BRIEF REPORT

Why Do Physicians Depart Their Practice? A Qualitative Study of Attrition in a Multispecialty Ambulatory Practice Network

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Background: **Physician departure causes considerable disruption for patients, colleagues, and staff. The cost of finding a new physician to replace the loss coupled with lost productivity as they build their practice can cost as much as $1 million per departure. Therefore, we sought to characterize drivers of departure from practice with the goal of informing retention efforts (with a special emphasis on the connection between electronic health record (EHR)-related stress and physician departure).**

Methods: **This qualitative study of semistructured interviews was conducted between October 2021 and April 2022 among 13 attending physicians who had voluntarily departed their position from 2018 to 2021 in a large multispecialty, productivity-based, ambulatory practice network in the Northeast with a 5% annual turnover rate to understand their reasons for departing practice.**

Results: **Among the 13 participants, 8 were women (61.5%), 3 retired (23.1%), and 6 (46.2%) left for new positions. Major domains surrounding the decision to depart included current features of the health care delivery landscape, leadership/local practice culture, and personal considerations. Major factors within these domains included the EHR, compensation model, emphasis on metrics, leadership support, teamwork/staffing, burnout, and work-life integration.**

Conclusions: **Opportunities for medical practices to prevent ambulatory physicians' turnover include: (1) addressing workflow by distributing responsibility across team members to better address patient expectations and documentation requirements, (2) ensuring adequate staffing across disciplines and roles, and (3) considering alternative care or payment models. (J Am Board Fam Med 2023;36:1050–1057.)**

Keywords: **Electronic Health Records, Leadership, Personnel Retention, Physicians, Psychological Burnout, Qualitative Research, Workforce**

Introduction

Physician turnover is costly, compromises care quality, and is associated with lower patient satisfaction and poorer quality measure performance, health outcomes, and increased acute care utilization.[1–6] Physician professional burnout has been identified as a major driver of physician turnover.[6–9] Burnout and dissatisfaction are both independent predictors of plans to leave practice. With burnout rates now dramatically increasing in the setting of the COVID-19 pandemic,[10] up to 54% of physicians report changing their employment plans.[11] Burnout involves a complex interplay of multiple interdependent factors related to practice efficiency, culture, and personal resilience.[12,13] In the domain of practice efficiency, there is growing evidence supporting the association of physician

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burnout with electronic health records (EHR) use and usability.[14–21] Currently, practice leaders have few evidence-based strategies to prevent physician turnover. To understand factors that drive physician departure, we conducted a series of in-depth interviews with physicians who had recently departed from a large, multispecialty ambulatory practice network.

Methods

A descriptive qualitative study of semistructured interviews was performed using thematic analysis to identify factors leading to physician departure.[22] The study protocol was approved by our institution's IRB (protocol #072105). Verbal and written electronic consent were obtained from all participants. Reporting followed the Standards for Reporting Qualitative Research (SRQR) guidelines.[23]

Participants were recruited from a human resources roster of physicians who voluntarily left employment between 2018 and 2021 from a large, multispecialty ambulatory practice (that uses a productivity-based compensation model) including in the Northeast region of the United States with more than 300 ambulatory physicians and a turnover rate of approximately 5% per year. Eligible participants were contacted by e-mail, phone call, and text message. Enrollment continued until thematic saturation was achieved.[22]

Each interview followed a semistructured interview guide developed and field tested (2 mock interviews conducted before data collection) by our multidisciplinary team. The interview guide (Appendix) included questions about primary reason for departure, job-related challenges, work environment and leadership support, and the EHR. All interview sessions were deidentified, audio-recorded, and professionally transcribed.

Audio-recordings and transcripts were analyzed using the constant comparative method:[24] essential concepts from interview data were coded and compared over successive interviews to extract recurrent themes. Qualitative analysis software (ATLAS.ti) was used to organize, sort, and code the data. Two investigators reviewed the audio files for each interview independently, discussed salient themes, then agreed on a set of codes to capture these themes. Initial themes were based on the Stanford Model of Professional Fulfillment, through 3 domains of culture of wellness, efficiency of practice, and personal resilience.[25] Transcripts were independently coded with interrater reliability (kappa) 0.94. Discrepancies were adjudicated and resolved by a third investigator. Themes were revised iteratively as patterns within the data emerged and grouped into discrete domains.

Results

The 27 physicians who had most recently voluntarily departed the practice network with sufficient contact information available were contacted. Of these 27, 14 (51.8%) responded and 13 interviews were conducted between October 2021 and April 2022. One respondent declined to participate because they felt their perspective was no longer relevant as they had departed practice before the pandemic. Out of the 13 participants, 8 (61.5%) were female, 5 (38.5%) were ages 35 to 44, 3 (23.0%) were age 65 and over, 6 (46.2%) were White Non-Hispanic, 2 (15.4%) were Asian, 1 (7.7%) was Hispanic, and 6 (46.2%) specialized in internal medicine. Approximately half (54%) of the participants left their practice for a new position, whereas approximately 1 quarter (23.0%) left because they were retiring.

Participants identified factors that contributed to their decision to depart their practice within 3 domains (Table 1): the current features of the health care delivery landscape, leadership/local practice culture, and personal considerations. Aspects from each domain were identified by all participants indicating that—like professional burnout—the decision to depart practice is complex with multiple interdependent factors contributing to it. Major themes affecting the decision to leave included the EHR, compensation model, emphasis on metrics, leadership support, teamwork/staffing, burnout, and work-life integration. Although burnout and EHR-related burden contributed to clinicians' decision to leave in many cases,[26] no participants reported either as the primary driver of their departure. Participants shared that they valued more time off, flexibility, or autonomy over higher earnings with some stating that additional compensation would not have convinced them to stay.

Of note, the 3 themes of EHR/other IT interfaces, infrastructure/resources/supplies/scribes, and collegiality/peer connections were noted to have overall more positive than negative quotations associated

Table 1. Domains, Themes, and Representative Quotes

Themes	Representative Quotes
BUSINESS OF MEDICINE, NATIONAL TRENDS IN HEALTHCARE DELIVERY	
Compensation model	*"I'm not really influenced by money much. I feel like what I have is enough. You could throw another $100,000 at me, and I wouldn't go back to the job.*
	"There's always gonna be that balance between running a financially stable organization where you can have growth and you can afford to pay the staff, the overhead costs, etc., and also not cause burnout in your physicians and expecting for them to see too many patients."
Emphasis on metrics	*"The parts of compensation that are tied to, 'If you click this many boxes for mammograms, we'll give you another $2000. If you do this, then we'll give you that,' and, 'No, if you think I'm doing a good job, and I have exceptional patient loyalty, then pay me better. Don't try to jump me through three hoops.'"*
Corporatization of medicine	*"After 26 years of education and 25 years of experience—how do I end up a follower of administration people?"*
	"[The word provider] is offensive. It's an insurance term that was brought forth to equalize us and keep us down. God forbid somebody should call you "doctor.""
	"It's spending so much time on prior authorizations and fighting for the things that people need. I never ordered anything that wasn't needed. When most of the day becomes fighting or doing free labor, I find that it becomes a bit taxing and overwhelming."
EHR	*"[The EHR] was very easy to learn, and it made a lot of other things super easy like keeping track of health maintenance, for instance. It was wonderful for that, for being able to graph all of your lab results, being able to access things so quickly, and it was just a great system."*
Inbox burden	*"I'd end up spending half to two-thirds of my day off just going through results because by 7:00 PM at night, you wanna have a little bit of time off. I'd triage through them and say, "Okay, this can wait 'til tomorrow." Patients, especially, don't realize that it takes time to go through results, at least for me."*
	"I got to a point where [my time] was maybe 40% patient-facing care and 60% in-basket management."
COVID-19, Patient expectations	*"The patient demands have gone up. At the very beginning, with the COVID pandemic, we would be thanked for what we were doing. They would express thanks. They would not put extraordinary demands on us and, as time went on, and everybody got stressed with COVID, it spilled over to how everybody was treating us. You've seen all the pictures of the unruly passengers online on the planes."*
LOCAL PRACTICE CULTURE, LEADERSHIP	
Leadership visibility and support	*"They didn't check in with us at all. At all. Like "How's it going?" even just once a week. If they did come by, it would be like, I'm in the middle of patient care. I don't have time to talk to you."*
Value alignment with leadership	*"[They are] the bosses, and they have their own agenda and their own things that they wanna achieve."*
Teamwork/coverage	*"All of my partners, every single one of them, was kind and compassionate, and somebody that you want to work with."*
	"There was no effort to, say, maybe have one of the PAs look at my paperwork because there was all this like, "Well, that's not my patient" attitude, too, in the background."
	"It was really hard to find anybody just to cover me for a weekend."
Staffing	*"Now you have eight physicians in one office. I don't know that the ratio's backed up. You have eight physicians and only three people up front. I can imagine that can get quite tight. That causes a lot of stress and strain on the staff."*
	"We had less staff to be able to do more work."
Professional development, teaching, and advancement/promotion opportunities	*"There were some things that I was promised at the beginning of my position that never came to fruition such as teaching medical students."*
	"I was offered a position to move up and be a residency director. That position may not have been as attractive if the current situation. . . wasn't as difficult as it was."
PERSONAL CONSIDERATIONS	
Family support/happiness	*"You make decisions as a married couple. She didn't have a path forward there."*
Work-life integration	*"When you go home and you know that you have another note to write, it's like an alarm that keeps going off in your head."*
	"I would say that I had a better work-life balance when I didn't have Epic on my phone. That was a big change because, when I left work, I could leave work, and it was my choice if I wanted to open up my laptop or not. But then when there's Epic on your phone, you're constantly getting the ping notifications."
Feeling isolated/stressed, burnout	*"I had noticed I was dreading going to work. [I had] never had a panic attack in my life and started having them at age 40."*
	"Part of it is that I have become mentally exhausted, and my motivation went in my boots, and I just didn't care."

Abbreviation: EHR, electronic health record.

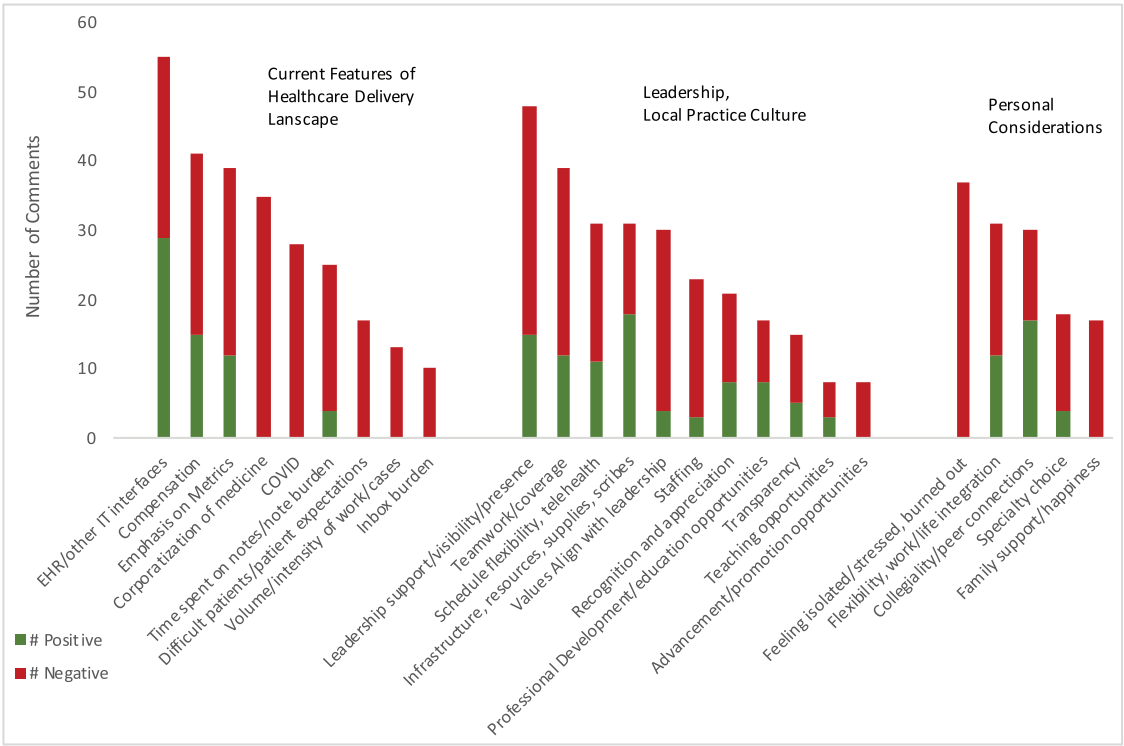
with them (Figure 1); whereas the following themes had only negative quotations: isolation/burnout, corporatization of medicine, COVID and inbox burden, difficult patients/patient expectations, family support, volume/intensity of work, and advancement/promotion opportunities.

Discussion

The major domains reported in this qualitative study have similarities to a 2004 review of 14 studies on physician turnover that identified reasons for physician departure in the following domains: financial issues, characteristics of the physician's practice (as it relates to professional alignment between the physician and their organization's expectations), and personal issues.[27] More recent cross-sectional survey studies have also reported burnout, leadership behavior, and COVID-related stress as related to an intention to leave 1's practice.[28–30] However, intention to leave practice may be more of a proxy for job dissatisfaction than an accurate predictor of actual behavior.[31] A 2019 longitudinal cohort study of 740 primary care clinicians based on survey data and human resources rosters of actual turnover also noted the contribution of burnout and concluded that solutions must recognize that turnover is multifactorial.[9] Self-reported survey data are subject to the limitations of self-report, including response fatigue and bias.[21] We are unaware of other qualitative studies that have explored drivers affecting a physician's decision to leave practice after their departure from a large, multispecialty ambulatory practice network. Postdeparture interviews could be a more reliable approach—given that interview responses no longer affect employment and individuals may provide more unfiltered feedback. Our qualitative approach allowed identification of a broad set of themes beyond those defined a priori by the investigators. To our knowledge, this study is the most comprehensive and up-to-date report on reasons why ambulatory physicians voluntarily depart their practice with updates from previous studies that account for more recent stressors in delivery systems including EHR adoption and the COVID-19 pandemic.

Despite the relatively low turnover rate of approximately 5% per year in the practice network being studied, the findings presented here offer an opportunity for a learning health system approach[32] to understand and mitigate physician departures.

Figure 1. Top 25 most common themes identified, organized by domain.



Furthermore, the findings offer a more comprehensive array of themes that may be contributing to troubling national trends in burnout that may be intervenable before departure.[10,11]

Successful interventions that aim to address factors identified in this analysis could help retain physicians in practice. Themes within the domain of local practice culture present opportunities for practice leaders to increase their visibility and presence in the clinical environment, increase opportunities for physician recognition, development, and advancement, distribute responsibility across team members, and ensure adequate staffing across disciplines and roles. The EHR can also be optimized, better training and technical support can be offered, inbox burden can be distributed to other team members, and scribes can offload documentation burden. Themes in the business of medicine domain have implications for policy makers to consider alternative care or payment models that deemphasize metrics and documentation burden.

Future research on physician turnover should work to quantify which factors identified in this study have the greatest influence on actual turnover. Doing so could help identify and retain physicians at high risk for departure. In this capacity, quantitative analysis in the same cohort presented here suggests nonlinear interactions exist between physician tenure, EHR use patterns, and departure.[33] Future research should also prioritize factors that are more modifiable and, therefore, amenable to intervention. For example, personal considerations may weigh heavily on an individual physician's decision to depart but may not be something that practice leaders can address. Although frequency of themes should not be used to determine theme importance, it warrants mentioning that workplace design and resources to support wellness were not mentioned frequently by participants. This could indicate that practice leaders seeking to retain their physician workforce should prioritize leadership visibility, staffing, and advancement opportunities over "wellness programs" and aesthetic office design.

This study is subject to several limitations regarding its approach, generalizability, and potential for bias. As with all qualitative research, the number of times that a theme arises does not indicate that theme's relative importance. For example, although EHR use was the most frequently cited theme as a contributor to departure, none of the participants listed the EHR as their *primary* reason for departure. Because the study was performed in a single practice network, it may not be generalizable. Although we reached thematic saturation, willingness to participate in this study could present participation bias with an inability to capture reasons for departure among nonparticipants. Participants had little racial and ethnic diversity, suggesting that our findings are likely subject to representative bias. Physicians from underrepresented racial and ethnic groups may depart their practice for reasons not identified in this study.

Conclusions

Physician turnover is influenced by factors at the societal, local, and individual levels. As COVID-19 transitions from pandemic to endemic, all industries and professions are facing the effects of the Great Resignation. Given the disruption physician turnover causes to patients, physicians, and the practices they leave, understanding factors that contribute to physician turnover is a critical first step to retaining the physician workforce at a local level.

To see this article online, please go to: http://jabfm.org/content/36/6/1050.full.

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Appendix.

PHYSICIAN INTERVIEW GUIDE

Interviewer initials: _____
Location: _____
Date: _____

Introduction

- Good morning/afternoon! Thank you for taking the time to talk with us. [INTRODUCE SELF].
- We are running a study …..
- Today I'd like to talk with you about your departure from XXXX and identify reasons for departure.
- Please keep in mind that there are no "right" or "wrong" answers to any of the questions I ask you today. Your input is very important, because it will help us understand hypotheses about practice characteristics that contribute to and can prevent departure
- Before we get started, I would like to outline a few important points from the consent form that you responded to within the link to the survey that you have participated:
    - This interview is voluntary. You may choose to answer or not answer any questions, and you can stop participating at any time without losing any benefits or rights.
    - All responses will be kept private. The information you share with us will be combined with responses from other participants and summarized without identifying information.
    - The principal investigator for this study is Dr. Ted Melnick. You may ask any questions you have now.
    - If you have questions, concerns, or complaints later, you may contact Dr. Melnick at XXXX. You can also call XXXX Institutional Review Board at XXXX.

- This interview should take approximately 45min and we will record the session.
- For study purposes we will be recording the entire session
- For deintifying purposes, we will not use your real name on camera, and use code name [xx] to refer you and you can keep your camera turned off (are we doing this??)
- If you are OK with all this, I am now going to turn on the recording now.

[RECORDING STARTED]

- Can you confirm that you are okay being recorded as we talk today?

Section I. Identifying Primary Factor for Departure.– Questions in this section will help us understand the primary reason(s) for a physician's departure:

- What was most important reason(s) that influenced your decision to leave XXXX?
- Tell me a bit about your new position and what makes it different from working at XXXX.
    - e.g., career advancement opportunities, professional development plan and skill building opportunities
- How did compensation and benefits factor into your decision for departure?
    - e.g., salary base and/or bonus, benefits (health, maternity/paternity, retirement)
- How did personals concerns contribute to your decision to leave?
    - e.g., flexibility in scheduling, personal health concerns, work-life integration, impact on personal relationships, fear of unanticipated termination, child-care options, spouse's/partner's career or health concerns, etc.

Section II. Job-Related Challenges or Problems. In this next section, questions will try to identify any job-related challenges.

- How did the work environment factor into your decision to leave XXXX?
    - e.g., hectic atmosphere, safety, teamwork and support from colleagues/nursing/technician staff; hostile work environment, stress, burnout,
- How did you feel about your workload at XXXX?
    - e.g., control over workload, sufficient time for documentation, pressure to produce clinical revenue, efficient teamwork, concerns that contract would be terminated if clinical revenue goals were not met, job fit for skill set/skill level
- How did you feel about promotion opportunities and how you were recognized by leadership, peers, and your team at XXXX?
    - e.g., supportive leadership behaviors, perceived gratitude, COVID-19 organizational support, feedback on performance, providing motivation, emotional support or encouragement
- Tell me a bit about your impression of XXXX leadership and work culture.
    - e.g., organizational-personal value alignment, sense of community/team, communication, supportiveness, trustworthiness, conflicts, voice was heard; addressing complaints, grievances and conflicts in a timely manner; respect for staff and employee; diversity, equity, and inclusion for gender, race, and ethnicity

Section III. Experience with EHR

- How frequently did the EHR at XXXX add frustration to your work day?
- Tell me about the amount of time you spent on the EHR at XXXX outside of normal scheduled work hours.
    - proficiency