatisfaction that a person or employer can tolerate from each other before adjustment of work status takes place.</p> <p>For example, the amount of unpaid overtime a person is willing to do before complaining to their boss will vary between people.</p>
Active adjustment	<p>When a dissatisfied person acts on their employer, or a dissatisfied employer acts on a person, to attempt to reduce discorrespondence.</p> <p>For example, a person wants a promotion as this would make them more content, so the person asks their boss for a promotion.</p>
Reactive adjustment	<p>When a dissatisfied person or dissatisfied employer acts on themselves, to attempt to reduce discorrespondence.</p> <p>For example, a person decides to regularly stay late after work to achieve increased recognition from their boss, as they believe this will get them promoted, and being promoted would make them more content.</p>
Perseverance	<p>The amount of time that a person or employer is willing to remain in a state of discorrespondence, after having engaged in some form of adjustment behaviour.</p> <p>For example, a person has made a change to work longer hours to achieve a promotion, but the person is still unhappy, as despite increased recognition from their boss, they have not been promoted. Perseverance measures how long this person will stay in the job and continue to work longer hours with no promotion.</p>

doctors. In the UK, on graduation, doctors are required to complete 2 years of foundation training, before embarking on specialist training. Doctors who have completed specialist training are called ‘consultants’ or GPs depending on whether they work in secondary care or primary care, respectively. All doctors who have not completed specialist training are called ‘junior doctors’.

The full demographics of the participants are outlined in [table 3](#).

The results are presented following the structure of the TWA—initially in the predictive model using the six values, and then the adjustment styles. In some interviews issues that were identified as dissatisfiers were compared with experiences in the new roles. There were several issues which might have been relevant to different categories. This might suggest that for the context of medicine in the UK, the six values might not be as independent as variables in a predictive model should be. In presenting the results, we have provided commentary where appropriate about categorisation issues.

Predictive model variables

Achievement

An issue that led to a high degree of dissatisfaction among participants was the number of excessive distractions that were getting in the way of actually providing patient care. This was particularly reflected among GPs and doctors who had left after reaching consultant level. Examples of these distractions included meetings and administrative

tasks, which some participants found to be excessive and lacking in purpose.

“The higher up I went, the less time I had face to face with patients.”—participant 7

“There seemed to be a lot of meetings for the sake of meetings.”—participant 9

Altruism

Many participants cited factors associated with an inability to provide a desired level of patient care to patients due to systemic reasons beyond their control, as a reason for leaving medicine. Feelings of guilt were common among participants.

“I just didn’t feel like I was helping people. When I kind of went into it to help people.”—participant 15

“I left the NHS because I couldn’t put my hand on my heart and say I can keep all these patients safe doing what I’m doing.”—participant 2

These two core values, achievement and altruism were difficult to differentiate in the data because of the very strong association between them.

Comfort

Many participants found that working as a doctor in the UK had a detrimental impact on their lives away from medicine. Several participants discussed their displeasure at having to work long and antisocial hours, which had

Table 3 Participant variables

Participant ID	Stage in medical career at which participant left medicine	Current career sector
1	After Foundation Year 2 completion	Business and finance
2	GP	Digital health
3	Hospital consultant	Works for charity
4	After Foundation Year 2 completion	Business and finance
5	GP	Coaching
6	During Foundation Year 2	Works for charity
7	Hospital consultant	Teaching
8	After Foundation Year 2 completion	Digital health
9	GP	Medical ethics
10	During specialist training	Recruitment
11	Hospital consultant	Business and finance
12	After Foundation Year 2 completion	Digital health
13	After Foundation Year 2 completion	Consulting
14	GP	Medico-legal
15	During specialist training	Medical writing
16	During specialist training	Pharmaceutical medicine
17	During specialist training	Business and finance

negative consequences on their quality of life. For those participants with young children, the impact that working as a doctor had on their family life was a key source of dissatisfaction.

“I never saw my kids from Monday to Friday at all.”—participant 2

“I remembered some of the consultants who I would frequently see still working, doing paperwork and still in the department really late in the evenings, and I thought, is this the life I want to have?”—participant 10

Some participants were confident they had experienced burnout, while others described feelings of fatigue and disconnect from the job. Participants who had not been satisfied by the work-life balance in UK medicine all reported that their new careers had rectified this problem. However, the issue of work-life balance was not a motivating factor to leave medicine for all participants and these participants were content to work even harder after leaving.

“I work harder now in consulting than I did as a clinician, but I guess I have no issue with working hard.”—participant 13

The issue of salary was not a principal motivator to leave medicine. Nevertheless, a minority of participants did factor it into their decision and subsequently noted increased earnings since leaving medicine. Most participants reported that their earnings had decreased from either their final medical salary or their potential future salary.

“When I started in this role, I actually took a pay cut to do it ... There was a financial hit to leave medicine.”—participant 9

Autonomy

When discussing their reasons for leaving the medical profession, many participants in this study also recalled being unhappy with the lack of control they had over their working conditions. These issues sometimes caused strong feelings of resentment towards working as a doctor in the NHS.

“There’s a feeling of total powerlessness ... We didn’t have any power over the things we were doing.”—participant 2

A specific example, where some participants still in training were particularly exasperated by their perceived lack of autonomy, was related to the geographical location in which they worked. Not being able to get jobs in specific areas had significant effects on the personal lives of these participants, as it often prevented them from being close to friends and family.

“I was applying for jobs around the UK, in places that I’ve never heard of, hoping I might get a job in London where my friends were.”—participant 13

Many participants believed that if they had greater autonomy over their working lives, they would have been more likely to stay in medicine. Most participants reported a greater sense of control over their working lives in their new careers. When reflecting on their medical career through the lens of their subsequent employment, one participant contrasted the difficulty of taking leave when working in the NHS to their current role.

“I can take leave when I want. That’s one of the things which is horrible about when you start working [as a doctor] is trying to get time off when you want to. I just feel more in control.”—participant 6

Safety

Participants discussed how feeling unsupported in their medical careers led to dissatisfaction. Many who left as junior doctors were particularly forthcoming in their opinions on the mentorship of junior doctors in the NHS. Some of these participants recounted difficult relationships with their supervisors, as they believed their supervisors to be disinterested in their well-being and progress.

“I remember after my first job in paediatric surgery, the surgeon who was my meant to be my clinical supervisor for the four months, didn’t remember what my name was at the end of the four months ... He just looked at me and said, “What should I write?”—participant 6

Some participants in this study described how instances of discrimination led to feelings of disillusionment with the NHS and the profession. A female participant, of South Asian heritage believed UK medicine to have a ‘racist, sexist and bigoted tension that people won’t admit to it’. This participant also believed that the subtle nature of the discrimination they experienced made it ‘harder to deal with’ from an external authority point of view. Another participant gave further views on the issue of racism in the NHS.

“I think there’s institutionalised racism. I’m quite certain that I’m already at a disadvantage simply by being black.”—participant 10

Participants also recounted various situations of conflict, with other colleagues while at work. One participant described their experience of feeling bullied by other healthcare professionals during their FY1 year.

“I think particularly being young and being female ... Because the nurses have historically had a problem with being mistreated by doctors ... they’re going to make it difficult for the junior doctors ... It was bullying.”—participant 6

Status

Issues relating to the value of status were generally not reported by participants as key motivations for leaving medicine. For many participants, respect from others was something that had originally attracted them to medicine. However, some participants recalled how their medical career had left them feeling unfulfilled. One participant described how a career change to life coaching gave them great personal satisfaction, something they had struggled to find in their final years of working as a GP.

“I’m empowered. I feel I’m able to empower others to live a healthy and happy life.”—participant 5

Process model

The process model considers how work adjustment is addressed, including the ultimate adjustment an employee can take, to change profession. By asking exclusively for the views of doctors who had left the profession, the data is from only those whose limits of flexibility and perseverance had been exceeded for the profession.

A major motivation behind leaving medicine for many participants was the attraction of specific alternative careers. This seems to add another dimension to the TWA. This motivation could not be assigned to any of the values

of TWA, but greatly impacted participants’ flexibility. TWA defines flexibility as the amount of dissatisfaction that an individual or the environment can tolerate from each other, before adjustment of work status takes place.¹⁸ Some participants had a reduced tolerance of a career in UK medicine, due to their awareness of other desirable careers. One participant spoke of how the attractiveness of their new role, led to them finally making the decision to leave medicine.

“When the job advert for my current role came up and it involved a bit of medical ethics, I spoke to my husband, we both smiled and he just said, ‘This is the perfect job for you.’—participant 9

Many participants had maintained strong interests outside of clinical medicine throughout their medical career, which they were able to use after leaving. One participant described how their long-standing interest in digital health led to their current career.

“I found working with technology, computers and digital health very interesting ... And so, I wanted to pursue that.”—participant 8

Some participants also believed that peer-influence made the decision to leave medicine much easier. These participants often spoke of being inspired by friends outside of medicine, while one participant discussed how the fact that they knew of other doctors who had also left medicine, gave them increased confidence to leave the profession themselves.

“If all of my friends were committed doctors and were spending their whole career in medicine ... I would be much more likely to stay.”—participant 4

These three examples show flexibility is reduced by the presence of external factors. Perseverance in TWA refers to the time that a person is prepared to remain in dis correspondence after an adjustment has taken place.¹⁸ This sample included doctors with a wide range of time between qualification and leaving medicine. Reasons for leaving medicine were not related to a specific job but were generally regarded as endemic to the way that the profession practices in the NHS. There is little in the data to suggest that active or reactive adjustments accounted for participants leaving the profession. Instead, the pattern was of deep-seated dissatisfactions that may have developed over a long time.

“You have just finished, you’re no longer being paid, and somebody says, ‘Could you just do this? You find yourself regularly doing all these unpaid extras. It’s absolutely constant.’—participant 7

There was little commitment to the identity of being a practising doctor despite the long period of practice in some cases. The strength of identity salience varies between doctors, and it is likely that those who leave the medical profession have lower identity salience. However, the picture is nuanced because for many there remained

the possibility of a return to medicine, which was acknowledged by some in the sample:

“There is no reason why you shouldn’t try and experiment and go back if it doesn’t work out.”—participant 10

The low identity salience is also suggested by the strong theme of ‘no regrets’. Some mentioned that they ‘should have done it sooner’, which suggests relatively high levels of flexibility, causing delays in the career move. One participant linked the idea of ‘should have done it sooner’ with maintaining the option of coming back.

“No, I think I should have done it a little bit sooner ... I don’t need to come back. I am employable.”—participant 8

This quote also develops the employability issue. For some, their current career draws directly on the medical knowledge and their credibility as a doctor, for example in medico-legal work, or in digital health. Even those participants who were working in sectors separate from medicine acknowledged that the skills they had developed in medicine, had given them an advantage in their current careers.

“Everyone’s job [in business] is diagnosing and solving problems. And the fact that I’ve done it for quite a number of years in training and practice, with reasonably high stakes, means that I’m probably better at it than the average person who has an economics degree or a history degree or something like that.”—participant 4

DISCUSSION

TWA provides a theoretical framework to contextualise the findings of the study,¹⁸ giving insight into which values participants regarded to be the most important, when leaving medicine. The major concerns that participants described relating to these values were a poor work-life balance (comfort), a perceived lack of control over working life (autonomy), an inability to provide a desired level of patient care (altruism) and feelings of being insufficiently supported (safety). These issues have also been frequently raised in existing literature about doctors leaving the NHS.^{10 14 15 28} That these reasons for leaving were shared by participants regardless of the stage at which they left medicine, is particularly significant, and suggests that addressing these factors will increase retention. It was also disappointing to find that the serious issues of discrimination and bullying, which have been raised in wider research on UK medicine,^{29 30} were also raised in this study too.

Participants in this study were attracted towards specific alternative careers because they offered work environments which satisfied their values, as proposed by TWA.¹⁸ For example, those participants who found the work-life balance of medicine to be problematic were able to

rectify this in their new careers, while those who did not find this to be a problem were not concerned by having to work harder. Thus, all participants reported greater satisfaction with their subsequent working lives, and in this dataset, none of the participants expressed regrets about their decision.

It is interesting to make comparisons between UK doctors who leave the NHS for alternative careers and those who leave to continue their medical careers abroad. For doctors who continue to practice outside of the UK, while there is no pull of an alternative career, many were attracted by the prospect of working as a doctor in a specific country.¹³⁻¹⁵ In this study, participants cited having ‘role models’ that gave them the confidence to leave. Often these were peers who had left in preceding years. While peer influence in career decision-making has been acknowledged as significant,³¹ it has not previously been reported as a reason why doctors leave UK medicine, and illustrates the risk to policy makers that leaving medicine will become increasingly normalised as a conventional career path for doctors.

Nevertheless, being a doctor is an intrinsically high-pressured vocation, meaning that a proportion of doctors would leave regardless of working conditions. Thus, applying a single theory such as TWA is not optimal when applied to the case of doctors changing careers. The pull of alternative careers, the importance of individual circumstances and identity salience, and supportive mechanisms in decision making are all complicating factors, and it should be acknowledged that TWA is orientated towards specific jobs rather than professions. However, using TWA does help connect the experience of doctors with wider literature, and highlights the importance of decision-making processes as well as the specific factors that cause dissatisfaction.

This study, in combination with previous research has highlighted common reasons why doctors decide to leave UK medicine, reasons often related to personal circumstances and values. Approaches to help encourage doctors to remain in the profession similarly need to be individualised, and many of our participants did suggest that more accessible career counselling for UK doctors may help to increase retention. The decision taken by Health Education England in 2022, to give all trainee doctors the right to apply for less than full time training, is an encouraging first step and will help address some of the issues surrounding autonomy raised in this research.³²

Future research also has a critical role in formulating future retention policies. Exit interviews with doctors as they leave the NHS have been called for,³³ and these would provide extensive, up-to-date research into the factors that cause doctors to leave UK medicine. It would also be worthwhile for senior doctors who are retiring to be included in these exit interviews, particularly as literature has shown that many doctors are opting to take early retirement.³⁴ On the other end of the scale, future research must also involve medical students, particularly those who are considering leaving medicine without ever

having worked a day as a doctor. This will not only aid those involved in the retention of doctors but will also allow those involved in medical school admissions to better inform admissions processes.

LIMITATIONS

The study has some notable limitations that must be acknowledged. The concept of reflexivity is important in qualitative research and recognises the impact that the field of research will have on the researcher, as well as the impact that the researcher will have on the field of research.³⁵ An example of this is how the status of the interviewer as a medical student as a may have influenced the outcomes of interviews. The absence of member validation³⁶ and further triangulation³⁷ are further limitations of the study, as only a single researcher conducted the interviews and coded the data. Furthermore, snowball sampling is highly susceptible to sampling bias and means the results cannot be deemed generalisable.²⁵

CONCLUSION

All participants had experienced some form of dissatisfaction while working as doctors and this ultimately contributed to their decisions to leave. Attraction towards alternative careers was also important, in many cases in a field closely related to medicine and drawing on a common skill set. What was consistent among participants was that a medical career did not fit their own personal values, and it was this that caused them to seek careers which better aligned with their values and achieve greater career satisfaction. Using the TWA connects the experience of doctors to a broader literature on career moves.

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Contributors AP was responsible for the conception and design of the study. AP conducted all semistructured interviews and performed the initial coding. IS revised the themes in relation to the theory of work adjustment. All authors read and approved the final manuscript. AP is the author acting as guarantor.

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Patient consent for publication Not applicable.

Ethics approval This study involves human participants. After submission of the research protocol (online supplemental file 2), ethical approval was gained from the University of Birmingham's BMedSci Population Sciences and Humanities Internal Research Ethics Committee (online supplemental file 3). All participants were given an information leaflet and required to sign a consent form to participate.

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