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How Physicians' Perceptions of Satisfaction and Morale Affect Retention

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This is to certify that the doctoral study by

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2024

Abstract

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by

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MBA, University of Findlay, 1999

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Doctoral Study Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Business Administration

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Abstract

Physician turnover affects care delivery and contributes to costs, emphasizing the need for retention to minimize unnecessary costs of hiring, training, and lost productivity among healthcare organizations. Healthcare leaders tend to be concerned about the negative affects that physician turnover has on patient care, profitability, and organizational viability. The U.S. healthcare system may benefit from reduced expenditures associated with retention. Grounded in Ellenbecker's job retention model, the purpose of this qualitative multiple-case study was to explore strategies healthcare organizational leaders use to retain employed primary care and internal medicine physicians. The participants comprised six physician leaders from three healthcare organizations in North Carolina. Data were collected through semistructured interviews and analyzed using thematic analysis and applied interpretative phenomenological analysis. Two key themes emerged, revealing the need to sustain the financial wants and needs of physicians by effectively collaborating and communicating with them. To meet financial needs, it is recommended physicians receive a base salary and additional commission for every extra patient they see to encourage patient care. Leadership should effectually communicate by conducting regularly scheduled interactions with physician subordinates in a setting and manner that allows for open an honest communication. Future research should include other stakeholders of the healthcare sector to study the phenomenon of interest. The implications for positive social change include the potential to enhance physician retention, which may lead to improved patient outcomes, reduced healthcare costs, and the overall well-being of communities.

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Dedication

Those who completed this journey before me know the effort and sacrifice necessary to succeed. I dedicate this study to my family of my loving wife Mary, my two beautiful and brilliant children, Miles and Isabelle, my grandfather George Merkt, my parents Ernest and Shirley Britton, my sister Tamra Britton, and my brother Gregory Britton. My family always encouraged me to follow my dreams and to persevere and finish what I started. They were my inspiration to succeed. My final graduation, receiving a doctorate degree, would not be possible without their love.

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Section 1: Foundation of the Study

The U.S. Department of Health and Human Services (HHS) expects a physician shortage of 90,000 physicians by 2025, while the average age and chronic disease prevalence continue to increase in the United States (Kerschner, 2019; Sinsky et al., 2017; Zhang et al., 2020). Increasing physician retention may benefit U.S. hospitals (Ahmed & Carmody, 2020; Goode et al., 2019; Koehler et al., 2016; Petrou et al., 2014). There is a need for a purposeful physician retention strategy to minimize unnecessary costs of hiring, training, and lost productivity (Barnett et al., 2023; Fibuch & Ahmed, 2015; Goode et al., 2019; Kirch & Petelle, 2017; Long et al., 2020; Pak et al., 2023).

Background of the Problem

Medical costs in the United States have increased dramatically, now representing 17.8% of gross domestic product (GDP) and surpassing the economic growth and inflation rate (Abdulai et al., 2022; Silverman et al., 2022; Stark & Peacock, 2022; U.S. Centers for Medicare & Medicaid Services, 2016). The U.S. Department of Health and Human Services (HHS) expects a physician shortage of 90,000 physicians by 2025, while the average age and chronic disease prevalence continue to increase in the United States (Kerschner, 2019; Sinsky et al., 2017; Zhang et al., 2020). There is a need for a purposeful physician retention strategy to minimize unnecessary costs of hiring, training, and lost productivity (Bashar et al., 2022; Fibuch & Ahmed, 2015; Goode et al., 2019; Kirch & Petelle, 2017; Scott et al., 2021).

Relationships between physicians and their patients have implications for patient health and well-being, as relationships may improve care quality and physician satisfaction (Henry, 2015; Williams et al., 2020b). Increasing physician retention may benefit U.S. hospitals (Barnett et al., 2023; Dillon et al., 2020; Goode et al., 2019; Koehler et al., 2016; Petrou et al., 2014).

Healthcare changes have added to stressors for physicians, including enhanced accountability and scrutiny, time limitations, increasing role definition by nonphysicians, and decreasing workplace control, all of which contribute to burnout (Attipoe et al., 2023; Deville et al., 2020; Gazelle et al., 2015; Reith, 2018; Shanafelt et al., 2017). Burnout negatively affects physicians' well-being, decreases physician retention, worsens patient care, adds to patient noncompliance, contributes to low physician morale, and prevents organizational unity (Attipoe et al., 2023; Shanafelt et al., 2017).

Problem Statement

A physician shortage potentially increases negative outcomes for patients. The HHS anticipates that the United States will have a physician shortage of 90,000 by 2025 (Malayala et al., 2021). Physicians are integral to population health and well-being (Cahill et al., 2015; Dewa et al., 2017; Gazelle et al., 2015; Søvold et al., 2021; Tziner et al., 2015). Physician retention affects care delivery and contributes to costs, emphasizing need for retention (Abayasekara, 2015; Fibuch & Ahmed, 2015; Hodkinson et al., 2022; Swensen et al., 2016). Recruiting and retaining physicians benefits the hiring group, individual hire, and patient (Chen et al., 2016; Jennings et al., 2022; Olson et al., 2019; Panagioti et al., 2018; Petrou et al., 2014). The general business problem is that a shortage of physicians negatively affects practice viability and patient care (Hartzband & Groopman, 2020; Lu et al., 2017). The specific business problem is that some healthcare leaders lack strategies to maximize physician retention.

Purpose Statement

The purpose of this qualitative multiple case study was to explore the strategies that healthcare organizational leaders use to retain employed primary care and internal medicine physicians. This study included practicing employed physician leaders in Alexander, Burke,

Caldwell, and Catawba Counties in North Carolina. I collected data through semi structured interviews with six physician organizational leaders. Addressing this issue is socially significant because high physician morale is needed to not only increase retention rates, but also optimize patient-centered care (Henry, 2015; Underdahl et al., 2018). Maximizing retention and patient-centered care can lead to a higher quality of service delivery and more efficient healthcare system (Henry, 2015; Jeong et al., 2021; Underdahl et al., 2018).

Nature of the Study

I used a qualitative research methodology to guide this study. I selected a qualitative design to explore the strategies that healthcare organizational leaders use to retain employed primary care and internal medicine physicians. I did not select a quantitative approach because they did not intend to quantify aspects of participants' experiences.

I selected a multiple case study design to explore and describe a phenomenon within the specific context regarding the strategies that healthcare organizational leaders use to retain employed primary care and internal medicine physicians (Shanafelt, 2021; Yin, 2018). I did not consider mixed-methods research and ethnography appropriate for the current study because such methodologies are not equipped to yield rich insight into a phenomenon specifically within the context in which it exists or to provide practical solutions to a pervading problem. I did not select other qualitative designs, such as grounded theory and phenomenology, because such designs do not allow for the same level of focus on a particular case as a multiple case study. I conducted open-ended interviews via Zoom to gain in-depth insight from experts in the field (Lewis, 2015; Schonlau et al., 2021). The multiple case study design yielded novel evidence based on these one-on-one interviews with leaders who have been successful in retaining healthcare professionals.

Research Question

The central research question that guided this study was: What retention strategies do hospital administrators and physician leaders use to retain primary care and internal medicine physicians?

Interview Questions

During the face-to-face, semi structured interviews, I asked the participants to answer the following open-ended questions:

1. What is your role for retaining primary care and internal medicine physicians?
2. What retention strategies do you use to maintain physician staffing in your system of primary care and internal medicine physicians, and how have these strategies contributed to your organization?
3. What approaches have you taken to overcome impediments or barriers to implementation of your retention strategies?
4. What are the internal factors that have aided or hampered retention of primary care and internal medicine physicians?
5. What are the external factors that have aided or hampered recruitment and retention of primary care and internal medicine physicians?
6. How have governmental entities or programs helped with retention efforts?
7. What measures do you use to monitor, update, or change retention strategies to ensure ongoing staffing of primary care and internal medicine physicians?
8. What else can you share about strategies that contribute to successful physician retention?
9. Would you like to share any other relevant information that we have not already discussed?

Conceptual Framework

Several models of stress and burnout exist that apply to the process by which healthcare workers and physicians develop intentions to quit. I selected Ellenbecker's (2004) job retention model as the conceptual framework for this study. Within this theory, Ellenbecker identified antecedents to job satisfaction of healthcare workers, which are intrinsic and extrinsic job characteristics. Through the model, Ellenbecker established that job satisfaction is directly related to retention and indirectly related to retention through intent to stay. I used Ellenbecker's model as the theoretical framework to analyze the perceptions of physician leaders regarding the effects of satisfaction and morale on physician retention. The antecedents to job satisfaction, as identified by Ellenbecker (2004), were used as a guide in the current study during the data analysis of physician leader perceptions.

Selye's (1936) classic stress theory, which explains the process by which physicians experience stress and become burnt out, is a contrasting supposition. Based on an understanding of the biological and psychological nature and how stress manifests and can lead to burnout and attrition, a theoretical model for morale and satisfaction may be more effectively applied to conceptualize how retention is maximized in healthcare professionals. One such model of retention that applies specifically to physicians is Ellenbecker's (2004) job retention model. This model identifies both intrinsic and extrinsic antecedents of job retention and intent to stay among physicians. Specifically, this model suggests that job retention and intent to stay are predicted by a combination of factors that the professional finds personally rewarding and those that are extrinsic in

nature (Ellenbecker, 2004). Intrinsically rewarding factors that increase job retention vary according to personal values, but generally include job satisfaction, meaning associated with the work, and peer relationships (Ellenbecker, 2004). Extrinsically rewarding factors that can increase retention include financial incentives, recognition at work, and prestige associated with the position (Ellenbecker, 2004). Scholars have used Ellenbecker's theory to predict retention and attrition in healthcare professionals, including physicians (Chen et al., 2016; Tarcan et al., 2017 Wang et al., 2022). In conducting the current study, I drew on Ellenbecker's (2004) theory to classify leaders' experiences with morale, satisfaction, and retention as either intrinsically or extrinsically rewarding.

Operational Definitions

The following terms are used throughout the current study:

Extrinsic characteristics: Extrinsic characteristics of job satisfaction include stress and work load, autonomy and control of work hours, autonomy and control of work activities, salary and benefits, and perception of and real opportunities for jobs elsewhere (Ellenbecker, 2004).

Intrinsic characteristics: Intrinsic characteristics of job satisfaction include autonomy and independence in patient relationships, autonomy in the profession, group cohesion with peers and with physicians, and organizational characteristics (Ellenbecker, 2004).

Job satisfaction: Job satisfaction is defined in this study as the level of enjoyment and fulfilment physicians express regarding their current positions (Jackson et al., 2018).

Retention: Retention is defined in this study as physicians' expressed intent to remain in their current positions (Castle et al., 2020).

Assumptions, Limitations, and Delimitations

Assumptions

I assumed that the sample interviewed would represent the population of employed family and internal medicine physicians in Alexander, Burke, Caldwell, and Catawba counties in North Carolina. I also assumed that employee satisfaction and morale might create an environment for improving organizational performance. Finally, I assumed that the respondents answered the administered questions honestly and not based on how the respondent believed they should answer.

Limitations

This study was limited in scope to the four counties of Alexander, Burke, Caldwell, and Catawba Counties in North Carolina. I adopted a convenience sample, which is exposed to risks of self-selecting bias and expectancy effects (see Williams et al., 2020a). Furthermore, I had personal biases, which may have an unwanted influence on the findings of the study (see Williams et al., 2020a). Another limitation of this study was the lack of outside stakeholder participation, such as patients and vendors who could potentially provide valuable perspectives on job satisfaction and morale. Another limitation was the geographical area of the study, as the study population was recruited from a defined area in North Carolina, which limits the findings' applicability to physicians practicing elsewhere. I did not explore the views of other specialty physicians or those who have left practice. I triangulated the findings with previous research and theory and adopted a systematic approach to analyzing data to minimize these potential limitations.

Delimitations

I conducted a qualitative multiple case study to explore the strategies that healthcare organizational leaders use to retain employed primary care and internal medicine physicians. Delimitations reference the choices a researcher makes to arrive at a feasible way to address a research topic (Ross & Bibler Zaidi, 2019; Yin, 2018). Interviewees were limited to employed physicians in Alexander, Burke, Caldwell, and Catawba counties in North Carolina. I did not include participants living outside these counties or those not employed by a larger care organization. The sample included six physician leaders specializing in family or internal medicine and employed for at least 2 years in their current institution. I conducted semi structured interviews to explore the experiences of the interviewees. Patient interviews are outside the scope of this study. No interviews were conducted with organization administrators and managers because I sought only to explore retention strategies based on physicians' perceptions of how satisfaction and morale affect retention.

Significance of the Study

As this study relates to healthcare, the findings may indirectly influence business practice. Specifically, the results from this study may improve understanding of factors that contribute to physicians' morale and satisfaction. This evidence may lead to higher retention and reduced costs associated with attrition and bumout. Findings from this study may contribute to positive social change and/or the improvement of human or social conditions by promoting the worth, dignity, and development of physicians. By understanding physician experiences in relation to morale and satisfaction more fully, healthcare leaders can ensure that their staff are better equipped to meet the needs of patients. The findings of this study may lead to a more efficient and effective healthcare system with reduced expenditures associated with retention.

Contribution to Business Practice

Physician retention affects care delivery and contributes to costs, emphasizing need for retention (Abayasekara, 2015; Fibuch & Ahmed, 2015; Smaggus, 2019; Swensen et al., 2016). Recruiting and retaining physicians benefits the hiring group, individual hire, and patient (Chen et al., 2016; Panagioti et al., 2018; Petrou et al., 2014; Weigl, 2022). Physician shortages negatively affect practice viability and patient care (Lu et al., 2017). Increasing physician retention may benefit U.S. hospitals (Andah et al., 2021; Goode et al., 2019; Koehler et al., 2016; Petrou et al., 2014).

Implications for Social Change

Findings from this study may contribute to positive social change and/or the improvement of human or social conditions by promoting the worth, dignity, and development of physicians. By understanding physician experiences in relation to morale and satisfaction more fully, healthcare leaders can ensure that their staff are better equipped to meet the needs of patients. The findings of this study may lead to a more efficient and effective healthcare system with reduced expenditures associated with retention and may allow healthcare leaders to develop strategies to maximize physician retention.

A Review of the Professional and Academic Literature

For the literature review, I included peer-reviewed evidence primarily published within the past 5 years pertaining to strategies used as a means of retaining primary care physicians. Although an abundance of research has already been performed on this topic, I provide a contemporary exploration of this issue and seek to extend the findings of the wide body of literature that has already documented experiences with stress, burnout, and retention/attrition in physicians. This literature review also contains seminal sources published more than 5 years ago

as theoretical evidence guiding the understanding of stress, burnout, moral, retention, and attrition in physicians.

I begin the review with a discussion of major trends in the literature related to key variables and/or constructs of interest, which include stress, burnout, and attrition in healthcare professionals; stress, burnout and attrition in physicians; morale, satisfaction, and retention in healthcare professionals; and morale satisfaction, and retention in physicians. Theoretical foundations relevant to this study are then explored. I then identify the gaps in the literature and reflect on why these gaps might exist. The relationships between studies are then considered. I conclude this section with a transition into Section 2.

To identify literature for this review, I used PubMed, MEDLINE, and Google Scholar databases. The following search terms were used to identify literature related to the topic of interest: *physician, morale, satisfaction, burnout, retention*, and *attrition*. I used Boolean logic to link search terms to expand or narrow the search as needed. I used the MeSH term function to identify studies that have utilized similar terminology as the key words used in this search. Studies were included if search terms were matched and were either (a) published within the past 5 years or (b) seminal in nature. I included both books and peer-reviewed journals as sources for the current study. Table 1 provides a comprehensive breakdown of the type of sources used in the literature review and the percentage of sources used that were published in the past 5 years.

Table 1

Literature Review Sources

Publication	TOTAL	Less than 5 years	Greater than 5 years	% Of total resources
Books	2	1	1	1.19

Peer-reviewed journals	166	107	59	98.81
TOTAL	168	108	60	

Organization of the Literature Review

Several models of stress and burnout exist that apply to the process by which healthcare workers and physicians develop intentions to quit. I selected Ellenbecker's (2004) job retention model as the framework for the current study. Selye's (1936) classic stress theory, which explains the process by which physicians experience stress and become burnt out, is a contrasting supposition.

Research Design and Methodological Issues in the Literature

A consistent issue that emerged in the literature relating to stress, burnout, and attrition in healthcare professionals and physicians was the high dependence on self-report instruments to identify the magnitude of these constructs. In an integrative review of physicians' intention to leave direct patient care, Degen et al. (2015) found that many of the 17 studies included in their research utilized subjective self-report instruments to identify physicians' perceptions of stress and satisfaction. While such instruments offer some insight into physicians' self-perceptions, they do not actually measure stress or attrition/retention directly and may not be indicative of physicians' actual intent to remain in their positions (Englander, 2016; Kim & Kim, 2023). Self-report instruments include several sources of potential bias (e.g., social desirability, inauthenticity) that render them only partially effective in addressing the topic of morale, satisfaction, and retention in physicians (Creswell, 2014; McEwen & Akil, 2020).

In the Degen et al. (2015) review, every study that applied a Likert-based self-report instrument fallaciously quantified data as if they were interval or ratio in nature; however, such

data are ordinal. Researchers often performed analyses of variance and logistic regressions to analyze Likert-based data when only rank tests (e.g., Chi squares) can accurately quantify such data (Creswell, 2014; McEwen & Akil, 2020). The use of variance and logistic regressions to analyze Likert-based data, when only rank tests can perform this function accurately, was a consistent gap in the literature that requires further research. Such findings may be expanded upon through more in-depth multiple case investigations to determine their validity.

Some researchers have conducted reviews to expand the understanding of stress, burnout, and attrition among healthcare professionals and physicians. While these reviews offer useful syntheses of the literature, they are also exposed to many of the same sources of bias as correlational and cross-sectional research (Ahmad et al., 2021; Degen et al., 2015; Dewa et al., 2017). Existing reviews pertaining to burnout in physicians have demonstrated several research design and methodological flaws in published studies on this topic. Of the 12 studies included in Dewa et al. (2017) systematic review, 10 were determined to have at least a moderate risk of bias, and two were considered to have a high risk of bias. The actual extent to which burnout and its antecedents are present in practicing physicians is very likely to differ from what has been shown in the existing body of research. Further investigation of this issue is needed to more fully understand burnout, stress, morale, satisfaction, and retention in physicians in the United States.

While many researchers have proposed solutions to stress and burnout in physicians, few have been empirically tested. Gazelle et al. (2015) and Yates (2020) proposed that professional coaching could help address problems with burnout in physicians and promote greater retention intentions. The coaching model proposed in this research, however, has not yet been studied using an empirical design, and its effects on stress, burnout, and attrition or retention are not

understood. Discovering the reasons why such a model may be effective requires in-depth, multiple case analysis involving experts in the field.

As with the literature pertaining to stress, burnout, and attrition, much of the literature regarding morale, satisfaction, and retention has been cross-sectional in nature (e.g., Arima et al., 2016). While such research is beneficial for identifying superficial relationships between factors that relate to satisfaction and retention, researchers are not able to identify strategies used as a means of retaining primary care physicians (Khankeh et al., 2015; Thomas et al., 2021). It may be the case that higher satisfaction with the work environment increases physicians' perception of work-life balance because they enjoy being at work and perceive no deficit in their home life as a result.

The literature pertaining to strategies used as a means of retaining primary care physicians has largely been retrospective in nature and dependent upon secondary data. Biddison et al. (2016) and Moffatt-Bruce et al. (2019) demonstrated an important link between worker morale, engagement, and patient safety culture. These researchers, however, relied on a retrospective cross-sectional analysis of secondary data. Despite the large sample size and strong statistical support for these relationships, the findings include numerous sources of bias and do not clearly show how improving morale can lead to reductions in attrition (Williams et al., 2020a). Further research is needed to determine the strategies used as a means of retaining primary care physicians

Much of the literature pertaining to this issue has been limited to argumentative papers, editorials, and conceptual analyses. Brennan and Monson (2014) presented a conceptual and argumentative paper on the role of professionalism in the determination of physician satisfaction. While the findings from the paper and arguments made by the author demonstrate face validity

and illustrate the need to develop professionalism within healthcare organizations to maximize physician retention, they are not generalizable and require empirical research to identify their actual significance to practice. Cutter and Miller (2017) also produced a conceptual paper pertaining to the attrition crisis in contemporary healthcare and strategies to manage this issue. While these authors presented several potentially valid points regarding the use of temporary associates and their importance on healthcare quality, they are not necessarily generalizable to the healthcare industry due to a lack of empiricism. Findings from conceptual papers like those of Brennan and Monson (2014) and Cutter and Miller (2017) may be important in advancing knowledge related to satisfaction and retention in physicians, but there is a need for empirical research to determine their validity and generalizability.

In a systematic review of interventions to recruit and retain physicians, Verma et al. (2016) also demonstrated that existing interventions designed to achieve this objective were generally of low methodological quality. Furthermore, interventions failed to fully consider well-being and work schedules as key contributors to morale and satisfaction, despite a large body of evidence showing these two variables are the strongest and most consistent predictors of satisfaction and retention (Cohen et al., 2023; Jackson et al., 2018; Tsai et al., 2016). Additional research is needed to improve upon both the scientific rigor of interventions designed to recruit and retain physicians and the focus of such interventions.

Although a large body of research exists pertaining to morale, satisfaction, and retention in healthcare professionals, some gaps in the literature remain. Much of the literature on this subject has been cross-sectional in nature (Arima et al., 2016; Jackson et al., 2018; Ramachandran et al., 2023). While such research is useful for identifying relationships between variables, it does not determine whether certain factors cause outcomes like satisfaction and retention (Roller,

2019; Williams et al., 2020a; Williams et al., 2020b; Wu et al., 2016). Multiple case investigations are needed to expand on the relationship between these variables (e.g., work-life balance and job satisfaction). Through interviewing professionals in the field, researchers can more fully elucidate why physicians value certain organizational factors and why these factors improve their intent to remain in their positions.

Literature Rationale and Justification for the Current Study

Based on the evidence presented in this section, the current researcher identified a need to understand the experiences of physicians regarding morale, satisfaction, and retention in greater depth. Specifically, the results from this study may improve the understanding of factors that contribute to physicians' morale and satisfaction. This evidence may lead to greater retention and reduced costs associated with attrition and burnout.

Findings from this study may contribute to positive social change and/or the improvement of human or social conditions by promoting worth, dignity, and development of physicians. By understanding strategies used as a means of retaining primary care physicians more fully, healthcare organizations can ensure that physicians are better equipped to meet the needs of patients. The findings from this study may lead to a more efficient and effective healthcare system with reduced expenditures associated with retention.

I used Ellenbecker's (2004) job retention theory as an effective lens through which to explore and understand the lived experiences of physicians regarding morale, satisfaction, and retention. Specifically, this model suggests that job retention is predicted by a range of individual and universal antecedents, all of which can be categorized as intrinsically and extrinsically rewarding (Ellenbecker, 2004). The physicians in the current study offered responses regarding strategies used as a means of retaining primary care physicians. This study was informed by

Selye's (1936) classic stress theory, which serves to offer an explanation as to how stress manifests and transforms into burnout and, subsequently, attrition in the healthcare profession.

Ellenbecker's Job Retention Model

Ellenbecker's (2004) job retention model identifies both intrinsic and extrinsic antecedents of job retention and intent to stay among physicians. Specifically, this model suggests that job retention and intent to stay are predicted by a combination of factors that a professional finds personally rewarding and those that are extrinsic in nature (Al-Harthy & Yusof, 2022; Ellenbecker, 2004). Intrinsically rewarding factors that increase job retention vary according to personal values but generally include job satisfaction, meaning associated with the work, and peer relationships (Ellenbecker, 2004). Extrinsically rewarding factors that can increase retention include financial incentives, recognition at work, and prestige associated with the position (Ellenbecker, 2004). Ellenbecker's theory has been used by other researchers to predict retention and attrition in healthcare professionals, including physicians (Chen et al., 2016; Mori et al., 2022; Tarcan et al., 2017). I drew on Ellenbecker's theory to classify physician leaders' experiences with morale, satisfaction, and retention as either intrinsically or extrinsically rewarding. Responses from physician leaders regarding morale and satisfaction supported this theory's assumptions that antecedents of retention fit within these two categories.

Ellenbecker's (2004) job retention theory was an effective lens by which to explore and understand the phenomena under study, specifically through the examination of lived experiences of physicians regarding morale, satisfaction, and retention. Analysis of this model suggested that job retention is predicted by several factors, which are categorized as intrinsically and extrinsically rewarding (Ellenbecker, 2004). I guided this study using Selye's (1936) classic stress

theory, which is used to explain how stress manifests and transforms into burnout and attrition in the healthcare profession.

Selye's Stress Theory

Selye's (1936) theory suggests that stress results in agitation and—without relief or when too severe—can result in exhaustion and burnout. Ellenbecker's (2004) theory suggests that intrinsic motivation is associated with higher rates of retention. Selye's classic stress theory is used to aptly explain the process by which physicians experience stress and become burnt out. This theory suggests that environmental conditions that exceed an individual's resources can cause cellular damage in the brain and remainder of the body, which, over time, causes fatigue, illness, and psychological symptoms such as depression (Selye, 1936). Using Selye's classic stress theory, Mravec et al. (2020) and Tan and Yip (2018) proposed that stress is present in an individual throughout the entire period of exposure to a nonspecific demand. Although this stress can produce positive adaptations when the individual is allowed to rest, a lack of rest exposes the individual to conditions that they are not capable of coping with; therefore, the individual must exit those conditions or die (Selye, 1936).

Other researchers have conducted research with the use of Selye's (1936) stress theory as a foundation (Amirkhan et al., 2020; Dartey-Baah et al., 2020; Larosa & Wong, 2022; McEwen & Akil, 2020). Amirkhan et al. (2020) explored the most stressful years in college. Regression analyses showed stress overload related to poorer performance and avoidance coping related to greater stress overload. Dartey-Baah et al. (2020) explored occupational stress, job satisfaction, and gender difference among bank tellers. Using a cross-sectional survey approach, Dartey-Baah et al. (2020) used questionnaires to collect data from bank tellers in Ghana and found that tellers

are more likely to exhibit counterproductive behaviors, such as job dissatisfaction, due to work-related stress.

Selye's (1936) stress theory has been used by several researchers in the healthcare profession to explain stress and burnout and how these factors reduce morale and satisfaction (Bliese et al., 2017; McEwen & Akil, 2020; Mullen et al., 2018). Morale, satisfaction, and retention cannot be fully understood without a theoretical and conceptual cognizance of how stress manifests biologically and psychologically in healthcare professionals. As can be understood from stress theory, physicians are subject to burnout, which may reduce retention rates. According to the stress theory, when individuals are exposed to a stressor, the initial reaction is to be taken off guard; the person then often attempts to resist the change by maintaining homeostasis (Juarez-Garcia et al., 2023; Tan & Yip, 2018). In the final phase, a person eventually falls victim to exhaustion in countering the stressor (Tan & Yip, 2018).

Stress, Burnout, and Attrition in Healthcare Professionals

This section includes a discussion of stress, burnout, and attrition in healthcare professionals. While I focused on physicians, much of the research guiding retention efforts of physicians has drawn from the field of nursing. The current discussion begins with stress in healthcare professionals, followed by burnout and attrition. The focus then narrows to physicians, and any distinctions between general healthcare professionals and physicians in relation to these factors are discussed. In the following section, I analyze morale, satisfaction, and retention, which is guided by an understanding of those factors that reduce morale and satisfaction gained from the literature review presented in this first section.

Stress in Healthcare Professionals

Stress is a perpetual problem affecting healthcare professionals, including physicians. Professionals in the healthcare industry exhibit the highest levels of chronic stress of any occupation, and this problem has increased over the past several decades (Burton et al., 2017; Denovan et al., 2019). This has led researchers to explore a range of different strategies to reduce stress, including mindfulness-based interventions (Burton et al., 2017). Evidence has only partially supported the efficacy of these interventions, and it is apparent that researchers still lack a thorough understanding of the factors that contribute to stress versus satisfaction in healthcare professionals and do not know how to fully address this problem (Burton et al., 2017; Linzer et al., 2017; Ross & Van Bockstaele, 2021). The degree to which individual versus organizational factors contribute to stress and its prevention is still under investigation within the healthcare industry.

While research involving stress, burnout, and attrition in physicians is scarce, a large body of evidence on this topic exists regarding general healthcare practice. Many of the organizational strategies that have been implemented to address the needs of physicians have been drawn from general healthcare literature. Linzer et al. (2017) explored ways in which work conditions influence healthcare practitioner performance. The authors performed a cluster randomized controlled trial of 34 clinics in the United States and combined this methodology with a case study of three primary care clinicians to determine the importance of quality improvement projects in improving individual and organizational performance. Following a 6-month intervention, the results showed that improvements in work conditions did not significantly reduce errors or improve quality of care; however, the intervention did improve stress levels and was associated with reduced symptoms of burnout. The authors concluded that improving work conditions might improve job satisfaction and well-being, even if this does not

immediately result in improvements in work-related performance (Bashir et al., 2020; Lu et al., 2017). Organizational strategies may be less important than addressing personal, psychological, and emotional factors in improving performance-related outcomes; however, the relationship between such interventions and retention versus attrition is not yet clear. Future research is needed to determine how organizational versus individual strategies influence stress and intent to remain within an organization.

Stress in health professionals has been a consistent problem during the COVID-19 pandemic. Garcia et al. (2022) assessed the prevalence of depression, anxiety, and stress symptoms in health professionals in the COVID-19 pandemic context. The researchers performed the assessment using the Depression, Anxiety, and Stress Scale (DASS-21) and calculated the prevalence of symptoms severity by point and 95% confidence interval. A total of 529 health professionals participated in this study. Regarding prevalence, moderate to extremely severe symptoms of depression, anxiety, and stress were found in 48.6%, 55.0% and 47.9% of the participants, respectively. Garcia et al. (2022) highlighted the continued prevalence of stress among healthcare professionals.

Burnout in Healthcare Professionals

Stress is closely related to burnout. Chronic stress increases the risk of burnout in healthcare professionals, which can negatively influence job performance and lead to attrition and undesirable rates of turnover (Malhotra et al., 2018). Despite a large body of research identifying burnout as a significant threat to the healthcare industry, practitioners and policymakers still do not fully understand the factors that contribute to this state (Keller et al., 2020; Malhotra et al., 2018). Burnout is not only a threat to the healthcare industry by leading to attrition, but it is also a significant health risk for healthcare professionals (Dyrbye et al., 2017). Burnout increases the

risk for chronic disease and co-morbidities, including obesity, diabetes, cardiovascular disease, dementia, and even some forms of cancer (Darvishmotevali & Ali, 2020; Dyrbye et al., 2017). As researchers become increasingly aware of the problems associated with burnout, a comprehensive effort is needed to address this growing concern to protect workers in the healthcare industry and to reduce the costs associated with attrition. The issue of attrition is discussed in more detail in the following subsection.

Attrition in Healthcare Professionals

The attrition problem in healthcare is significant because of the increasing demand for healthcare services. Services are in need for a range of factors, one of which is globalization of healthcare (Fisher, 2016; Rech et al., 2022). Migration from areas around the world, especially Central and South America, along with globalization have led to an increased need for healthcare access in nations that experience high levels of immigration like the United States and have stable economies (Abayasekara, 2015; Jackson et al., 2018). Migration combined with a perpetually increasing population has led to a steadily rising need for healthcare services (Fisher, 2016; Lebano et al., 2020). In Canada and European countries where healthcare is partially or fully covered by government funding, this shortage of healthcare professionals increases costs in several ways, including the lack of ability to prevent and control diseases on a macro level based on limited public health professionals to incite the necessary legislation in which to engage in societal disease prevention efforts.

Immigration and healthcare reforms have been the primary contributors to the healthcare crisis and physician shortage in the United States. Somewhat ironically, however, scholars have also posited that healthcare worker immigration may be a valid solution to this problem. Fisher (2016) and Gandhi et al. (2021) noted that implementing reform to allow more prevalent

healthcare worker immigration into the United States would play an important role in restoring the physician pipeline and addressing the current healthcare worker shortage. Fisher found that the federal immigration system is outdated and poorly equipped to meet contemporary population needs, particularly with respect to healthcare. By allowing more qualified foreign healthcare professionals, including physicians, to enter and remain in the United States, the nation would save money by preventing the high costs associated with attrition and turnover (Fisher, 2016; Woolhandler et al., 2021). The extent to which such policy would affect the healthcare system is unknown, but increasing the number of physicians within existing clinics can have significant positive effects on work-life balance and job satisfaction and may reduce turnover intentions (Adriano & Callaghan, 2020; Azmi et al., 2021; Mullen et al., 2018; Murale et al., 2015; Underdahl et al., 2018). Macro-level solutions like immigration reform may serve as components of the general strategy to improve physician morale in the United States and prevent turnover and attrition.

Costs may be incurred primarily because of the inability to access and provide care for a substantial portion of the population (e.g., low socioeconomic groups, minorities, undocumented immigrants), which increases health risks for the entire country (Abayasekara, 2015; Fisher, 2016; Salles et al., 2019). The average age of the population continues to increase due to longer life expectancies (Jackson et al., 2018). This increasing average age may be partially a testament to advancements in healthcare quality, although this trend also perpetuates the cycle of imbalance in the supply and demand of qualified healthcare professionals to meet population needs (De Biasi et al., 2020; Jackson et al., 2018). As a result, researchers have turned their focus to addressing these workforce shortages on micro levels in many regards (Leong et al., 2021; Super. 2020).

Because of this attrition crisis, scholars have begun to consider the fact that the United States currently resides in a healthcare economic bubble where asset prices of care are much higher than underlying fundamentals. Evidence from a switching regression model of healthcare bubble episodes in the United States pertaining to macroeconomic variables and public financing has shown that the nation is in a bubble (Chen et al., 2016). This bubble has been caused by a misallocation of resources, which does not align with the growing imbalance in supply of healthcare professionals and the demand for services (Chen et al., 2016). Monetary and fiscal policies, while playing critical roles in determining healthcare provider deviation and inflation, have not accurately reflected healthcare professionals' need for wage growth (Chen et al., 2016). This bubble, which has been building for at least 3 decades, reflects an increasing societal need for healthcare services (Chen et al., 2016). Researchers remain uncertain regarding how to manage this bubble and to restore balance in the supply and demand of workers (Ambrogio et al., 2022; Kaufman, 2011; Satiani & Prakash, 2017). This problem is exacerbated by attrition and high rates of turnover, which are partially caused by a lack of consideration of wage growth needs and reduced job satisfaction by healthcare professionals throughout the country (Kaufman, 2011; Satiani & Prakash, 2017). Practitioners, policymakers, and researchers have begun to increasingly focus on how to achieve a balance in workforce supply and demand and prevent high rates of attrition.

One way in which researchers have explored how to address clinician workforce shortages is in underserved areas. Abayasekara (2015) reviewed secondary data regarding healthcare service demand and shortages underserved areas. Abayasekara estimated that based on trends analyzed up until 2014, the shortage of qualified healthcare professionals would increase by 20,000 full-time equivalent professionals in the United States by 2020. The shortage in qualified healthcare professionals also places an added burden on existing professionals who are

already under severe duress and face demanding shifts and work conditions (MacLeod, 2015; Rawal et al., 2020). This high demand contributes to stress in existing professionals, which can lead to low job satisfaction and, eventually, burnout (Massachusetts Medical Society, 2013; Rawal et al., 2020). Burnout negatively influences retention rates, which the healthcare industry cannot afford during the current healthcare professional shortage crisis (Chesak et al., 2020; Terry & Brown, 2016). While it has been suggested that an increase in the supply of physicians can be expected in the next decade, these new professionals will still be exposed to extremely demanding conditions and may suffer from similar risks of stress, low morale, and low intent to remain in the field. A need exists to understand the experiences of existing professionals in relation to their work environments, specifically with respect to morale, satisfaction, and retention.

Attrition has also potentially contributed to an unexpected reduction in healthcare quality in some places where turnover is high because of the time spent training and retraining new staff members. Healthcare organizations have turned to short-term staffing options, such as temporary agencies, to fill vacant positions (Chesak et al., 2020; Cutter & Miller, 2017). Healthcare worker attrition has also led to increased travel for existing healthcare professionals to fill vacancies, adding to the stress they already experience and detracting from their work-life balance (Cutter & Miller, 2017). Despite advancements in healthcare technology and practice, high levels of stress and burnout in existing healthcare professionals impede these professionals' ability to provide optimal patient-centered care (de Vries et al., 2023; Tarcan et al., 2017). A need exists to not only reduce attrition, but also to smooth the transition process between professionals in settings with high turnover.

The average age of the population has increased, which has contributed to increased strain on existing practitioners and professionals within the U.S. healthcare system. The growing and aging U.S. population places burdens on healthcare with increasingly frustrated physicians leaving practice (Collins & Beauregard, 2020; Hariharan, 2014; McGrail et al., 2017). Changes in healthcare practice have added to stressors for physicians, including enhanced accountability and scrutiny, time limitations, increasing role definition by nonphysicians, and decrease in workplace control contributing to burnout (Gazelle et al., 2015; Wangmo et al., 2019; Willard-Grace et al., 2019). Willard-Grace et al. (2019) found that burnout has negative implications on physician well-being, morale, and retention. A focus on physician retention is likely to benefit the hiring group, employees, and patients (Han et al., 2019; Petrou et al., 2014; Wangmo et al., 2019).

Stress and burnout are two factors that have been demonstrated above as causes of attrition. Several additional correlates of these variables have been identified in the literature, many of which are distinct from other industries beyond healthcare (Rao et al., 2020; Skarzauskiene, 2010; Swensen et al., 2016). Work hours have been shown to strongly predict attrition in healthcare professionals (Neumann et al., 2018; Sander et al., 2015; Shanafelt et al., 2022). Most healthcare workers already report moderate to high levels of satisfaction with their careers and the financial incentivization associated with the profession (Lyubarova et al., 2023; Neumann et al., 2018; Sander et al., 2015). Many healthcare professionals develop stress and burnout largely due to the demanding schedules and long shifts, which can have unavoidable negative cognitive consequences (Lyubarova et al., 2023; Neumann et al., 2018; Sander et al., 2015). Eventually, the demanding hours and chronic stress produce burnout and increase professionals' intent to quit their current environments (Neumann et al., 2018; Sander et al., 2015; Shanafelt et al., 2022). Even despite financial incentives and increases in compensation, the attrition problem has only increased in recent years in the healthcare industry. Healthcare workers

value additional factors beyond compensation, and it is scheduling and lack of work-life balance that largely predict attrition in the healthcare industry. The degree to which these factors are distinct between healthcare professionals in general and physicians in particular has been the subject of recent research and is discussed in more detail in the following subsection.

Stress, Burnout, and Attrition Specifically in Physicians

Burnout affects physicians for similar reasons as healthcare professionals, although researchers have identified some distinctions between the factors that predict burnout in physicians versus other members of the healthcare industry. Researchers have also begun to explore how physician burnout affects healthcare organizations differently than burnout in other healthcare professionals. Dewa et al. (2017) conducted a systematic review of the relationship between physician burnout and healthcare quality in civilian settings. Based on their research, Dewa et al. (2017) found that physician burnout is inversely and significantly associated with patient safety and safety culture. These authors also found that physician burnout had a stronger negative influence on patient safety and safety culture than general health practitioner burnout. A significant need exists to prevent burnout in physicians and to identify those factors that improve morale and satisfaction in these professionals. The findings from this study support those within the general healthcare literature but also illustrate an increasing need to prioritize stress in physicians and maximize work-life balance (Shanafelt & Noseworthy, 2017; Verret et al., 2021).

Based on evidence of burnout in physicians, some practitioners and researchers have proposed strategies for addressing this issue once it is experienced. While preventative methods are likely to be more effective longitudinally, a need also exists to address burnout as it occurs in physicians to prevent attrition (Gazelle et al., 2015; Karakash et al., 2019). At least one in four physicians are believed to experience burnout across all specializations in the healthcare industry

(Gazelle et al., 2015; Karakash et al., 2019). Because of the high correlation between burnout and attrition and the exorbitant costs associated with recruitment and training new staff, this problem can be financially detrimental to healthcare organizations (Hariharan, 2014; Karakash et al., 2019). Researchers have offered professional coaching as a potential *ex post facto* solution for burnout in physicians (Karakash et al., 2019). This process involves promoting self-awareness of predispositions to burnout due to traits like self-denial and compulsiveness and the reinforcement of increasing physicians' internal loci of control (Gazelle et al., 2015; Karakash et al., 2019). Professional coaching can be used to change perspectives and professional orientations so that personal and professional values are more aligned (Gazelle et al., 2015). While this approach of professional coaching has not yet been empirically tested and the importance of professional coaching on burnout and attrition in physicians is not yet known, this research illustrates the increasing interest in addressing this issue in contemporary healthcare.

Work stress of physicians has a range of direct and indirect influences on both individuals and organizations. Tziner et al. (2015) investigated how work stress, burnout, satisfaction at work, and turnover intention were related in a sample of 124 hospital physicians. These researchers hypothesized that a positive and significant relationship would be found between burnout and work-related stress, while a negative (i.e., inverse) and significant relationship would exist between work-related satisfaction and burnout as well as work-related satisfaction and turnover intention. A structural equation model showed that all hypotheses were confirmed, with burnout partially mediating the relationship between work satisfaction and stress. Work-related satisfaction partially mediated the relationship between intent to quit and burnout. These findings support previous research showing the strong and significant relationship between work stress, burnout, and turnover intentions (Nantha, 2013; Schrijver, 2016; Wang et al., 2020). This

evidence suggests that healthcare organizations must strive to reduce work stress experienced by physicians if they seek to address the persistent problem of burnout and attrition.

Researchers have begun to explore how attrition among physicians has influenced the healthcare industry based on growing evidence of the shortage and imbalance in the supply and demand of these professionals. Degen et al. (2015) performed an integrative review of physicians' intent to leave the direct patient care setting. Drawing on a previously validated and systematic process of integrative review, these authors located 17 studies from five countries that matched their inclusion criteria to identify factors that contributed to physicians' intent to leave. These researchers found that variables that strongly predicted intent to leave included being of a higher age, being female, poor work-life balance, longer total work hours and longer shift duration, and differing career aspirations. These findings support the literature pertaining to general healthcare, illustrating that many of the factors that contribute to attrition are modifiable on an organizational level (Dodek et al., 2016; Filho et al., 2016; Lee et al., 2021; Nantha, 2013). Leaders of organizations, while unable to adjust for age and gender, can work to improve work-life balance and restructure shift and total work hours to improve satisfaction and increase the likelihood that physicians will remain in their positions.

Debates exist in the literature with respect to how national healthcare policy, such as the Affordable Care Act, has affected physicians' turnover rates. Henry (2015) used critical medical anthropology to analyze the policy's importance in a range of industry outcomes, including physician intention rates. Henry noted that the policy was implemented to suggest strategies to add new physicians but lacked guidance on how this would be funded. The policy also included ambiguous language regarding the roles of new hires within medically underserved populations. A need exists to establish more collaborative care teams and focus on patient-provider

relationships to mitigate any concerns about how adding new staff members will influence existing healthcare organizations (Anandarajah et al., 2018; Hoffman & Cowdery, 2021).

There is little question that physician turnover and attrition is expensive for healthcare organizations, and these expenses outweigh the costs of improving work conditions for existing practitioners. The reasons why healthcare organizations have not been more proactive in implementing strategies to prevent turnover is not clear. While many of the factors that predict physician turnover are unmodifiable on an organizational level (e.g., age, gender, career aspirations), other factors can be controlled by healthcare facilitates to mitigate the costly effects of attrition (Attenello et al., 2018; Degen et al., 2015; Fibuch & Ahmed, 2015; Rotenstein et al., 2021). Estimates of the physician shortage crisis vary according to different reports, although some suggest that by 2020, the United States will have nearly 100,000 fewer physicians than what is ideally needed to meet population needs (Attenello et al., 2018; Butzner & Cuffee, 2021; Fibuch & Ahmed, 2015). Some researchers expect this amount to reach more than 130,000 by 2025 if actions are not taken at the time of writing. Every time a physician leaves their position within a healthcare organization, researchers estimate that the annual replacement cost is between $300,000 and $500,000 (Attenello et al., 2018; Fibuch & Ahmed, 2015; Mahoney et al., 2020). Small incentives and efforts to promote work-life balance and satisfaction, including scheduling flexibility and continuing education, can potentially have substantial cost-saving effects across the healthcare industry.

Scholars have continued to document the extent of the physician attrition crisis in the United States with the aim of identifying the determinants of this problem. Such researchers have supported decades of previous literature showing that satisfaction is a primary determinant of intent to remain within an organization (Filho et al., 2016; Rotenstein et al., 2017; Wright et al.,

2022). Jackson et al. (2018) conducted an investigation of job satisfaction and attrition among surgeons in the United States that closely resembled many previous studies on this topic. Using a cross-sectional survey – as have numerous previous researchers on this issue – Jackson et al. identified that personal factors were more highly correlated with intent to remain or quit a position than organizational or occupational factors. These findings reinforce the importance of addressing psychological and emotional needs in physicians to maximize retention. Examples include reducing stress and increasing well-being and happiness. The findings from this study support previous research showing that reducing physician work hours can increase well-being, happiness, satisfaction, and intent to remain in the organization (Tsai et al., 2016; Wright et al., 2022). While organizational factors are important correlates of retention, healthcare facilities may more efficiently allocate their resources toward addressing physicians' personal needs to address problems with attrition and increase physician retention.

Morale, Satisfaction, and Retention in Healthcare Professionals

The previous section included a review of literature pertaining to stress, burnout, and attrition. Based on the evidence presented in this previous section, a more informed understanding of morale, satisfaction, and retention can be gained. This section includes a review of literature pertaining to morale, satisfaction, and retention in the general healthcare population first, as there is a large body of evidence on this subject. A narrower focus on morale, satisfaction, and retention specifically in physicians is then provided. This section is followed by a consideration of theoretical models of stress and retention as well as gaps in the literature and a justification for the current study.

Morale in Healthcare Professionals

Improving morale in healthcare professionals offers several benefits to employees, patients, and healthcare organizations. In a study by Biddison et al. (2016), improvements in healthcare worker morale led to improved safety within a large cohort of inpatient hospital units in the United States. Based on a retrospective analysis of secondary data using the Safety Attitudes Questionnaire with more than 2,000 participants in the U.S. healthcare system, the researchers' findings indicated moderate to strong and significant correlations between worker morale and safety culture (Biddison et al., 2016). This relationship was mediated by increased employee engagement (Biddison et al., 2016). These findings suggest that working to boost healthcare workers' morale can increase their engagement and positively influence their attitudes toward safety and patient care (Biddison et al., 2016). The research conducted by Biddison et al. (2016) is supported by previous evidence that increasing morale and positively influencing organizational attitudes has benefits for not only healthcare workers, but also patients and healthcare organizations (Rosenstein, 2017; Tziner et al., 2015). Though correlational and retrospective in nature, these findings produced by Biddison et al. (2016) add to the literature demonstrating the necessity to focus on improving the work climate for healthcare professionals, particularly physicians, to achieve organizational outcomes like patient safety and optimal patient-centered care while also reducing attrition and costs associated with turnover.

Satisfaction in Healthcare Professionals

An additional benefit of improving job satisfaction in healthcare professionals is that doing so may increase care outcomes, healthcare quality, and patient satisfaction. There is evidence suggesting that higher levels of healthcare professional satisfaction are associated with a more patient-centered culture and greater patient satisfaction (Cliff, 2012; Downing et al., 2018;

Owoc et al., 2022). Although research linking healthcare professional satisfaction directly with patient satisfaction is scarce and this relationship is mediated by several factors, there is sufficient evidence to suggest that increasing worker satisfaction can facilitate improvements in healthcare quality (Cliff, 2012; Downing et al., 2018). Healthcare organizations are often bounded by strict budgets that prevent them from implementing long-term strategies to increase professional satisfaction via incentives, although Tziner et al. (2015) suggested that trying to retain existing employees is significantly more cost-effective than managing high levels of turnover. Leaders of organizations are more likely to reduce total costs longitudinally when they optimize the work and patient care culture and provide incentives to high-performing professionals to ensure that they remain within the organization (Fibuch & Ahmed, 2015; Folbre et al., 2021). By increasing morale and satisfaction, healthcare professionals consistently show greater intent to remain in their positions, thus improving patient care outcomes and reducing costs associated with educating and training new and/or temporary employees.

Retention in Healthcare Professionals

Another factor that has been demonstrated in the literature to facilitate higher levels of retention is the recruitment process. In the highly competitive market for qualified physicians where a perpetual shortage exists, healthcare organizations often resort to long-term recruiting strategies and incentive packages to lure the most skilled graduates (Hariharan, 2014; Wiederhold et al., 2018). According to Hariharan (2014), "In order to overcome the inevitable physician shortage, physician groups and hospitals must acknowledge and incorporate effective recruiting techniques into their practices" (p. 14). As a result, researchers have recently begun to investigate how the recruitment process influences retention rates over time (Block, 2016). Although still primarily anecdotal in nature, Block (2016) proposed several factors that may lead to more effective and efficient recruitment of skilled professionals and thereby reduce attrition and

increase retention rates. Scholars have shown that skill building, continuous learning opportunities, active engagement with recruits and relationship development, and incentivization can all increase retention longitudinally (Block, 2016). However, these researchers do not currently understand why these factors influence retention.

Early recruitment helps to instill organizational values into potential employees and increase their identification with the work environment (Block, 2016). This instillation of organizational values may translate to improved perceptions of job satisfaction. No known studies have centered on the relationship between organizational identification and perceptions of job satisfaction in physicians. Much of the literature pertaining to retention used in the healthcare industry has drawn from general organizational literature. The work of George (2015), which involved the retention of professional workers, has been cited by numerous healthcare researchers because of its pertinence to general organizational factors that determine worker satisfaction and morale. Based on a cross-sectional design involving 138 workers in the UK, George sought to identify consistent factors related to retention. The findings showed that retention factors could be categorized into two dimensions: organizational factors and job-level factors. A combination of these two factors most strongly predicted retention intentions, as did each independently. Maximizing retention in general workers requires both organizational and job-related strategies, although addressing each one individually will also likely have a positive effect on retention in any organization (George, 2015).

Morale, Satisfaction, and Retention Specifically in Physicians

As a result of the physician shortage crisis in the United States, researchers have begun to explore ways in which to increase retention and restore the physician pipeline. Previous researchers have identified several challenges that may impede this process, despite best efforts

by healthcare organizations and policymakers. Daye et al. (2015) provided an editorial paper and review of challenges that still exist concerning filling this gap in qualified physicians. Specifically, the length of training and lack of administrative support have been identified as perpetual problems that negatively influence retention in physicians (Daye et al., 2015). These problems are exacerbated by the rapidly changing and evolving nature of the medical field, which requires consistent and vigorous continuing education (Daye et al., 2015; Seehusen et al., 2018). The retention of physicians is, therefore, crucial for providing optimal patient-centered care and meeting the increasing population need for healthcare services (Daye et al., 2015; Seehusen et al., 2018). Because of the limited funding of the National Institutes of Health, stakeholders play an increasingly important role in supporting healthcare organizations and providing incentives to increase those factors that boost the likelihood that physicians will remain in their positions (Gazelle et al., 2015). Researchers have only recently begun to investigate what this support encompasses.

Despite generally limited research in the area of physician satisfaction, some preliminary reviews on the subject exist. Hoff et al. (2015) conducted a narrative review of the issue of physician satisfaction in the United States. Hoff et al. explored research published over a 5-year period between 2008 and 2013 and compared their findings with literature published between 1970 and 2007 to identify trends and changing physician needs during these periods. Based on 22 studies that matched the inclusion criteria, these authors found that physicians experience moderate to high average levels of work-related stress. Interestingly, physician satisfaction appears to have remained stable between 1970 and 2007 despite evidence suggesting gradually declining levels of this outcome. This finding is surprising given the large number of researchers and practitioners suggesting that high rates of turnover are caused by low satisfaction (Hoff et al., 2015; Jackson et al., 2018). The results from the review conducted by Hoff et al. (2015)

suggested that factors beyond satisfaction are contributing to the undesirable rates of turnover that exist within the healthcare industry, specifically among physicians. Specifically, demographic factors and healthcare policies may have stronger influences than just job-related factors in predicting attrition, turnover, and retention.

Work-life balance is a particularly strong determinant of satisfaction in physicians. Women appear to be more strongly influenced by this variable than men (Arima et al., 2016). Arima et al. (2016) performed a cross-sectional study involving 2,159 physicians to determine their levels of satisfaction with the work environment and factors that contributed to satisfaction. The results showed that work-life balance was a significant predictor of job satisfaction in both men and women, although the percentage of women reporting this factor as a source of satisfaction was significantly higher than that of men. Conversely, men more highly valued salary when determining factors contributing to job satisfaction. This study was cross-sectional in nature and confirmed previous evidence showing that work-life balance is a critical determinant of job satisfaction (Hoff et al., 2015; Jackson et al., 2018). Leaders of organizations that strive to improve work-life balance through strategies like reducing shift times and increasing intervals between shifts may experience more satisfied staff and reduced rates of attrition.

Previous researchers have indicated that understanding physicians' ideas of job satisfaction can influence morale and retention (Brennan & Monson, 2014; Cofer et al., 2018; Gazelle et al., 2015; Hariharan, 2014; Nantha, 2013; Plomp & Van Der Beek, 2014). Dissatisfaction in a physician's employment negatively influences well-being, decreases physician retention, worsens patient care, adds to patient noncompliance, contributes to low physician morale, and decreases organizational unity (Gazelle et al., 2015). U.S. physicians

experience more position dissatisfaction compared to other U.S. workers, increasing turnover intentions within this profession (Tziner et al., 2015).

Incentivization does not appear to make as strong of a difference to prevent stress, burnout, and attrition in physicians as does modifying work hours. Tsai et al. (2016) performed a nationwide survey of 2,423 full-time physicians in Taiwan to determine the degree to which satisfaction with pay influenced turnover intention. Tsai et al. (2016) found that approximately 15% of the sample demonstrated a strong intention to leave the current work setting, and the average number of hours worked per week was nearly 60. Interestingly, while work hours independently predicted turnover intention, pay satisfaction did not significantly moderate this relationship (Tsai et al., 2016). This finding illustrates that financial incentives are not strong predictors of turnover intentions in physicians and supports previous studies also demonstrating this relationship (Jongbloed et al., 2017; Lu et al., 2017).

Physicians value well-being and work-life balance more highly than financial incentives, and at the time of writing, hospital managers are misguided in their belief that increasing salaries justifies the long work hours and demanding work environments that physicians face. Instead of spending more to compensate physicians, hospitals may more effectively address the turnover problem by reducing work hours and providing physicians with shorter shifts. Hospitals may also potentially hire more staff and simultaneously increase salaries.

Increased competition for physician talent requires that care organizations have an integrated approach focusing on physician engagement and well-being to improve retention (Brennan & Monson, 2014; Windover et al., 2018). The results from this study may be useful for increasing physician retention rates and reducing costs associated with continually hiring and

training new physicians. These findings may lead to reduced costs of care and a more efficient healthcare system.

Reducing the total number of hours worked and reducing shift durations can improve organizational outcomes, according to recent research. Grossman et al. (2018) performed a cross-sectional and retrospective study comparing 183 physicians in 2015 and 176 physicians in 2016 to determine productivity based on part-time versus full-time work hours. The results indicated that physicians who work part-time demonstrate equal, and oftentimes greater, productivity than full-time physicians. The reasons for this outcome may be increased work-life balance and greater job satisfaction, leading to higher organizational commitment and greater performance during the shortened shift (Shanafelt & Swensen, 2017; Yeager & Nafukho, 2012). In full-time physicians, the high level of demand and stress incurred on a daily basis likely detracted from any increased productivity associated with longer shift durations. Reducing the number of hours worked and allowing physicians to take part-time roles in healthcare organizations appears to be a valid way in which to promote work-life balance and increase retention intentions within the healthcare industry.

Cultural factors influencing job satisfaction also warrant consideration. Arima et al. (2016) conducted a study in Japan, where the cultural perception is generally collectivistic in nature. As a result, work-life balance may be more highly valued by the participants of this study than what can be expected in the individualistic West. Lu et al. (2017) also found that physicians in China valued work-life balance more highly than those in the West. Drawing on a cross-sectional design involving nearly 4,000 Chinese physicians, these authors sought to determine the relationship between work-family conflict, work-related stress, job satisfaction, and turnover intentions. The authors found that turnover intention was significantly and positively correlated

with longer work hours, job dissatisfaction, work stress, and work-family conflict. The findings showed that physicians that worked in rural areas demonstrated greater turnover intentions than those in rural areas. These findings offer a range of predictive variables for turnover intentions that apply to Chinese physicians, which may be useful in guiding future interventions to mitigate stress, burnout, and turnover intention. The degree to which these findings can be generalized to physicians in the West warrants further investigation. Research is needed to account for cultural perceptions in determining factors that contribute to work-life balance and organizational strategies to promote this construct.

Professionalism can influence job satisfaction, specifically in physicians. In a conceptual and argumentative paper on the role of professional in healthcare organizations, researchers suggested that professionalism was likely to be more highly valued in physicians than lower-level healthcare professionals (Brennan & Monson, 2014; Lacy & Chan, 2018). The reason for this finding may be that physicians are more involved in organizational and administrative aspects of the facilities in which they are employed than other healthcare professionals. As a result, physicians may find that professionalism is a strong determinant of satisfaction in their work environments because of their need to impart leadership roles and responsibilities on other members of the organization. Factors such as communication and interpersonal skills contribute to perceptions of satisfaction in organizational leaders, while those in lower-level positions typically favor transactional rewards, such as compensation and time off from work (Tsai et al., 2016). Leaders of healthcare organizations are advised to consider the role of professionalism in determining physicians' satisfaction and strive to enhance this construct whenever possible.

Similar to general healthcare workers, early recruitment may be an effective strategy to retain physicians as well. Verma et al. (2016) performed a systematic review of the literature

pertaining to recruitment and retention strategies in primary care doctors. Based on the identification of 51 studies involving 42 interventions, these authors found that multiple strategies had been employed to recruit and retain qualified physicians. These strategies included financial incentives, recruiting rural graduates, recruiting internationally, undergraduate placements, providing postgraduate training to underserved areas, focusing on well-being and social support, marketing, mixed interventions, and continuing education strategies. The most frequently used strategy was financial incentivization, while well-being and peer support were the least used strategies. This trend reflects a problem within existing healthcare organizations and their attempts to promote retention, as previous evidence suggests that personal and emotional factors related to well-being most strongly influence turnover intentions (Filho et al., 2016; Murale et al., 2015).

Filho et al. (2016) established that healthcare organization leaders falsely believe that financial incentivization is sufficient to retain qualified physicians and should focus more on promoting work-life balance and satisfaction (Filho et al., 2016). No scholars have evaluated the efficacy of reducing hours or modifying the work schedule in improving satisfaction and decreasing turnover attentions (Verma et al., 2016). The belief that financial incentivization is sufficient to retain qualified physicians (Filho et al., 2016) is also contradictory to studies showing that long work hours are the most significant predictor of stress, burnout, and attrition in physicians (Tsai et al., 2016). Verma et al. (2016) found that studies in the review were of low methodological quality, and no randomized controlled trials have been performed to determine the effectiveness of different retention strategies. Verma et al. (2016) indicated that improvement in research design and intervention focus is needed to mitigate the growing physician shortage crisis.

Some researchers have investigated how individual factors contribute to morale and general well-being of physicians. Tak et al. (2017) performed a cross-sectional study to determine how intrinsic motivation contributes to physician well-being. Drawing from data from a national physician survey of 1,289 physicians in the United States, these researchers found that the strongest predictors of well-being included job satisfaction, high meaning, sense of calling, career satisfaction, and life satisfaction. Burnout was strongly negatively correlated with all indicators of well-being. Those with higher job satisfaction were significantly more likely to remain in their positions (Tak et al., 2017). These findings align with those of previous research and offer strong support for the role well-being and intrinsically motivating aspects of the work environment play in determining retention versus attrition rates (Fida et al., 2018; Nantha, 2013). Striving to maximize well-being through intrinsically rewarding factors can increase physician morale and satisfaction and reduce undesirable rates of attrition within the industry. The rationale behind why healthcare organizations have not yet implemented a consistent and cohesive policy or strategy to achieve this objective is unclear. There is no comprehensive strategy to address the turnover problem, which may be due to a lack of understanding as to how to promote well-being in physicians and why some physicians respond to organizational factors more strongly, while others more highly value personal factors in determining their levels of satisfaction with the work environment.

Physician job satisfaction may also be related to the relationship between actual versus preferred job size. Jongbloed et al. (2017) performed a cross-sectional analysis of previously published longitudinal data pertaining to physician job satisfaction and retention. Based on a sample of 506 participants, most physicians preferred not to work full time, and larger job sizes were significantly and inversely correlated with job satisfaction. Twelve percent of the sample reported wishing to increase their work hours. Physicians who preferred to increase their work

hours did so because of dissatisfaction with their professional accomplishments. Improving job satisfaction in physicians generally requires reducing total work hours as well as shift duration. The mediating role of perceived or actual professional accomplishments warrants further exploration. No previous researchers have incorporated this factor into predictive models of satisfaction and retention. Low professional accomplishments may be due to a combination of individual and organizational factors, and the role this variable plays in retention versus attrition offers an interesting direction for future research (Jackson et al., 2018). Jackson et al. (2018) clearly showed that most physicians report feeling overworked and perpetually experience undesirable levels of stress and symptoms of burnout as a result of the long hours associated with their positions.

Strategies used by Organizations to Retain Employed Primary Care and Internal Medicine Physicians

Previous literature reflects various strategies used as a means of retaining primary care physicians. Willard-Grace et al. (2019) examined physician burnout as well as strategies to reduce high turnover. The researchers examined data from 2013 and 2014 across 740 primary clinicians and staff across San Francisco. The findings indicated that 53% of clinicians reported burnout, and 35% reported high engagement. As a result, physicians that reported high burnout were less likely to be employed 2 to 3 years after the initial survey period. According to the authors, a reduction of clinician turnover rates is associated with reduced burnout and improved engagement. Basu et al. (2020) similarly reported that to improve retention of primary care and internal medicine physician, reduction burnout strategies must be considered. Other strategies can include improving work-life balance and support from other staffing procedures.

Improving retention in primary care physicians requires improved strategies regarding work-life and integration-based approaches. Parlier et al. (2018) argued that strategies to improve the retention of primary care physicians are related to the ability to address financial incentivization, integration, and work-life balance. Particularly, physicians within rural environments may benefit from improved incentivization to increase retention. Underdahl et al. (2018) noted that improved physician retention is based upon engagement. Underdahl et al. noted that factors such as resiliency and grit may potentially increase physician retention, indicating that multiple internal and external variables are used when considering appropriate retention strategies for physicians. However, a qualitative assessment specific to these considerations is absent in the literature.

Various factors are related to the potential issue of reduction of retention, including burnout and gender. Wangmo et al. (2019) reported that high burnout of physicians is one potential factor that requires assessment to improve retention. According to the authors, reduction of burnout within survey strategies can be effective in terms of improving the retention rate of primary care physicians. Carr et al. (2018) identified potential differences in retention between physicians based on gender. Data were collected from 1,273 facilities of medical schools across 17 years. The findings indicated that women were less likely than men to achieve higher academic career advancement, which resulted in reduced retention of physicians. These findings indicate potential differences regarding strategies based upon personal and interpersonal factors.

The physicians' location may also mediate the optimization of retention strategies. Asghari et al. (2019) examined the retention of physicians with a focus on rural areas. The findings indicated that rural physicians require different supports and resources to optimize retention strategies. Similarly, Paladine et al. (2020) explored the retention of rural physicians and

noted similar issues regarding lack of engagement, poor job satisfaction, and increased workload because of a lack of supportive staff. The findings indicate that the physicians' location may also mediate the specific retention strategy employed.

Job satisfaction can also mediate retention levels and appropriate strategies. Wangmo et al. (2019) examined the job satisfaction of physicians and identified a reduction in outcomes of various populations. According to Wangmo et al., the attention of physicians requires addressing job satisfaction. Higher job satisfaction, associated strategies, and resources can potentially improve the retention of physicians. Perrigino et al. (2019) indicated that increased job satisfaction and work-life balance, including being able to spend time with family, are important factors that can optimize the retention of physicians.

Predicting physician retention is also mediated by the factors related to improving outcomes of family physicians' ability to engage with their families and spend time with their communities. Minor et al. (2019) indicated that physician retention requires a healthy work-life balance. Similarly, Asghari et al. (2019) indicated that improved work-life balance and community integration can retain physicians in a long-term based assessment. The findings of Asghari et al. (2019) and Minor et al. (2019) indicate that one such optimization strategy can include addressing work-life balance and other associated community factors for physicians.

The reduction of stress, as identified by Burton et al. (2017), is one factor that may improve interventions designed to improve retention strategies. According to Burton et al., mindfulness-based interventions can be effective to improve retention strategies as a means of reducing stress and other emotional exhaustion faced by physicians in the workplace. Linzer et al. (2017) argued that organizational factors also contribute to stress experienced in the workplace. This indicates that improved approaches for optimizing retention may be based on the methods

employed specifically in the organization and the culture created within the medical facility. Linzer et al. (2017) collected data from a cluster-randomized trial of 35 clinics in the United States. Six months after the intervention, the researchers found that work conditions could improve the reduction of errors and quality of care period; however, stress levels continue to increase burnout symptoms of physicians. The findings illustrate the importance of understanding organizational strategies optimization. These reflections also indicate a lack of focus specific to the qualitative perceptions of physician leaders, which the current researcher addressed.

One optimization strategy to reduce retention effects among medical facilities within primary care physicians is the reduction of burnout. Malhotra et al. (2018) and Dyrbye et al. (2017) indicated that burnout serves as a threat to healthcare industry practitioners not only based on physical and mental effects, but also in terms of increasing retention issues. Improving retention rates can potentially be optimized by addressing burnout, reducing stress, and improving work-life balance. Physicians must manage work-life balance, overloaded working hours, and other factors that ultimately increase stress and burnout. One optimal strategy for improving retention is to reduce burnout and stress by focusing on personal and organizational factors (Abayasekara, 2015; Jackson et al., 2018).

Optimal strategies to reduce burnout can include professional coaching. Karakash et al. (2019) argued that professional coaching is an appropriate model for improving self-awareness, identifying burnout, as well as understanding compulsiveness to improve the mental and physical wellness of physicians. Gazelle et al. (2015) argued that professional coaching can also be effective in reducing burnout. Empirical studies specific to understanding how the reduction of burnout through professional coaching strategies is effective for the reduction of turnover associated with physicians are lacking within the review literature.

Other strategies appropriate for optimizing retention include improving morale. Biddison et al. (2016) and Tziner et al. (2015) indicated that reduction of morale can ultimately decrease job satisfaction and increase stress and burnout of physicians. Thus, improving morale can improve organizational attitudes and may also benefit physicians' retention rates (Rosenstein, 2017; Tziner et al., 2015).

Summary and Conclusions

I reviewed the literature pertaining to stress, burnout, and attrition in the healthcare profession in general, followed by a specific focus on physicians. Stress is a perpetual problem influencing healthcare professionals, including physicians. Professionals in the healthcare industry exhibit among the highest levels of chronic stress of any occupation, and this problem has increased over the past several decades (Burton et al., 2017). While research involving stress, burnout, and attrition in physicians is scarce, a large body of evidence on this topic exists regarding general healthcare practice, and many of the organizational strategies that have been implemented to address the needs of physicians have been drawn from general healthcare literature. The attrition problem in healthcare is significant because of the increasing demand for healthcare services. This factor is due to a range of factors, one of which is globalization of healthcare (Tsai et al., 2016). Researchers have begun to explore how attrition among physicians has affected the healthcare industry based on growing evidence of the shortage and imbalance in the supply and demand of these professionals; however, practitioners have yet to fully understand how these constructs are experienced in healthcare professionals in general and among physicians specifically. Only through an understanding of stress, burnout, and attrition, can morale, satisfaction, and retention be facilitated.

I reviewed the literature pertaining to morale, satisfaction, and retention both in the general healthcare professional population as well as in physicians. I found that working to boost morale of healthcare workers can increase their engagement and positively influence their attitudes toward safety and patient care (Biddison et al., 2016). Higher levels of healthcare professional satisfaction are associated with a more patient-centered culture and greater patient satisfaction (Cliff, 2012). Most physicians report feeling overworked and perpetually experience undesirable levels of stress and symptoms of burnout as a result of the long hours associated with their positions (Jongbloed et al., 2017). Retention factors may be categorized into two dimensions: organizational factors and job-level factors (George, 2015). These findings suggest that maximizing retention in general workers requires both organizational and job-related strategies, although addressing each individually will also likely have a positive effect on retention in any organization.

Transition

This concludes Section 1, in which I presented foundational materials for the current study. This section included a discussion of the study's background, problem statement, purpose statement, and pertinent aspects of the study scope. The following two sections include an overview of the project and results, respectively. Specifically, Section 2 includes the methodology and research design that were implemented to address the purpose of this study. In Section 3, I present the findings of the study, an overview the application of findings to professional practice in healthcare, and recommendations for future practice and research.

Section 2: The Project

The need for and costs associated with the U.S. healthcare industry have grown dramatically over the last 50 years (W. Y. Chen et al., 2016). The number of physicians has not kept pace; as such, it is necessary to address physician retention. By 2025, a physician shortage of 90,000 is expected due to increases in both the average age of the population and the rate of chronic disease (Sinsky et al., 2017). These shortages in physicians may lead to other problems, such as decreased quality of patient care (Gazelle et al., 2015; Henry, 2015); the accumulation of unnecessary costs (Fibuch & Ahmed, 2015); and physician burnout, which contributes to decreased physician retention (Gazelle et al., 2015). The retention of physicians is critical for mitigating these issues, and retention should be a hiring goal within the healthcare industry (Petrou et al., 2014). With that in mind, I explored the strategies that healthcare organizational leaders use to retain employed primary care and internal medicine physicians.

In this section, I present and rationalize the qualitative multiple case method that was utilized to address the problem outlined above. This method was deemed the most appropriate because it is used to identify phenomena as opposed to distilling correlations between individual variables (see Roller, 2019; Williams et al., 2020a; Wu et al., 2016). I present all aspects of the research process in this chapter, including the participants and how they were selected, the research method and design, and the data collection and analysis instruments.

Purpose Statement

The purpose of this qualitative multiple case study was to explore the strategies that healthcare organizational leaders use to retain employed primary care and internal medicine physicians. I collected data through semi structured interviews with six physician leaders regarding reasons for attrition and how to optimize retention based on their experience. The

research population included five organizational leaders from three healthcare organizations with demonstrated success retaining primary care and internal medicine physicians serving Alexander, Burke, Caldwell, and Catawba counties in North Carolina. Addressing this issue is socially significant because maximizing retention for patient-centered care can lead to a generally higher quality of service delivery and a more efficient healthcare system (Henry, 2015; Underdahl et al., 2018).

Role of the Researcher

In the context of a qualitative multiple case study, the role of the researcher is to record the participants' honest experience of the case being studied. Qualitative research is a suitable method for business problems with explorations of operational processes aiding the researcher in understanding the significance and importance of life situations (Roy et al., 2015; Yin, 2018). According to Degen (2017), qualitative researchers seek to obtain unseen interpretations, feelings, emotions, understanding, and motivations from participants. Qualitative research is the result of knowledge acquired from the understandings and significances of those involved in a phenomenon under study, with an attempt to understand the experiences of study participant (Merriam & Tisdell, 2015). Qualitative inquiry depends on engaging research practice, with the researcher understanding the role and process of objective observation and negating biases (Roger et al., 2018). For this reason, I took precautions to ensure that participant responses were not influenced by researcher bias. To mitigate researcher bias, the researcher may prioritize the first-hand experiences of participants (Roy et al., 2015; Yin, 2018). A qualitative case study method is associated with the assumption that individuals know the most about their own lives; therefore, the researcher trusts that what participants say is the truth (Merriam & Tisdell, 2015). Within this context, the researcher is an observer whose role is to listen and record, but not to influence.

Keeping an ongoing log of the researcher's own thoughts and interpretations throughout the research process can provide a check for the researcher that enables them to analyze the validity of their understanding of the data (Conroy, 2003). This type of ongoing analysis also adds greater transparency to the research process, which is helpful in identifying and accounting for any potential influence over results that the researcher may have (Levitt et al., 2018). As the interviews occurred, I continuously analyzed these notes with the intention to ensure that the results reflected the participants' true experiences. The participants for this study included six physician leaders recruited from Alexander, Burke, Caldwell, and Catawba counties in North Carolina. As I am a doctoral candidate within the business school at Walden University, there were no existing conflicts of interest relating to prior work relationships or power dynamics.

Aside from the roles and responsibilities of the researcher mentioned above, upholding the three elements of the *Belmont Report* (1979) is also an important role of the researcher. The *Belmont Report* requires that researchers address the following: (a) respect for persons; (b) beneficence and (c) justice (Brothers et al., 2019). To ensure respect for the persons was upheld in the study, I maintained participants' confidentiality through pseudonyms. I also completed an informed consent process and eliminated any forceful acts to encourage participation to show respect for persons. To ensure that the study upheld the value of beneficence, I minimized risks to participants during the recruitment and data collection. To uphold the value of justice, I kept all procedures reasonable and nonexploitative. All actions and scope of participation were explained to the participants prior to them deciding whether they agreed to be part of the study.

Participants

The participants for this study included six physician leaders recruited from Alexander, Burke, Caldwell, and Catawba counties in North Carolina. To gain access to participants, I

contacted potential participants through the hospitals that employed eligible individuals for this study. First, I contacted the administrative officials in the human resources department of hospitals in the area, who disseminated information about this study to their staff via email and fliers. A sample size of six physician leaders has been identified as an appropriate and manageable number. If during this first step I could not identify six physician leaders willing to participate in the current study, I would have adopted a secondary plan. The secondary plan for recruiting and selecting study participants would be the snowball sampling technique, where additional participants would be acquired by asking participants in the primary plan to share recruitment materials with other potential participants. I expected that if the first step did not lead to the recruitment of six required participants, the second step would help to achieve that goal.

To be eligible for the study, physician leaders were required to have been employed by their current institution for a minimum of 2 years. This minimum length of employment was included as a qualifying attribute because I aimed to focus on the long-term retention of physician leaders. Any individual who has not worked at the same institution for at least 2 years would not be able to provide the same insight into long term plans or burnout. Further, the physician leaders were required to be able to understand and speak English fluently. The interviews were conducted in English, and participants must be able to succinctly understand the questions provided in English to answer them adequately. Furthermore, the responses were required to be in fluent English for me to be able to understand and analyze them.

Because researchers conducting qualitative multiple case studies are concerned with understanding a very specific phenomena within a real-life context that only affects a small group of people, the sample size for studies in which this method is used can be quite small (Converse, 2012). Of more importance than data saturation is the ability for the data collected from

participants to adequately reflect the case under study. It should also be noted that a large sample size may be hard to manage in multiple case studies because the interviews with each participant are extensive and complicated. For these reasons, I identified a sample size of six physician leaders as an appropriate and manageable number.

Research Method and Design

The research method for this study was qualitative. I deemed this approach to be the most appropriate approach because the findings from this study may illuminate the strategies that healthcare organizational leaders use to retain employed primary care and internal medicine physicians. I selected a multiple case study as the design because the semi structured interviews used for data collection in this method resulted in nuanced and personal accounts of the relationships between variables.

Research Method

I used a qualitative research methodology to guide the current study, desired was to identify and describe the experiences of physician leaders regarding reasons for attrition and how to optimize retention (see Smith, 2015). I did not select a quantitative approach because I did not intend to quantify aspects of participants' experiences in any way. Further, I selected a multiple case study design to explore and describe a phenomenon within the specific context in which it exists and to identify optimal strategies to enhance retention within that context (see Yin, 2018). I did not consider mixed-methods as appropriate because this methodology does not result in rich insight into a phenomenon specifically within the context in which it exists and to provide practical solutions to a pervading problem. Other qualitative designs, such as grounded theory, ethnography, and phenomenology, were not selected because such designs do not allow for the same level of focus on a particular case as a multiple case study. I conducted semi structured

interviews with six physician leaders regarding reasons for attrition and how to optimize retention through in-depth insights from experts in the field.

The method for the current study was qualitative. Qualitative studies are appropriate when the researcher wishes to collect emerging data and data that account for individual experience (Roller, 2019; Williams et al., 2020a; Wu et al., 2016). Qualitative researchers focus on the complex and nuanced aspects of phenomena (Ormston et al., 2013). Researchers use this approach to distill themes within phenomena, as opposed to quantitative research, in which the investigators draw conclusions about the relationships between specific variables (Roller, 2019; Williams et al., 2020a; Wu et al., 2016). Qualitative research can be used to discern themes within specific phenomena, rendering it integral in the initial process of naming and relating variables that have not previously been statistically correlated. For this reason, qualitative research is often used as way of understanding the topics about which little is known (Levitt et al., 2018).

Previous researchers have established the links between morale, satisfaction, and retention of healthcare professionals (see Ellenbecker, 2004; Filho et al., 2016; Murale et al., 2015; Tsai et al., 2016). There have been limited investigations into the factors that increase satisfaction and morale in physicians (Roller, 2019; Williams et al., 2020a; Wu et al., 2016). Qualitative investigations into this topic are, therefore, needed to distill what personal, interpersonal, and environmental factors increase the satisfaction and morale of physicians. I used qualitative methods to gain deeper insight into the connections that individual physicians perceive between their workplace satisfaction and morale as well as their intention to stay at their job. These insights may inform the design of both programs for increasing physician retention and quantitative hypotheses in future studies of healthcare employees' satisfaction, morale, and retention rates.

Research Design

I chose a qualitative, multiple case study design because my goal was to describe the strategies that healthcare organizational leaders use to retain employed primary care and internal medicine physicians in a real-life context. Yin (2018) defined the case study research method as an empirical inquiry that is used to investigate a contemporary phenomenon within its real-life context, when the boundaries between phenomena and their context are not clearly evident, and in which multiple sources of evidence are used. The interviews are then analyzed extensively for themes. Researchers use this technique to develop new patterns and connections between variables and within phenomena (Roller, 2019; Williams et al., 2020a; Wu et al., 2016).

In multiple case studies, the ability to derive understanding from participant experiences is only possible because the information provided by participants within a real-life context is assumed to be true and valid (Moustakas, 1994). An assumption exists that the information given by participants is true because individuals are the inherent authorities of their own lives (Merriam & Tisdell, 2015). Using a multiple case study method, I was able to pinpoint what personal, interpersonal, and environmental factors influence the satisfaction and morale of physicians at work. Furthermore, the findings may provide insight into the strategies that healthcare organizational leaders use to retain employed primary care and internal medicine physicians.

Population and Sampling

Sampling techniques within multiple case studies are different than those used within other types of qualitative research in that they typically encompass a small sample size and are less generalizable (Converse, 2012). Although a small sample size would be undesirable within other types of research, it is acceptable within the context of a multiple case study because the concepts and trends under investigation are so specific. A small sample size is, therefore,

appropriate for investigating a phenomenon within the small group of individuals to whom it is applicable (Khan, 2014).

Most multiple case study researchers use a purposeful sampling technique, which entails gathering participants who have some sort of experience or expertise relevant to the phenomena under investigation (Converse, 2012). There are three types of purposeful sampling: (a) judgement sampling, which involves the selection of participants who have answers to specific research questions; (b) quota sampling, which involves selecting quotas of participants who match different aspects of the research phenomena; and (c) snowball sampling, which involves the selection of participants solely based on their applicability to the phenomena under investigation (Khan, 2014). Because snowball sampling is a method for selecting participants that can provide rich insight into the phenomena under investigation (Khan, 2014), I selected this method as the sampling procedure for the current study.

I contacted potential participants for this study directly or through the hospitals in which they are employed. I obtained contact information by contacting each hospital directly via each institution's publicly available contact information. Recruitment occurred directly or via HR or administrative officials, who distributed knowledge of this study to their staff via e-mail and fliers. Potential participants responded directly or via e-mail, at which point they were screened for eligibility. Those who did not meet the eligibility requirements were informed that they could not participate, while those who did were asked to choose a time for the face-to-face interview. This recruitment process continued until I recruited six participants. All participation in this study was voluntary.

Ethical Research

Before beginning their interview, every participant was required to read, sign, and date a consent form that detailed how the data for this research would be collected, stored, and used. Participants were required to return the consent form prior to participating in any part of the study. This information included an overview of the ways in which the findings of this study could possibly contribute to the larger field. Participants who were not willing to take part in this informed consent process were not able to continue with their interview.

Although participants' names were attached to their interview, only I had access to this information. Both the audio and Microsoft Word files that contain the interviews were housed in encrypted locations. I removed participants' names from any information pertaining to participants that was not contained within an encrypted location.

For the purposes of protecting participants, the data collected from each interview were completely anonymous. Protecting the identities of participants in this study was important because these physician leaders may disclose information regarding intentions of employment management. Knowledge of intentions of employee management or an employee's intention to leave could negatively affect the employer/employee relationship. Furthermore, discovering management plans regarding employed staff could change relationships with patients. It was important that participants in this study remained anonymous.

If participants wished to withdraw from the study, they were required to inform me no more than 2 weeks after the completion of their interview. Participants were not required to provide any reasoning for their decision to withdraw. At that time, all interviews and other information pertaining to that participant would be deleted or shredded. Information on the withdrawal process was included within the informed consent paperwork.

Data Collection Instruments

The central research question that guided this study is as follows: What retention strategies do hospital administrators and physician leaders use to retain primary care and internal medicine physicians? The data for this study were collected through face-to-face open-ended interviews. This is the standard form of data collection for multiple case study research designs (Petty et al., 2012). The questions that were included in these interviews are as follows:

1. What is your role for retaining primary care and internal medicine physicians?
2. What retention strategies do you use to maintain physician staffing in your system of primary care and internal medicine physicians, and how have these strategies contributed to your organization?
3. What approaches have you taken to overcome impediments or barriers to implementation of your retention strategies?
4. What are the internal factors that have aided or hampered retention of primary care and internal medicine physicians?
5. What are the external factors that have aided or hampered recruitment and retention of primary care and internal medicine physicians?
6. How have governmental entities or programs played in your retention efforts?
7. What measures do you use to monitor, update, or change retention strategies to ensure ongoing staffing of primary care and internal medicine physicians?
8. What else can you share about strategies that contribute to successful physician retention?
9. Would you like to share any other relevant information that we have not already discussed?

I carefully designed and analyzed these questions to answer the research question, What retention strategies do hospital administrators and physician leaders use to retain primary care and internal medicine physicians? All participants were presented with definitions for the terms *job satisfaction* and *retention* before beginning their interview. This ensured that the participants and I were speaking about the same concepts throughout the interview.

Data Collection Technique

The participants for this study included six employed physician leaders recruited from Alexander, Burke, Caldwell, and Catawba counties in North Carolina. To gain access to participants, I contacted potential participants through the hospitals that employ eligible individuals for this study. First, I contacted the administrative officials in the human resources department of hospitals in the area, who disseminated information about this study to their staff via e-mail and fliers. A sample size of six physician leaders was identified as an appropriate and manageable number. If during this first step I could not identify six physician leaders willing to participate in the current study, the secondary plan would have entailed recruiting and selecting study participants via the snowball sampling technique, where additional participants would be acquired by asking participants in the primary plan to share recruitment materials with other potential participants. I expected that if the first step did not lead to the recruitment of the six required participants, the second step would help to achieve this goal.

Prior to any data collection taking place, several permissions and approvals were required to be obtained. Prior to any data collection taking place, I obtained IRB approval, which was expected to be granted based on the initial proposal presented to the IRB. Each of the participants were also required to have completed and returned the consent form provided during participant

selection. Because Zoom was utilized to interview participants, I did not expect to need site permission to interview participants onsite.

The instrument for data collection was a semi structured interview protocol that was developed to align with the research questions and the theoretical framework. The semistructured format was selected because this creates consistency from one interview to the next, as each participant answers the same set of core questions (Qu & Dumay, 2011). However, there was flexibility to ask probe questions between core questions, which lead to greater depth and variety of responses (Stuckey, 2013). Prior to the start of each interview, I ensured that each participant had completed the informed consent form. I also explained to all participants that their participation was voluntary, and they may withdraw from the study at any point in time if they wish. The interview took place via Zoom. I used Zoom to ensure that interviews could take place wherever and whenever the participant was comfortable. Each interviewee was also required to have the Zoom application. Recorded meetings on Zoom were used to generate interview transcriptions. These recordings and transcriptions were utilized during the data analysis process. After the meetings were transcribed, I also asked participants if they would be willing to participate in member checking, which entailed the participants reviewing their interview transcript to verify the accuracy of the information therein (Petty et al., 2012).

During the interview, I asked the participants a particular set of questions that were aligned to the research questions (Creswell, 2013). I expected that each interview would take between 30 and 45 minutes to complete. Digital audio versions of the entire interview were recorded via Zoom so that a transcript of the interview could be generated to ensure that I could refer to the interview details later in the research process if needed. After the completion of the

interview, each participant was provided with my contact information so that they could ask any further questions.

Data Organization Technique

The data for this study were organized as both mp3 files and Microsoft Word documents. All files were hosted in an encrypted folder, to which only the primary researcher had the password. The files were organized in the order of their assigned letter/number sequence followed by the word "interview," starting with "P1_interview."

Throughout the analysis process, I reorganized the data into groupings that reflected themes. To distill the themes, I listened to the audio and readings of the transcriptions multiple times. I took separate notes on each interview and organized these notes in Word documents with identifying titles (e.g., "P1_notes," "P2_notes"). After the interviews were sufficiently analyzed, all emergent themes were categorized within a Microsoft Excel spreadsheet. Important information was included with each theme, including the number of participants who mentioned it, the total number of times it was mentioned, and relevant quotes that helped to explain the theme.

To ensure that the data collected for the study were secured, I kept all physical data and information sheets in a locked cabinet in their private office. All electronic data were kept in a password-protected hard drive that was placed inside the same cabinet where the datasheets were stored. All files will be kept for 5 years from the completion of the study. After 5 years, all data will be destroyed, and all physical documents will be burnt. All electronic files will be deleted, and all devices will be formatted to ensure no remnants of data remain.

Data Analysis

I completed data analysis using the methods of interpretive multiple case analysis and thematic analysis. Interpretive multiple case analysis is a way of analyzing interview data that allows the researcher to study both the meaning that participants give to their circumstances as well as the meaning given within the larger context of the phenomena being studied (Austin & Sutton, 2015). When using this method to analyze interviews, it is recommended that researchers remain fluid in their interpretation, allowing new insight from the data to change how it is perceived (Callary et al., 2015). According to Smith (2011), all studies that use interpretive multiple case analysis must include the following in their analysis:

- A defined focus that contributes insight into the nuances of a very specific topic.
- Both descriptive and interpretive analysis that incorporates convergence and divergence of themes must be included.
- The above must be included in the final write up of the analysis. (Smith, 2011)

Interpretive multiple case analysis was a useful analysis tool within the current study, as it facilitated deep investigation into the personal perceptions of the participants. This part of the analysis also helped me to distill the larger trends that influence the relationships between physician job satisfaction and morale and their intention to remain at their job.

I also used thematic analysis, which is a process of finding patterns in qualitative data through text analysis (Maguire & Delahunt, 2017), to analyze the emergent themes within the data. This type of data analysis provides the researcher with flexibility in terms of what they want to concentrate on. It is possible to perform thematic analysis on the entire dataset or on a specific area of the data, offering opportunities for insight on both a macro and micro level (Braun &

Clarke, 2012). Furthermore, this aspect of the analysis provided a more concrete interpretation of the data, which provided greater insight into the findings of the interpretive multiple case analysis.

Thematic analysis is a popular method for analyzing qualitative studies. Consequently, many methods for conducting this type of analysis have been proposed, resulting in misperceptions in terms of how thematic analysis should be conducted (Maguire & Delahunt, 2017). I loaded all data into the NVivo software, which was the tool used to aid in data organization and analysis. I used the six-step method of thematic analyses as laid out by Braun and Clarke (2012) in the current study. The steps involved in this process are as follows: (a) become familiar with the data, (b) create initial codes, (c) search for themes, (d) review themes, (e) define themes, and (f) write the report.

Becoming Familiar with the Data

According to Degen (2017), qualitative researchers seek to obtain unseen interpretations, feelings, emotions, understanding, and motivations from participants. The data for this study were collected through face-to-face open-ended interviews. As the interviews occurred, I continuously analyzed these data with the intention to ensure that the results reflected the participants' true experiences. I became familiar with the data by continuous review of the information and identifying possible codes and themes.

Generating Coding Categories

According to Braun and Clarke (2006), it is possible to perform analysis on an entire dataset or on a specific area of the data that offers potential insight on both a macro and micro level. Coding data allows the researcher to identify characteristics of the information.

Furthermore, researchers can use coded data to arrive at themes. I uploaded all of the data into the NVivo software, which was the tool used to aid in data organization and analysis.

Generating Themes

Computer assisted qualitative data software is a useful tool to increase the efficiency and help with interpretation. I uploaded all of the data into the NVivo software, which was the tool used to aid in data organization and analysis. I used thematic analysis, which is a process of finding patterns in qualitative data through text analysis (Maguire & Delahunt, 2017), to analyze the emergent themes within the data. I used the six-step method of thematic analyses as laid out by Braun and Clarke (2012) in the current study. The steps involved in this process are as follows: (a) become familiar with the data, (b) create initial codes, (c) search for themes, (d) review themes, (e) define themes, and (f) write the report.

Reviewing Themes

I applied Braun and Clarke's (2012) thematic analysis approach to analyze the interviews. Along with the thematic analysis approach, I also applied IPA to determine and discover the participants' most common but meaningful perceptions and experiences regarding the retention strategies for primary care and internal medicine physicians. I incorporated thematic categories to maximize the interviews and address the main research question as wholly and thoroughly as possible.

Defining and Naming Themes

I used the six-step method of thematic analyses as laid out by Braun and Clarke (2012) in the current study. The fifth step is to define and name themes that are the essential information about the research question. Major themes and minor themes are the parent themes of the study, where the major themes represent more significant meanings than the minor themes. The major

themes include the most crucial findings with the most references from the participants. Meanwhile, minor themes followed and are considered important but with fewer references than the major themes. Lastly, I also included subthemes to provide examples and details about the parent themes shared by the participants. Numerous themes were generated in response to the study's research question allowing for a final results report that supports the themes described (Braun & Clarke, 2006).

Reliability and Validity

Although ensuring reliability and validity within qualitative research is different than doing the same for quantitative methods, it is just as important (Noble & Smith, 2015). These concepts are also related to the trustworthiness of a qualitative study, which refers to the measure of the credibility, dependability, confirmability, and transferability of the data within a study (Connelly, 2016). The actual strategies for ensuring reliability and validity within qualitative research act as checks of authenticity and bias throughout the research process (Noble & Smith, 2015). Researchers use these strategies to reasonably confirm that all results truly reflect the phenomena under investigation.

Reliability

Reliability refers to the consistency of participant answers throughout the study as well as the means by which a researcher works to minimize their influence on the study. The recognition of bias is an important aspect in the data analytical process that increases reliability (Noble & Smith, 2015). This process is known as bracketing, which is an exercise that allows researchers to set aside the preconceived notions they have based on who they are. Researchers are then better able to fully comprehend the experiences of participants (Callary et al., 2015), which allows them to produce, comprehend, and analyze data in a more reliable way. To improve reliability, I

performed member checking of the transcripts and the initial interpretations. Member checking is an effective means of improving the credibility of a qualitative research (Candela, 2019). I asked the participants to review the transcript and my initial interpretations of their interviews to provide feedback about the correctness and accuracy of the information found in the document. I conducted member checking prior to processing the data through thematic analysis.

Validity

The process of defining researcher bias is also important for ensuring validity, which refers to how well aligned the results are with the data (Noble & Smith, 2015). Furthermore, the validity of this study was critiqued through thorough record keeping, the inclusion of quotes within the final manuscript, and engagement with other researchers and the participants in terms of their perceptions of the study (Noble & Smith, 2015). This final strategy was utilized with bracketing to ensure that my own biases were acknowledged and kept in check.

To ensure validity of the study, I also transcribed each interview and wrote an initial interpretation of the interview data collected. After transcription, I performed member checking, wherein feedback regarding the accuracy of initial interpretations was obtained from the participants (Lincoln & Guba, 1985). I sent the initial interpretations of an interview to its respective participant. The participant had 7 days to review the accuracy of these initial interpretations. For any misinterpreted interviews, the participant sent the details of the misinterpreted information and corrected the wrong information within the given period. After 7 days from sending the document, no changes were made.

Transition and Summary

The qualitative multiple case study research method and design outlined in this section was appropriate for the study of physician leaders' perceptions of job satisfaction, morale, and

intent to remain in their job, as the connections between these variables have not been adequately investigated in the pre-existing literature (Roller, 2019; Williams et al., 2020a; Wu et al., 2016). Qualitative multiple case study methods are appropriate as a means of defining connections between concepts when none have previously been pinpointed, as this design prioritizes the subjective realities of participants above all else (Roller, 2019; Williams et al., 2020a; Wu et al., 2016). Although there has been a large amount of research conducted on the connections between the relevant variables in the healthcare context (Ellenbecker, 2004; Filho et al., 2016; Murale et al., 2015; Tsai et al., 2016), little research has addressed the factors that help support job satisfaction and morale in physicians as well as how they perceive the factors affecting their intention to stay in their current job. I sought to fill this gap using the qualitative methodology outlined in this section. In Section 3, I provide an overview of how this research applies to professional practice in healthcare and suggests the changes that it may be able to foster in both practice and research.

Section 3: Application to Professional Practice and Implications for Change

The general business problem is that a shortage of physicians negatively affects practice viability and patient care (Lu et al., 2017). The specific business problem is that some healthcare leaders lack strategies to maximize physician retention. The purpose of this qualitative multiple case study was to explore the strategies that healthcare organizational leaders use to retain employed primary care and internal medicine physicians. I used the theory of Ellenbecker's (2004) job retention model as the theoretical framework for this study. The following central research question was addressed in this study: What retention strategies do hospital administrators and physician leaders use to retain primary care and internal medicine physicians?

I performed a qualitative multiple case study with six physician leaders in order to explore the phenomenon of interest. I recruited the sample using both purposeful and snowball sampling methods. The six participants were from Alexander, Burke, Caldwell, and Catawba Counties in North Carolina. I interviewed four female and two male participants. The roles or positions of the physician leaders who participated in the study varied, including managers, executive officers, department directors, a vice president, and an administrator.

The source of data for this study was open-ended semi structured interviews via Zoom. I used Zoom to ensure that the interviews took place with the convenience and comfort of the participants in mind. I analyzed the data from the interviews using Braun and Clarke's (2006) six-step thematic analysis method. I also applied IPA to ensure that I could determine and discover the participants' most common but meaningful perceptions and experiences regarding the retention strategies for primary care and internal medicine physicians. I provide the

interpretations and implications of the study to practice and social change along with recommendations based on the findings.

Demographics

I recruited and interviewed six participants for the current study. These six participants were physician leaders recruited from Alexander, Burke, Caldwell, and Catawba Counties in North Carolina. Of the six participants, four were female and two were male. These participants held different roles and positions in the healthcare industry but had wide and varying experiences concerning the retention strategies of physicians in their respective institutions. Table 2 contains the breakdown of the participants' backgrounds.

Table 2

Breakdown of the Participants' Demographics

Participant number	Gender	Role/ Position
Participant 1	Female	Financial Operations Manager
Participant 2	Male	CEO of Health Council
Participant 3	Female	Director of Human Resources
Participant 4	Male	Chief Ambulatory Officer and Vice President of a Medical Group
Participant 5	Female	Executive Director of a Medical Group
Participant 6	Female	Administrator of Psychiatry Services

Analysis

I applied Braun and Clarke's (2006) thematic analysis approach to analyze the interviews with the six participants. Along with the thematic analysis approach, I also applied IPA to

determine and discover the participants' most common but meaningful perceptions and experiences regarding the retention strategies for primary care and internal medicine physicians. I incorporated thematic categories to maximize the interviews and address the main research question as wholly and thoroughly as possible. Furthermore, major themes and minor themes are the parent themes of the study, where the major themes represent more significant meanings than the minor themes. The major themes include the most crucial findings with the most references from the participants. Minor themes followed and are considered important but with fewer references than the major themes. Lastly, I also included subthemes to provide examples and details about the parent themes shared by the participants. As seen in Table, a total of 15 themes were generated in response to the study's main research question.

Table 3

Breakdown of the Total Number of Themes

Thematic category	Number of major themes	Number of minor themes	Number of subthemes	Total
TC1	1	3	1	5
TC2	1	6	3	10
Total	2	9	4	15

Presentation of Findings

In this section, I discuss the themes that emerged from the thematic analysis and IPA of the interviews with the six participants. The main research question that guided the study was as follows: What retention strategies do hospital administrators and physician leaders use to retain primary care and internal medicine physicians? I uncovered two key themes or perceptions in response to the phenomenon after completing the analysis process. According to the three participants, the primary challenge faced by healthcare and physician leaders was the need to

sustain the financial needs of physicians, given the low patient population in some areas. Five participants reported that the most effective retention strategy for them is to demonstrate and give value to the needs of providers by collaborating and communicating with them. In particular, three practices helped them immensely: practicing flexibility and concession when dealing with physicians' needs and requests, understanding the personalized needs of providers, and having a physician leadership structure in place. Table 4 contains the complete breakdown of study themes. In this section, I only discuss the themes with references from at least 35% of the participants. Minor themes with limited participant references or only one participant reference are found in their respective tables. These themes may require further research to improve their trustworthiness.

Table 4

Breakdown of the Complete Study Themes

Thematic category	Themes	Number of references	Number of participants
TC1. Challenges faced in retaining primary care and IM physicians	Needing to sustain the financial needs of physicians	7	3
	** Not reaching the average number of patients being served*		
	Having constant rotations in manpower	1	1
	Competing with healthcare institutions with larger funds and more significant resources	1	1
	Addressing workload and time management issues	1	1
TC2. Retention Strategies in Place	Giving value to the needs of providers by collaborating and communicating with them	22	5
	**Practicing flexibility and concession*		

when dealing with physicians' needs and request		
**Understanding the personalized needs of providers*		
**Having a physician leadership structure in place*		
Offering tuition, training, and certification reimbursements	5	3
Offering life insurance and other insurance benefits	3	3
Promoting work-life balance	3	2
Offering other financial incentives and bonuses based on performance	2	2
Offering a stipend instead of an insurance policy	2	1
Highlighting the value and mission of their work	1	1

Thematic Category 1. Challenges Faced in Retaining Primary Care and IM Physicians

The first thematic category includes the challenges faced by healthcare and physician leaders in retaining primary care and IM physicians. From the thematic analysis and IPA of the six interviews, three participants reported the barrier to sustaining the financial needs of physicians. For them, it has become increasingly challenging to ensure the financial stability of the physicians in their respective institutions given the many internal and external factors present. The three other minor themes are presented in Table 5 and may need further research given the limited participant references recorded under them.

Table 5

Breakdown of the Themes Addressing Thematic Category 1

Thematic category	Themes	Number of references	Number of participants
TC1. Challenges faced in retaining primary care and IM physicians	Needing to sustain the financial needs of physicians **Not reaching the average number of patients being served*	7	3
	Having constant rotations in manpower	1	1
	Competing with healthcare institutions with larger funds and more significant resources	1	1
	Addressing workload and time management issues	1	1

Major Theme 1: Needing to Sustain the Financial Needs of Physicians

The first major theme falls under the first thematic category of challenges faced in retaining primary care and IM physicians. For this theme, it was found that the major challenge for retention was the need to sustain the financial needs of physicians. Participants highlighted that being a physician is a job. Several participants expressed the problems encountered about sustaining salaries and addressing other financial issues in order to retain physicians. Furthermore, physician leaders expressed that the shift from perceiving the role of a physician as a mission or calling to being just a job has affected the financial needs and demands of physicians.

This finding from the data contrasts several studies included in the literature review in Section 1. For example, Tsai et al. (2016) claimed that physicians' satisfaction with the pay they received does not significantly predict turnover intentions. Other studies included in the literature

review also corroborated Tsai et al. (2016) by claiming that financial incentives are not strong predictors of turnover intentions in physicians (see Jongbloed et al., 2017; Lu et al., 2017). Moreover, other authors claimed that physicians value well-being and work-life balance more than financial incentives (Windover et al., 2018). Many healthcare professionals develop stress and burnout largely due to the demanding schedules and long shifts, which can have unavoidable negative cognitive consequences (Neumann et al., 2018; Sander et al., 2015). Based on some of the literature reviewed, reducing work hours and avoiding a demanding work environment are more effective means of retaining physicians than increasing salaries. In another study, Parlier et al. (2018) claimed that work-life balance and financial incentives or salaries all have positive influences on improving the retention rate of primary care physicians.

A contradicting study was included in the literature reviewed in Section 1. Filho et al. (2016) found that healthcare organization leaders falsely believe that financial incentives are sufficient to retain qualified physicians. This claim offers indirect support for the first major theme. Similarly, other scholars claimed that the inability to address the wage growth needs of physicians has reduced healthcare professionals' job satisfaction (Kaufman, 2011; Satiani & Prakash, 2017). The participants of the study are physician leaders who commonly claimed that physicians place high value on their salary or incentives more than other components of their profession, such as the mission to serve the people and treat those who are sick.

The existing literature revealed contradicting claims regarding the importance of financial incentives and salaries on the retention of physicians. Some studies support the claims under the first major theme that sustaining the financial needs of physicians is important, as physicians may quit their job if their financial needs are not met. However, some researchers agree with the first major theme that leaders perceive the salary of physicians as a strong determinant of retention. In

this manner, more data or explanations may be needed in order to fully understand the importance of financial needs of physicians in relation to retention and turnover.

According to three participants, although physicians have an noble mission of serving and saving patients' lives, it is also crucial to acknowledge that being a physician is a job. In this regard, it has become challenging to manage and sustain physicians' salaries when other factors affect the management's ability to provide for the physicians financially. As Participant 1 narrated during the interview, recently, physicians have had a shift in their mindset. At the same time, with the physicians' refusal to serve the number of patients assigned to them, financial issues emerge as well. The participants stated the following:

> After a while, that did not work. Therefore, they go back to the hospitals and become employees again. So now you have this pendulum that is going back and forth. And what, in essence, happened, which I think is a very critical point leading you up to retention, is in the beginning it was an vocation, it was a calling, and now it's a vocation. It is a job and that is the big switch.

> Yes. In addition, that takes the whole mindset to, "I just work here. It is not my ship to steer; it is not my burden to carry. I'm just here to punch a clock and leave." In addition, that has led to the challenges now that management has on what more can we do, but what can we sustain? That is my role in it, is you can promise this, but if I cannot sustain it monetarily for the next few years, you are in trouble.

> Therefore, again, I would want to fall back on base salary plus commission. I would think if you had the right kind of personality, they would see that, as the sky is the limit. Moreover, "Boy, I'm going to get in there and see some patients this week. Put them on my schedule." In addition, I do not want it to sound like a machine, but currently, if I

> have a provider who is seeing six patients a day that is not covering the salary. That moves that person from being an asset to a liability. And that is what is happening. We are asking our providers to see 13 a day and they are balking.

Participant 2 shared the same perception and experience. For this participant, there would always be revenue and financial constraints. However, these are heightened when physicians are unable to reach the target number of patients to be served. Participant 2 shared,

> It is always being constrained by revenue and finances. So, what can I afford? Yet, I have to be somewhat, again, flexible with current employees and potential candidates, about what I can use them for or how I can use them… So, they are not going to be able to see 18 to 20 patients a day. At best, during their tenure here, which is going to be about three to four years before they decide to move on... they have that experience now, and they go to the hospital for more money because they have that experience now, they are seeing averaging 10 to 12 patients a day, as opposed to 15 to 16 patients a day.

Lastly, Participant 6 commented on the direct impact and influence of the COVID-19 pandemic on the financial stability of the healthcare institution and their ability to retain their financial obligations to physicians. The participant stated, “And again, I'm speaking recently, the COVID pandemic that drastically hit. Financially, the organization had a hit. We had to revisit salaries, contracts, and some negotiations occurred.”

Thematic Category 2. Retention Strategies in Place

The second thematic category of the study was the retention strategies already in place that have been deemed effective by the participants. Five of the six participants reported the strategy of giving value to the needs of providers by collaborating and communicating with them. Three participants noted the effectiveness of offering tuition, training, certification

reimbursements, life insurance, and other insurance benefits. Two participants also added the importance of work-life balance and the availability of other financial incentives and bonuses based on performance. I uncovered two other minor themes or strategies of highlighting the value and mission of their work and offering a stipend instead of an insurance policy. These minor themes were referenced by only a few participants and may require further research to develop their trustworthiness. Table 5 displays the themes in response to the second thematic category of the research study.

Table 6

Breakdown of the Themes Addressing Thematic Category 2

Thematic category	Themes	Number of references	Number of participants
TC2. Retention Strategies in Place	Giving value to the needs of providers by collaborating and communicating with them	22	5
	*Practicing flexibility and concession when dealing with physicians' needs and request		
	*Understanding the personalized needs of providers		
	*Having a physician leadership structure in place		
	Offering tuition, training, and certification reimbursements	5	3
	Offering life insurance and other insurance benefits	3	3
	Promoting work-life balance	3	2
	Offering other financial incentives and bonuses based on performance	2	2
	Offering a stipend instead of an	2	1

insurance policy		
Highlighting the value and mission of their work	1	1

Major Theme 2: Giving Value to the Needs of Providers by Collaborating and Communicating With Them

The second major theme falls under the second thematic category of effective retention strategies that are already in place. Collaborating and communicating with physicians may be effective in promoting retention. From the data, I found that collaborating and communicating between leaders and physicians is an effective strategy to promote retention, as this shows that the leaders value the needs of these healthcare professionals.

The importance of having leaders that value the needs of physicians is supported in the literature reviewed in Section 1. For example, a lack of consideration of needs, specifically regarding wage growth, was found to reduce job satisfaction among healthcare professionals (Kaufman, 2011; Satiani & Prakash, 2017). Other scholars have also highlighted the importance of addressing the psychological and emotional needs of physicians to maximize retention (Filho et al., 2016; Jackson et al., 2018; Rotenstein et al., 2017). For example, Jackson et al. (2018) highlighted the importance of leaders satisfying the personal needs of physicians in order to maximize the physicians' retention.

In terms of collaboration and communication, the data that led to the emergence of this aspect of the second major theme were indirectly supported in the literature reviewed in Section 1. Tsai et al. (2016) expressed that leaders' communication and interpersonal skills contribute to their followers' perceptions of satisfaction. Anandarajah et al. (2018) highlighted the importance of collaboration between and among physicians to mitigate any negative concerns about how

adding new staff members will influence existing healthcare organizations. These studies focused on the role of communication and collaboration but did not explicitly claim the influence of communication and collaboration to the retention of physicians.

The need for leaders to show that they value the needs of physicians in order to maximize retention has been supported in the existing literature reviewed in Section 1. However, there is a lack research that supports the claim that physicians need proper communication and collaboration in order to maximize their retention intention. Overall, there may be a need to further explore existing research to further understand the concepts involved in the second major theme. There is also a need to collect more data in order to fully understand how physician leaders value the needs of their physician subordinates as shown through communication and collaboration.

The major theme was discussed by five of the six interviewed physician leaders. According to Participant 2, "But primarily, just working with the providers to see what their needs, again, professional and personal needs are and their fit within WC Health Council, how we meet that." Participant 3 highlighted the culture that they have created within their healthcare institution and how they have tried to become as inclusive as they can for their physicians. Furthermore, Participant 3 added the importance of communicating closely with the physicians to ensure that the physicians are aware that they are heard and valued at all times. Participant 3 said,

> And in addition to that, I just feel that the culture that we have within our organization is so important. We strive to be one of inclusive. We want to include our employees, so we have good communication. And we twice a year have company-wide events. In the summertime, we have an employee development day outside in the park where we take

> the afternoon and we have fun and we also have education. And then at holiday time, we also... and we give bonuses. So, merit raises, increases, things like that. Is that helpful?
>
> Well, I will tell you what, it has been a struggle. Culture is something that we have really... its part of our strategic plan, right. We are doing a better job now. Just in the last year, we seem to have improved in developing a culture where we want our employees to feel like they are valued. And then how do we do that, right? We communicate with them. We include them in... we let them know about decisions. We value their opinion, we hear them. We show them that we hear them. If they make a recommendation and we can implement that, we do that, right? But it is tough, it is tough. COVID and trying to recruit, it has been difficult. Everybody has their own idea these days of what their workday and their work week and their paycheck should look like. It is hard. Recruitment is hard, it truly is. Especially if you are a specialist like a pediatrician, they are difficult to come by. Very difficult.

Based on Participant 4's experience, an inclusive and conducive environment for physicians to perform at their best abilities is crucial. Physician leaders must ensure that physicians feel recognized and valued for their work. The participant narrated the following:

> So, I think the big thing and the thing that I have talked with my team about over the years both from the operator side of things, as well as from the physician recruitment and retention side of things, is we have to create an environment that physicians enjoy practicing medicine. Now, again, just like burnout, everything is different for every physician, so you have to have that relationship with them. The physicians that we brought in 15 years ago under an acquisition of a practice that they had built over the last 20 years, how we retain those folks is different than how we retain the new physician

> coming out of residency and what they're wanting to see in terms of a great place to practice medicine.
>
> You have to know your physicians. My leadership team knows that the requirement I have is 80/20, 80% you are rounding, and 20% you are sitting at your desk answering emails. If you are out there and you are talking to those physicians, you are building the relationships with them; they are going to tell you when there are things that make them unhappy. And then it is up to leadership at that point to make those adjustments. And again, just like the word burnout is different for everybody, retention is different for everybody. And you have to be flexible and know that what retains Physician X in McDowell is not going to retain physician Y at Table Rock.

For Participant 5, feedback through close communication is an effective retention strategy. Participant 5 explained that communicating with the physicians demonstrates that they are heard and cared for. The participant shared,

> We truly use provider feedback. Our providers are going to tell us what they are seeing in the practices. They are going to tell us how they are feeling. One of the strategies and measures we are using right now and really trying to figure out is panel size. So, what can a physician adequately see, still provide the care they want to give and still see patients? So, we have providers, for example, that are seeing in a panel size of over 2000.
>
> I mean, the biggest thing that I have learned over the past year with retention is communication with your current providers and knowing what they need, knowing where the gaps are, following up with your newly hired physicians. I mean, building that trust. I mean, if they have trust with administration and trust with their other providers, that

> retention's going to be much easier. They are going to feel that loyalty that you need him to feel to stick with you

Lastly, Participant 6 also took note of the importance of creating the right environment for their physicians. This participant stated that an environment that promotes respect, collaboration, and positive values has been crucial for them.

> And so, we have those that a retention strategy. And then we have of course our culture here, there is a lot of collegiality and collaboration because they are employed providers. If you have a lot of providers that are not employed, it is hard to get them to do the things you need them to do education wise, talk to each other. But when they are employed, you set standards and set a culture in place. And there is a lot of collegiality here. They respect each other even among the different disciplines though.

Subtheme 1: Practicing Flexibility and Concession When Dealing With Physicians' Needs and Request. In light of giving value to the needs and preferences of the physicians, a subtheme that emerged under the second major theme was the need to be open and flexible to the requests raised by the physicians. For Participant 2, giving value to physicians can be described through the practices and acts of flexibility and concession. This participant shared specific examples of how these are applied in their institution and how these have helped them recruit and retain physicians:

> So, flexibility. I think now more than ever, I have had to try to adjust to a C word that I can hardly roll it off the end of my tongue there. I think it is called concession. Concession, there it is. I can get it out there every once in a while… But understanding that if I want to keep this individual, can I make a concession in order to keep that

> individual? Can I make a concession to get that individual, that I would not really have entertained doing eight or 10 years ago, simply because I didn't have to? So, making those concessions, flexibility. Again, looking at the environment within Caldwell and surrounding counties, understanding that I do not have the financial wherewithal that UNC Healthcare has.
>
> I guess a case in point is, how many days a week are they going to work? They want one day off a week. Before I'd say, "Well, sorry, but I need somebody five days a week," or "We need to be open on Saturdays, and I need you to work half a day on Saturday, but in compensation for that, I'll let you have all day Monday off." So, making those types of concessions that used to be somewhat foreign, but now are common practice with the competition. So, you have to adapt and adopt some of those same flexible work schedules and expectations that your employees have, that you may not always agree with, but it's keeping the doors open. That's ultimately what the goal is, to keep the doors open, because without it, there's no access. Without access, there are no patients. And without patients, there's no revenue.

Subtheme 2: Understanding the Personalized Needs of Providers. Another subtheme was acknowledging that physicians have different needs and preferences. Participant 5 shared how they identify and address the needs of the different physicians, saying,

> So, we're looking at, what do cardiologists need? What do urologists need? What do pulmonologists need? Because that may be different than what primary care is going through right now. So being one group, those strategies have to, we have to move them as the providers need them moved.

Participant 6 shared the process that they follow when hiring their physicians. In this process, the participant demonstrated the value of getting to know the physicians and gathering their thoughts, feedback, and feelings about their work and employment, which are all crucial for long-term employment, and sustaining the relationship. The participant noted the following:

> When I hire providers, I ask questions regarding what is important to them. And things that I've asked them is things like ... So, I employ a provider that would be in the inpatient location and outpatient location. So, I have to find out are they particularly interested in what the call schedule looks like? Do they like leaving early each day? Because if you're working in outpatient clinic, that might not be necessarily something they can do.
>
> So, I have to find out what drives them, so on-call scheduling, money, RVUs? What's important to them? Is it important, like I said, mostly in the hospital or the outpatient setting. Some would prefer to be in an office setting. Some want a mixture. Some would rather be in the hospital. Do they like having partners in a group? Some do. Some like to have resources to lean on. And then just things like that, the workload, if they like having advanced practice providers like NPs and PAs and things like that. So that's how the rest, I think when they do interviews and hire, those are the questions that providers ask.

Subtheme 3: Having a Physician Leadership Structure in Place. Lastly, a subtheme that emerged was giving value to the physicians by assigning a leadership structure to ensure that physicians are being heard and provided with the best possible support system. Participant 4 shared how the creation of a formal and actual support team has helped them manage and retain their physicians. Participant 4 provided examples, stating,

> I think the big thing here that we did; one of the big things that I think really helps with retention is having a physician leadership structure. One, so that physicians feel they have another physician to talk to that has the right ear of me and my operations team. Because, let's be honest, a lot of times the rub between employed physicians is the operators. The operators are saying, "Well, you have to do it this way, not the way that you want to do it," kind of thing. And so having a strong physician leadership structure in place I think really helps because, one, you have a physician that can speak to other physicians to say, "Look, this is the why behind it. I know it's different from how we want to practice, but here's the why behind us practicing this way." And two, it is a person then who is on our leadership team that can think like a physician, because none of us are physicians at the end of the day.

Participant 5 noted how close communication and the assignment of a support team have made their physicians much happier and more satisfied. The participant explained the following during the interview:

> And we've seen, even with providers that we've not had the best relationships with in the past, they've become our support system of, "Hey, this is what we need. How do we get there?" And I think, from what I'm seeing, it's definitely made our physicians happier and feel like they have a voice, which I think helps with retention.

Minor Theme 1: Offering Tuition, Training, and Certification Reimbursements. The first minor theme that emerged was the strategy of offering tuition and other professional development reimbursements. The theme was shared by three of the six participants. As Participant 1 stated, “And also, I would think that those tuition reimbursements are probably through those federal resources or governmental programs too.” Furthermore, Participant 3

explained how the tuition and loan reimbursements have been valuable to the physicians and have also been critical in retaining them:

> So as a federally qualified health center, our providers coming in, if you are a licensed provider, you can apply for tuition or loan reimbursement from the National Health Service Corps. So we do have that as a benefit as well. And that has been very, very helpful. We have probably 12 providers who are taking advantage of the National Health Service Corps loan repayment.
>
> So, I think that one of the most important benefits that we offer our providers coming in is the tuition reimbursement, National Health Service Corps. We do have 12 providers who are taking advantage of that. And a lot of our recruiting efforts when we're recruiting medical providers and dental providers, that's one of the questions that comes up, "Do you offer tuition reimbursement or loan repayment with the National Health Service Corps?" So, I think that's key as an FQHC.

Finally, Participant 6 provided several examples of how the reimbursements of the professional needs and development opportunities and programs have helped them retain their physicians. Participant 6 narrated the following:

> And then reimbursement for professional expenses like license, which can be costly, certifications, the professional memberships, subscriptions. Because not only do they have their license, you know you've done pharmacy stuff, but they have to have their medical license, but they also have to have a DEA license and things they have to maintain, so that can get costly. So, we do that. We do provider recognition. So pre COVID times, now they're starting to get back to some more things. But pre COVID, we had banquets for providers where they can bring their wives [inaudible] nice outing for

> them. And then we have advanced practice providers, which is a huge thing. So, the APPs or the nurse practitioners and the PAs, they help do physical assessments. They help do that rounding piece because the providers can't see everybody. So, when they can't see everybody every day, those APPs fill in the gaps. So, they help with a lot of that. Or when they have urgent consults, they've got to get to, if the APP can help with some of the stuff, they help with that.
>
> Yeah, an underserved area, and I can't remember the program it's under. But because of that, the government offers grants or whatever the program is, to provide school loan reimbursement.

Minor Theme 2: Offering Life Insurance and Other Insurance Benefits. The second minor theme was the availability of life insurance and other types of insurance benefits to the physicians. The minor theme was discussed by three of the six participants. According to Participant 1, physicians also value different insurance benefits, such as life, dental, and family coverage.

> Now, see, we offer free life insurance, we offer free dental coverage. If you want family coverage, you'd pay the remaining balance. And now we're going to be offering, for a nominal amount, Blue Cross Blue Shield coverage. Of course, again, if you want family coverage, you would pay that portion, but your portion is going to be free.

Participant 3 was proud to share their benefit package and how this has significantly aided in the retention of their physicians. Participant 3 narrated,

> The one thing that I believe that High Country Community Health does very well is we do offer a good benefit package. We have medical, we have dental, we have vision, we

> have short-term and long-term disability, and a life insurance policy is a company paid benefit. It costs our employees nothing. We spend a significant amount of money. We have 176 employees, and so we spend a significant amount of money on an annual basis toward our benefit package. In addition, we have paid time off, we have paid holidays. We offer an incentive, kind of like a production incentive. We set the quota. If they meet that quota on a monthly basis, there is additional monies that go to providers.

Minor Theme 3: Promoting Work-Life Balance. The third minor theme of the study was the value of work-life balance, as shared by two of the six participants. For Participant 1, work-life balance has become increasingly important to physicians:

> Currently, we do offer quite a bit of time off from day one. We put that X number hours in a bucket, and maybe you've only worked here two days, but if you say, "I'm going to be gone for the next three weeks," well, you're gone. Doesn't help us, but we're in a position where we feel we have to give more. Unfortunately, I don't think we're getting more. And so, there's your quagmire… Work-life balance.

Participant 4 provided examples of how work-life balance has affected the recruitment and retention of their facility. Participant 4 stated,

> If you want inner city and a ton of money, you don't need to come to Morganton, but if you want to make a decent wage, have some work-life balance, which is a thing that we pride our physicians have a little bit more work-life balance than the folks down in Charlotte do, this is the place for you. You're not going to make a gazillion dollars, but you're going to be able to raise your family, you're going to be here, you're going to take care of a population that really needs you, and is grateful for you to take care of them.

Minor Theme 4: Offering Other Financial Incentives and Bonuses Based on Performance. The fourth minor theme of the study was the strategy of offering other financial incentives and bonuses based on the physicians' performance. This minor theme was discussed by two of the six participants. For Participant 6, many other benefits and incentives encourage and motivate physicians to stay in their institution. Some of the examples provided by Participant 6 include the following:

> I wrote some of this too and I did touch on it just a little bit, but not all of it. So, I'll tell you what I had thought through this. But we have to balance what they want to ensure a level of fairness. It has to be equitable among all of them. Contracts are structured. Some standard items are in there in regards to the liability insurances, structured, paid time off, that doesn't waiver much. The paid time off is consistent among the providers and the CME days that they get for CME. Offering the liability insurance is a retention factor, and I already talked about that, can be very costly in the private practice. Creative scheduling has been offered in some areas. And then some other retention strategies include competitive salary with ongoing benchmark efforts.

Alignment with Conceptual Framework

I used Ellenbecker's (2004) job retention theory as this study's theoretical framework. According to this theory, job retention is predicted by a range of individual and universal antecedents, which could be categorized as intrinsically and extrinsically rewarding (Ellenbecker, 2004). Job retention and intent to stay are predicted by a combination of the factors that a professional finds personally rewarding (Ellenbecker, 2004).

Intrinsically rewarding factors that increase job retention vary according to personal values but generally include job satisfaction, meaning associated with the work, and peer

relationships (Ellenbecker, 2004). I found that intrinsic rewards, such as giving value to physicians' need for collaboration and communication with their leaders, may improve retention. Therefore, the second major theme is aligned with the concept of intrinsic reward as a promoter of retention based on the job retention theory.

Work-life balance was found to be associated with physician retention. Participants revealed that work-life balance was paramount in their lives. A strategy reported to enhance retention through work-life balance was offering off days to physicians so that they could have time off work. Since an individual's values and priorities influence their perception regarding work-life balance, this falls under meaning associated with work in the Ellenbecker's job satisfaction theory (Ellenbecker, 2004), classifying work-life balance as an intrinsic rewarding factor.

Extrinsically rewarding factors that can increase retention include financial incentives, recognition at work, and prestige associated with the position (Ellenbecker, 2004). I found that extrinsic rewards, such as appropriate wages or support for financial needs of physicians from their leaders, are important in maximizing retention. Therefore, aspects of job retention theory are aligned or exhibited in the first major theme for this study.

Tuition and loan reimbursements were found to be valuable in physician retention. This includes tuition and loan reimbursements for developmental programs, certification courses and professional expenses such as licenses and professional memberships. Offering insurance to physicians has also been described as a strategy to retain physicians. These insurances include life insurance and health insurance such as vision, dental, and long-term insurance. Since the above strategies fall under financial incentives, according to Ellenbecker's job retention theory (Ellenbecker, 2014), they are categorized as extrinsic rewarding factor.

Applications to Professional Practice

The two main findings from this study are reflected in the two major themes that emerged from the data. The first major theme revealed that satisfying the financial needs of physicians is one of the most prominent problem that hinders retention of physicians. The results of the first major theme diverged from those of previous literature. Previous literature highlighted that sustaining the financial needs of physicians was not a strong predictor of physician retention (Jongbloed et al., 2017; Lu et al., 2017; Tsai et al., 2016). The current study revealed that meeting the financial needs of physicians such as salaries and bonuses based on performance plays a crucial role in their retention. The divergence in these results highlights the importance of conducting further research on the impact of the financial needs of physicians in relation to their retention and turnover.

The second major theme revealed that giving value to the needs of physicians by collaborating and communicating with them promotes retention. Findings revealed that collaboration and effective communication between leaders and physicians could be an effective tool in promoting the retention of physicians. This is because collaboration and communication meant that the leaders valued the needs of healthcare professionals. This finding converged with those of previous literature that highlighted that failure to consider needs, specifically regarding wage growth, reduced job satisfaction among healthcare professionals (Kaufman, 2011; Satiani & Prakash, 2017). A decrease in job satisfaction levels could be a reason for turnover among healthcare professionals decreasing their retention. This was supported by Jackson et al., (2018) who revealed that satisfaction of physician needs by their leaders maximized physician retention.

The above findings have implications. In this subsection, I discuss the implications of these findings to professional practice. This includes the impact of these implications on the society and healthcare industry.

Implications for Social Change

High rates of physician turnover have negative implications to the field of healthcare and to society as a whole. The direct implications of high turnover of physicians to the healthcare industry include high costs for recruitment of replacements and lower productivity and revenue for healthcare institutions (Abayasekara, 2015; Fisher, 2016; Salles et al., 2019). As for society in general, high turnover rates of physicians may lead to fewer available attending physicians, which may translate to poorer access to patient care services. Healthcare institutions may be unable to provide care for a substantial portion of the population (e.g., low socioeconomic groups, minorities, undocumented immigrants), which increases health risks for the entire country (Abayasekara, 2015; Fisher, 2016; Salles et al., 2019).

The results of the study may be used to improve policies and practices in the field of healthcare to mitigate turnover of physicians and improve retention rates of these professionals. By improving these performance measures, the availability of healthcare service may be maintained and improved. Therefore, society in general could benefit from having enough physicians to attend to the needs of patients in the country.

Recommendations for Action

The following recommendations for action are based on the implications to practice that I identified in the previous subsection. The findings revealed the importance of supporting and sustaining the financial needs of physicians. Therefore, I recommend that physicians receive a base salary and additional commission for every extra patient they attend to. This

recommendation is based on the suggestion of one participant who presented this idea during data collection. In this manner, physicians would be encouraged to attend to patients instead of being disheartened to attend to as many patients as possible because of the perceived inappropriate salary levels.

Another recommendation for action is for physicians to have a target number of patients to attend to per day. By having this target, leader physicians would reach sufficient levels of revenue to satisfy the financial needs of the physicians. However, these implications have yet to be tested for effectiveness in achieving improved retention of physicians, as a possible negative effect of these recommendations would be increased stress levels or possible burnout.

I also recommend that physician leaders be more mindful of communicating and collaborating with physician subordinates. Leadership should conduct regularly scheduled interactions with physician subordinates in a setting and manner that allows for open an honest communication. Communication and collaboration leads followers to perceive that their leaders look out for their well-being and needs. These perceptions could cultivate positive emotions and outlook towards work among physicians. Therefore, stakeholders of the healthcare industry (e.g., physicians, leaders, and patients) could realize the benefits of these interactions and relationships between leaders and subordinates.

Recommendations for Future Research

Recommendations for future research are based on the limitations and delimitations of the study. A limitation was that I included only four counties (Alexander, Burke, Caldwell, and Catawba Counties in North Carolina) in the study. Therefore, it is recommended that future researchers expand the geographical scope of the study beyond these counties. In expanding the scope of the study, future research may improve the transferability of the study to other settings.

Another limitation of the study is the lack of outside stakeholder participation, such as patients and vendors, who could potentially provide valuable perspectives on job satisfaction and morale. Therefore, researchers should include other stakeholders of the healthcare sector to study the phenomenon of interest in the future. This recommendation may advance knowledge in the field of healthcare by exploring topics where literature may be scarce. Further, the study was delimited to a small and specific sample. The sample included only six physician leaders specializing in family or internal medicine and employed for at least 2 years in their current institution. Therefore, I recommend increasing this sample size in future studies.

Reflections

The topic of physician turnover has been interesting to me because of its pressing and large-scale implication to society. As a doctoral candidate within the business school at Walden University, I have been interested in determining how to improve businesses and establish favorable impacts to the healthcare industry. I believe that every entity has its specific challenges and strong points. In this study, by identifying the challenges or weak points of primary care and internal medicine, I was able to target a specific issue that required a solution. Through the findings of this study, modifications to policies and practices in the field of healthcare may be informed. Moreover, I have realized that through this research, I am able to help in improving not only the professional practice of medicine, but also the ability of patients to have easy access to physicians instead of experiencing difficulty in accessing healthcare treatments due to a shortage of physicians.

Conclusion

The purpose of this qualitative multiple case study was to explore the strategies that healthcare organizational leaders use to retain employed primary care and internal medicine

physicians. The general business problem is that a shortage of physicians negatively affects practice viability and patient care (Lu et al., 2017). High turnover rates of physicians have been a pressing issue in the field of healthcare (Malhotra et al., 2018). The specific business problem is some healthcare leaders lack strategies to maximize physician retention. The shortage of physicians has been the basis for the pressing need of determining effective physician retention strategies to minimize unnecessary costs of hiring, training, and lost productivity (Fibuch & Ahmed, 2015; Goode et al., 2019; Kirch & Petelle, 2017). Therefore, the following central research question was addressed in this study: What retention strategies do hospital administrators and physician leaders use to retain primary care and internal medicine physicians?

I addressed the research problem through the implementation of a qualitative multiple case study. I interviewed six physician leaders from Alexander, Burke, Caldwell, and Catawba Counties in North Carolina to collect relevant data to answer the central research question of the study. The results of the interviews and thematic analysis revealed two thematic categories: (a) challenges faces in retaining primary care and IM physicians and (b) retention strategies in place. Under each category, I found one major theme. The first major theme under the first thematic category was physician leaders' primary challenge of sustaining the financial needs of physicians given the low patient population in some areas. The second major theme under the second thematic category was that the most effective retention strategy involved demonstrating and giving value to the needs of providers through proper collaboration and communication. These findings implied the need for policies and programs to ensure the ability of the healthcare facility to generate revenue that could cover the financial needs of physicians while managing the expectations that physicians have from their leaders and vice versa. Collaboration and communication must be embedded into the processes and programs of healthcare institutions to support the needs of physicians. With these recommendations for practice, the healthcare sector

and its stakeholders (e.g., leaders, physicians, and patients) could realize the benefits of addressing the shortage of physicians and problems of retaining these medical professionals.

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