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The reasons for staying when so many depart: An exploratory study of junior hospital doctors' intentions to stay in Ireland

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A thesis submitted in fulfilment of the requirement for the degree of

Doctor of Philosophy

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2024

Abstract

Voluntary turnover continues to be a significant issue impacting the ability of the Irish healthcare system to provide the necessary level of care to its citizens. Junior hospital doctors are at the bedrock of hospital care, but Ireland has a substantial issue with the numbers departing to other countries. Much research has focused on why hospital doctors are leaving in such large numbers with poor working conditions being amongst the most cited reasons for this.

Using a qualitative methodology involving in-depth, semi-structured interviews with more than 30 junior public hospital doctors, this thesis addresses two interrelated research questions. First, why do some junior hospital doctors intend to stay in their roles despite the prevalent challenges and poor working conditions which cause many to leave? Second, did the COVID-19 pandemic impact the working and personal lives/experiences of doctors and their intention to stay, and if so how? Addressing these questions are important through enabling a move away from the somewhat narrow focus in the literature on turnover (i.e. why doctors leave) by providing a more enriching and holistic perspective through focusing on intentions to stay . This additional perspective has become more commonplace in the broader employee turnover literature but has received little consideration in the healthcare literature and context.

Job embeddedness theory is employed to unpack the organisational (on-the-job) and community (off-the-job) factors that influence doctors' intentions to stay in their jobs. The study illustrates the crucial role of community embeddedness, which arises from doctors' fit and links, and their reluctance to sacrifice connections, with family, social networks, culture, lifestyle, and the local community. In other words, non-work factors are especially critical in why these doctors remain working in Ireland. This study also provides empirical data on the

lived experience of junior hospital doctors during the COVID-19 pandemic, and it offers rich accounts and narratives of the positive and challenging impacts that these critical workers were faced with regarding work and non-work practices and how these were influencing their intention to stay.

This thesis demonstrates the value of applying job embeddedness theory in the healthcare field and in helping us understand junior hospital doctor retention through illustrating the important, yet different, roles that organisational and community embeddedness play in retaining doctors. While the study adds to the existing calls for greater investment in staffing, improved working conditions, and more consistent implementation of HRM practices, the argument is also made for a more proactive approach to assisting doctors, especially those from other countries, in becoming embedded in their communities to improve their intentions to say, and as result aid organisational retention. While we find strong levels of embeddedness amongst many doctors, this is entirely left to individuals themselves rather than there being any assistance offered.

Declaration

This is to certify that the work I am submitting is my own work and has not been submitted for another degree, either at University College Cork or elsewhere. All external references and sources are clearly acknowledged and identified within the contents. I have read and understood the regulations of University College Cork concerning plagiarism.

Signature: *Siva Shaangari Seathu Raman*

Date: 22/08/2024

Dedication

This dissertation is dedicated to my family—my husband and our two daughters. To my six-year-old, who fills our days with wonder, and my four-month-old, who is just beginning to explore the world, your presence has been my constant source of joy and inspiration. Your unwavering love and support have given me the strength to pursue my dreams, reminding me that no goal is too far out of reach. This journey has been enriched by our shared love, proving that persistence can conquer even the toughest challenges. To my daughters, I hope you always remember: despite the obstacles, your mum persevered. This achievement belongs to all of us—it's a testament to our collective strength and love.

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As I near the end of this important phase of my PhD journey, I am truly filled with appreciation for those who have been there for me providing support, motivation, love**,** and care throughout these four years.

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I owe a special thanks to my family for all their care and support. To my husband, Prima Nanda, your unconditional support, love, and understanding have been the foundation of my success. You believed in me even when I doubted myself. To my parents, Seathu Raman and Nalini, you truly are the best and thanks for always believing in me. To my three brothers, Shenthil Nathan, Nishanth, and Sathur Haasan, your constant presence and support have been invaluable. Thanks for always reminding me that the finish line is in sight and that every challenge faced today will indeed pave the way for a rewarding tomorrow. All your unconditional belief in me has been my source of strength and determination.

I have also been fortunate to have the great support of friends and colleagues in the Department of Management and Marketing. Thank you for the camaraderie, shared insights, and moments of respite that helped me maintain my sanity and focus. These relationships have not only made

my PhD experience more enriching but have also given me a sense of belonging that was crucial. I cherish our friendship and am grateful for each of you. I would also like to extend my heartfelt thanks to my proofreader Siobhán Burke from Wordhoard Communications for her meticulous attention to detail and invaluable support which have been instrumental in refining this work for final submission. Her expertise and dedication have truly been a great help, and I am deeply grateful for her contributions.

I wish to thank the Irish Research Council (IRC): GOIPG/2021/1758 and Cork University Business School (CUBS) for their support through the provision of funding during my PhD. I also want to acknowledge my participants, the public hospital doctors who took part in this study, for their involvement. It was my privilege to hear all your insights. All your interest, encouragement, and passion for this exciting topic has motivated me to make my research the best that it can be.

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CHAPTER ONE

Introduction

1.1 Introduction

This thesis focuses on job retention, and specifically on junior hospital doctors' intention to stay working in the Irish public health system. Ensuring good retention of these professionals is critically important to the effective functioning of the national healthcare system. More precisely, the thesis centres on understanding why hospital doctors intend to stay when so many are departing, whilst also illuminating the influence of the COVID-19 pandemic through their own lived experiences. This chapter sets out the overall context of the thesis and covers four core topics. First, it provides key background information and the rationale for this research. Second, the chapter details the study's research aim, objectives, and research questions. Third, it discusses the research approach and methodology. Fourth, the chapter sets out the core contributions arising from the rich accounts offered by the doctors involved in this study and the application of job embeddedness theory.

1.2 Background information and the rationale of the study

Hospital doctors are the backbone of any health organisation and public health system (Keogh, 2013). They are at the epicentre of public access to health services and are one of the key determinants of the quality of care that a population receives (Hayes *et al.*, 2019; Oliveri *et al.*, 2004). Indeed, for the long-term success of any health organisation, high levels of retention of hospital doctors are crucial. Retention of hospital doctors refers to the ability of a hospital to retain its doctors over time to ensures stability in the workforce (Seathu Raman *et al.*, 2024).[i] Low levels of labour turnover amongst hospital doctors facilitate continuity of patient care through ensuring consistent medical attention and effective ongoing relationships between doctors and patients (Van Walraven *et al.*, 2010). High retention rates contribute to a stable and efficient workforce and reduce the need for the frequent recruitment and training of new doctors, and the costs that this brings (Brugha *et al.*, 2020; Mok *et al.,* 2020; Zhang *et al.*, 2020;

Darbyshire *et al.*, 2021; Bashar *et al.*, 2022). Likewise, ensuring proper retention helps to maintain productivity, improve morale, and protect a company's reputation and key knowledge (Carbery and Cross, 2017). The World Health Organization's (WHO, 2022) global strategy for Human Resources for Health acknowledges the importance of retention to the effective delivery of healthcare services. In particular, the strategy emphasises that, for a healthcare system to function at its best and to its fullest capacity, it must be able to retain enough doctors to deliver care (WHO, 2022).

It is widely acknowledged that the Irish healthcare system has excessive levels of hospital doctor turnover (e.g. McGowan *et al.*, 2013; Humphries *et al.*, 2015, 2018, 2020; Pflipsen *et al.*, 2019; Brugha *et al.*, 2020). Ireland has a relatively low number of doctors per capita, with only 181 doctors per 100,000 people in the population (Thompson, 2022). Ireland is among the European countries with the highest percentage of doctors working outside of their own healthcare employment system (García-Pérez *et al.,* 2007; Chalikonda, 2023). Between 2008 and 2014, approximately 3,800 doctors were reported to have exited, with an additional 1135 departing in 2019. In line with this, the number of Australian working visas granted to Irish doctors increased by 44% between 2018 and 2021 (Brugha *et al.*, 2021; Humphries *et al.*, 2015; Ní Aodha, 2022). Houston (2023) similarly reported that, in 2020, 70% of newly qualified doctors voluntarily left Ireland and are currently practising medicine abroad. It is especially relevant that a substantial cohort of the doctors who leave are junior doctors (Brugha *et al.*, 2020, 2021; Noel, 2020) resulting in the Irish healthcare system currently experiencing a shortage (McGowan *et al.*, 2013; Bowers, 2023).

Several studies have been published which seek to address the causes of high turnover and the consequences of doctors' departure (e.g. Bidwell *et al.*, 2013; Humphries *et al.*, 2017, 2018; Brugha *et al.*, 2020, 2021). High levels of staff turnover can lead to negative effects on staff morale and individual doctors' health, and they have also been shown to increase incidences

of medical errors, putting patients at risk and disrupting the overall quality of care (Chojnicki and Moullan, 2018; Kirch and Petelle, 2017). High turnover can lead to productivity losses and substantial intangible costs in terms of the loss of valuable tacit knowledge, and it can disrupt the work environment and impair organisational performance too (Zhang *et al.*, 2017; Oh and Kim, 2019). Among the core causes are the unfavourable working conditions which go back over a decade (McDermott *et al.*, 2015; McAleese *et al.*, 2016; Humphries *et al.*, 2017). Generally, doctors working within the Irish public health system face excessive workloads (McGowan *et al.*, 2013; Humphries *et al.*, 2015), long working hours (Flinn and Armstrong, 2011; Humphries *et al.*, 2020), and poor training conditions (Degen *et al.*, 2014; Tyrrell *et al.*, 2016). Contributing to these worsening problems is the fact that intense, understaffed and overstretched working conditions within the Irish public healthcare system have become normalised to such an extent that even the human resources teams within hospitals view poor working conditions as an inherent aspect of the job that doctors working within the system should accept as a natural part of the medical field (Humphries *et al.*, 2019, 2024). Tragically, this has resulted in some disturbing incidents, including reports of doctors involved in car accidents due to extreme fatigue from working long hours, which highlights the danger of such working conditions (Niall, 2011). Therefore, to avoid such situations, doctors choose to leave the health system voluntarily (Houston, 2023).

High levels of departure also create a shortage of doctors who possess the knowledge and capabilities necessary to perform at an adequate level, thereby impeding the Irish healthcare system's ability to evolve and improve as it loses some of its most talented, skilled, and competent doctors (Humphries *et al.*, 2017). High turnover of hospital doctors is also extremely costly. For example, the cost of one doctor's turnover has been estimated to be equivalent to 2–3 times their salary (Misra-Hebert et al., 2004; Atkinson et al., 2006), as the hiring of new

doctors requires time to produce and deliver recruitment strategies, advertising, onboarding mechanisms, and so forth (Ali Jadoo *et al*., 2015; Degen *et al*., 2015; Fibuch and Ahmed, 2015).

While some doctors who leave Ireland express an intention to return at some point, their absence remains a pressing concern and a source of uncertainty and challenge. This is problematic because research indicates that a growing proportion of emigrating doctors ultimately decide not to return (McDermott *et al.*, 2015; McAleese *et al.*, 2016; Humphries *et al.*, 2017). Doctor migration was traditionally linked to doctors' interest in acquiring specialist skills before returning to take up consultant positions in Ireland; however evidence is increasingly casting doubt on this. The trend of doctors returning to Ireland to take up consultant positions is in steady decline. A survey conducted among 307 Irish-trained doctors who had been working in Australia since 2008 indicated that approximately half intended to return to Ireland after some time but changed their mind after 5 years, while 34% of them decided to stay in Australia permanently; 25% decided to return (McAleese *et al*., 2016). Ireland's high level of doctor turnover has resulted in an increasing reliance on the recruitment of international doctors, rising from 13.4% in 2000 to 33.4% in 2010, and then from 42% in 2017 to 43% in 2021 (Bidwell *et al.*, 2013; Cronin *et al.*, 2019, Irish Medical Council, 2021).

Given the real and substantial problems created by high turnover, health systems and organisations should have retention strategies in place. Failure to prioritise retention will continue to see deterioration of the overall quality and effectiveness of healthcare services provided (Brugha *et al.*, 2020b; Mok et al., 2020; Bashar *et al.*, 2022). The extent to which attention is given to the retention of doctors is, however, very much open to question (Humphries *et al.,* 2018; Brugha *et al.*, 2020). There has been much Irish media attention given to working conditions and raising questions about whether the health system is fit for purpose (Nolan, 2018; Kelleher, 2022; Lauren, 2022; O'Neill, 2022; Thompson, 2022). This has led to greater attention being placed on the recruitment of more doctors and related initiatives. While

these measures are needed and welcome, they are also insufficient on their own. Focusing solely on the attraction and recruitment of new doctors without giving real attention to how to better retain current staff will mean that the longstanding cycle of high turnover will not be stopped.

A substantial corpus of research has been dedicated to understanding the turnover of hospital doctors. Most has focused on factors that contribute to these doctors' voluntarily leaving their jobs (e.g. Moss *et al.*, 2004; Heponiemi *et al.*, 2008; Zhang and Feng, 2011; Bruce-Brand *et al.*, 2012; Sharma *et al.,* 2012; Humphries *et al.*, 2013, 2017; Fang *et al.*, 2014; Ali Jadoo *et al.*, 2015; Heponiemi et al., 2016; McAleese *et al.*, 2016; Lambert et al., 2018; Pantenburg *et al.*, 2018; Cronin *et al.*, 2019; Humphries *et al.*, 2019, 2020, 2021; Chalikonda, 2023). This literature provides a relatively extensive body of research on the 'push' factors that lead to hospital doctors leaving their jobs, with scholars identifying motivations and issues that encourage turnover. These factors include organisation-related issues such as unfavourable working conditions, including high workload, long working hours, incidences of violence, and workplace bullying (McGowan *et al.*, 2013; Ali Jadoo *et al.*, 2015; Lu *et al.*, 2017; Lambert *et al*., 2018; Humphries *et al.*, 2019; Zhang *et al.*, 2019). Additional factors include problems related to poor teamwork and workplace relationships (Walsh, 2013; Wang *et al.*, 2015; Clarke *et al.*, 2017; James and Gerrard, 2017); poor leadership, supervisory support, and quality of management (Roy *et al.,* 2017; Lambert *et al.,* 2018; Duan *et al.*, 2019; Martinussen *et al.*, 2020); and inadequate training, development, and career progression (Brugha *et al.*, 2020, 2021; Byrne *et al.*, 2021). Some studies have highlighted a lack of government funding or limited healthcare expenditure as factors which adversely affect the availability of resources in hospitals (Zhang *et al.*, 2019; Brugha *et al.*, 2021). Furthermore, institutional challenges, such as poorly defined governance structures, poor working policies, uncertainty regarding future contracts, and placements in isolated rural areas, can collectively contribute to exacerbating

turnover among hospital doctors (Sharma *et al.,* 2012; Zhang *et al.*, 2017; Humphries *et al.,* 2018; Lambert *et al.,* 2018; Gutacker *et al.*, 2019). Similarly, individual factors such as low autonomy, high levels of job-related stress, workplace burnout, and reduced job satisfaction, as well as insufficient work-life balance and lack of satisfaction with pay and safety concerns, have been found to increase withdrawal behaviours (Fuß *et al.*, 2008; Williams *et al.*, 2010; Bruce-Brand *et al.*, 2012; Heponiemi *et al.*, 2014; Ali Jadoo *et al.*, 2015; Tziner *et al.*, 2015; Roy et al., 2017; Humphries *et al.*, 2020).

The question as to why employees stay or remain in their jobs has been gaining attention in the wider (non-healthcare) literature on employee turnover (e.g. Mitchell *et al.*, 2001; Holtom and Inderrieden, 2006; Chew and Chan, 2008; Johari *et al.*, 2012; Ghosh *et al.*, 2013; Shanker, 2018). While some healthcare studies have focused on aspects surrounding retention (Sirili *et al.*, 2018; Brugha *et al.*, 2020, 2021; Chevillard, 2020), the primary emphasis has remained centred on doctor turnover and its adverse impact on retention. In other words, existing research tends to examine fundamental concerns about turnover – an issue related to, but different from, retention – leaving a notable gap within the literature in terms of our understanding of why doctors stay in their jobs.

While the literature on turnover has made significant contributions to the field, it is important to recognise that turnover and retention are distinct concepts (Holtom *et al.*, 2008). Retention is the process though which employees are encouraged to remain in an organisation, while turnover is more about understanding why an employee decides to leave (Mitchell *et al.*, 2001; Das and Baruah, 2013; Kamalaveni *et al.*, 2019). Differences between these phenomena arise because the psychological, emotional, and normative factors involved in the quitting process differ from the factors involved in employees choosing to remain in their current jobs (Holtom and Inderrieden, 2006). As Steel *et al*. (2002, p. 8) observed, ‘the fact is often overlooked, but the reasons people stay are not always the same as the reasons people leave’. Therefore, the

absence of turnover factors does not mean that an individual will remain in their current job. This is because the accumulated reasons why an employee stays in a job are not directly opposite to the reasons why they might choose to leave the same job (Herzberg, 1966). Consequently, greater focus on why employees stay has been encouraged (Lee *et al.,* 2014).

This issue is obviously of particular importance in the Irish context because of worsening retention which indicates we still lack a comprehensive understanding of what drives doctors to remain, even though they face similar situations and challenges to those who leave. Some have suggested that the Irish healthcare system needs a 'radical overhaul' rather than incremental improvements, and they have advised Ireland not to approach the change 'through the lens of the current system' (RCPI, 2017, p. 7). In the current state of crisis, it may be useful to depart from the conventional approach, which examines why hospital doctors are leaving, and instead explore reasons why hospital doctors choose to stay, placing a greater focus on retention. Consequently, this research focuses on the intention of doctors to stay which is defined as an individual conscious decision or inclination to remain in their current job, role and organisation. High intention to stay is commonly a sign of a positive work environment, whereas low intention to stay can indicate potential turnover risks.

While Irish healthcare was already under severe pressure, the COVID-19 pandemic made circumstances in the Irish health system even more difficult (Humphries *et al.*, 2019; Byrne *et al.*, 2021). The pandemic arrived at a time where the system was already struggling in every way (McGowan *et al.*, 2013). However, the arrival of COVID-19 can be thought of as an urgent wake-up call which not only highlighted the system's fragility but also drove demand for improvement.

The factors noted above all are work-related, and it is important to note that research surrounding hospital doctor turnover has primarily concentrated on the work-related and

organisational domains, which can also be classified as on-the job-factors (Fuß *et al.*, 2008; McGowan *et al.*, 2013; Walsh, 2013; Degen *et al.*, 2014; Ali Jadoo *et al.*, 2015; Tsai *et al.*, 2016; Zhang *et al.*, 2017; Humphries *et al.*, 2019, 2020; Martinussen *et al.*, 2020b; Byrne *et al.*, 2021). Off-the-job factors include activities and responsibilities within the family domain, as well as obligations and events arising from interests and/or duties outside the workplace environment in which employees routinely find themselves involved. These activities, which can include important commitments linked to household activities, caregiving responsibilities, and social obligations, can also impact the decision to stay in a job or leave. For example, emotional attachment to family and friends, support systems that comprise neighbourhoods and service providers, and active participation in religious activities are some of the factors that can bind an individual to their occupation and incentivise them to remain in their current location (Blegen *et al.*, 1988; Beggs *et al*., 1996; Feldman *et al.*, 2012; Tariq *et al.*, 2021).

When exploring doctors' turnover decisions, studies have typically omitted the connections that employees have to the larger community and their life outside of work and how these factors have affected their career decisions. This has resulted in the neglect of non-work factors or off-the-job factors that may significantly influence a doctor's decision to stay or go (Feldman *et al*., 2012; Ng and Feldman, 2014; Treuren and Fein, 2021). Notably, Mitchell *et al.* (2001) suggest that work and non-work factors should be weighted equally, and some studies mention that hospital doctors seek improvements to their quality of life (Lambert *et al*., 2018; Pantenburg *et al.*, 2018). However, what this means for retention prospects is still unclear. Therefore, there is a need to consider, not just work-related factors, but also non-work factors, given that life outside of work for doctors will play an important role in key decisions they make.

Job Embeddedness Theory and Intention to Stay

Given the focus on intention to stay, job embeddedness theory takes on particular relevance and utility (Mitchell *et al.*, 2001). Job embeddedness theory explicitly addresses employee retention (staying) and encompasses both work and non-work-related factors in predicting and understanding retention. In other words, job embeddedness is a retention theory that emphasizes the factors that keep employees in their jobs (Mitchell *et al.*, 2001; William *et al.,* 2014). This approach involves looking at a comprehensive set of influences that impact an employee's intentions to stay in their current job (William *et al*., 2014), and these influences are understood to stem from both on-the-job (organisational embeddedness) and off-the-job (community embeddedness) factors. The theory is unique in examining a broad range of off-the-job influences on employee retention as it assumes that every individual is part of an attachment 'web' spanning both work and non-work domains. The more complex this web is, the more attached the individual is likely to be to their status quo, which can make it more difficult for them to leave their job (Holtom and Inderrieden, 2006). Research suggests that employees with a greater number of connections are likely to be more enmeshed and have a greater preference for staying. This situation also makes it more difficult for them to leave than others (Mitchell *et al.*, 2001; Lee *et al.,* 2014; Halvorsen *et al.,* 2015). In job embeddedness theory, work and non-work factors are classified as organisational (on-the-job) and community embeddedness (off-the-job) respectively, and they are commonly measured using three dimensions: fit, links, and sacrifice (Mitchell *et al.*, 2001). These dimensions provide a holistic understanding of individual suitability and connections to both their work and non-work factors (Holtom and Sekiguchi, 2018).

Organisational embeddedness involves workplace factors, including organisational culture, mission, and requirements, that relate to the connections and structural ties employees have

within their organisations, such as relationships with colleagues and supervisors. *Fit* refers to the extent to which an individual's interests and needs match organisational values and rewards. *Links* refer to the number of ties an individual has with other people and activities at work. *Sacrifice* refers to the benefits or rewards that one has to forgo when one leaves an organisation (Mitchell *et al.*, 2001; Ng and Feldman, 2007; Sessa and Bowling, 2020).

Community embeddedness mostly relates to a person's immediate working environment. Factors typically involve physical surroundings, local culture, people, and activities in a certain place, and they may include weather conditions and schools as well as the existing political and religious climate. *Community fit* is the extent to which an individual's needs and interests are aligned with their overall surroundings. *Links* refer to the number of ties individuals have with other people and activities within their communities, such as their family and extended family members and social activities, including religious activities. *Sacrifice* refers to the advantages an individual would lose if they left their current community (Mitchell *et al.*, 2001; Feldman *et al.,* 2012; Ng and Feldman, 2014; Sessa and Bowling, 2020).

It is important to note that, prior to the development of job embeddedness theory, researchers looking into retention tended to primarily focus on the broad question of why people stay (Hom *et al.,*1984), and the concepts of job satisfaction (Carsten and Spector, 1987) and organisational commitment (Allen and Meyer, 1990) were prominent research terms in the field. There was critical consensus that, even if other opportunities arose, employees with high job satisfaction who were highly committed to their organisations would be more likely to stay (Mitchell *et al*., 2001). However, this assumption offered only a partial explanation for decisions to stay or leave, and later researchers demonstrated that an employee who is satisfied and committed may still choose to leave their job due to other circumstances, including non-work factors or disruptive events (Lee *et al.*, 1996; Crossley *et al.*, 2007; Richards and Schat, 2011). Research

has shown that looking into these aspects of employee decision-making through the lens of job embeddedness theory offers a useful approach to examining retention, as job embeddedness has been indicated to be a more effective predictor of employee retention than other constructs such as job satisfaction, organisational commitment, and job attachment, (Mitchell *et al.*, 2001). These factors are discussed further in Chapter 2.

Overall, exploring hospital doctor retention through the lens of job embeddedness theory is likely to allow the researcher to uncover valuable and novel insights, as it permits exploration of the core reasons behind people's intentions to stay. It also, crucially, allows one to reflect on a question which is seldom asked – namely, why employees stay. Besides, the inclusion of both work and non-work-related factors in the job embeddedness approach encourages a holistic perspective which is vital, as existing research has indicated that different forms of embeddedness (both within and outside of a workplace) have unique relationships with, and make different contributions to, retention (Holtom *et al.*, 2008; Ng and Feldman, 2014; Singh, 2019). Therefore, it is important to differentiate between them and analyse the influence of on- and off-the-job aspects that ultimately affect doctors' intention to stay.

1.3 Research objectives, aim, and questions

The initial motivation for this PhD research was derived from the author's personal interest in the issue of acute staffing shortages within the Irish public healthcare system. This issue triggered a deep personal sense of interest and academic curiosity due to the impact that healthcare quality has on a population. While existing research allowed me to gain some understanding of the factors that contribute to doctors leaving, I was particularly interested in exploring the less researched issue, which is why doctors stay and which led me to focus on intentions to stay.

This study focuses on junior hospital doctors, also known as non-consultant hospital doctors (NCHDs), in the Irish healthcare system. These doctors are not consultants but provide important medical care to patients and are often still conducting their postgraduate training in a particular specialty (McGowan *et al.*, 2013). This cohort is often key to providing frontline care for patients, and its members represent the majority (68%) of hospital doctors employed in the Irish public healthcare system. Research has highlighted that poor and challenging working conditions are more prevalent for these junior doctors, mainly because they are at an early stage in their careers and still hold junior status in their hospitals' organisational hierarchies (McGowan *et al.*, 2013; Humphries *et al.*, 2015; Creese *et al.*, 2021; Boland, 2022). For example, a recent news article indicated that 78% of junior hospital doctors are at high-risk of burnout which is caused by overwork (Boland, 2022). This is also a group faced with considerable shortages with many posts lying vacant (McGowan *et al.*, 2013; Bowers, 2023). It is increasingly difficult to recruit these doctors which increases the reliance on those in the system (Bowers, 2023).

This study also explores the impact of the COVID-19 global pandemic on junior doctors' intentions to stay. Although, the focus of the study was established before the outbreak of COVID-19, the pandemic became a significant factor in doctors' working lives. As a result of the national response to the pandemic, the Irish health system underwent a radical transformation, with efforts being made to add capacity to deal with the surge in COVID-19 patients. As a result,, it was deemed essential to explore junior doctors' lived experiences of the COVID-19 pandemic and to assess how these experiences influenced their levels of embeddedness and intentions to stay or leave.

The primary objectives guiding this research are:

i. To explore the factors that contribute to the intention of junior hospital doctors to stay within the Irish public healthcare system.

ii. To provide relevant insights into less explored aspects of healthcare staff retention by identifying and analysing the factors that encourage doctors' intention to stay in the Irish public healthcare system, with the goal of contributing to the development of strategies and policies aimed at improving retention.

Based on this motivation, the following overall aim was formulated:

> *To better understand the intention to stay amongst junior hospital doctors in the Irish public healthcare system and illustrate how understanding their level of embeddedness, through their organisation and community, informs their intention to stay and can assist in addressing the retention issues the system faces.*

To address this aim, this study centred on addressing two research questions:

1. Why do some junior hospital doctors intend to stay in their roles despite the prevalent challenges and sometimes poor conditions which cause others to leave?
2. Did the COVID-19 pandemic impact the working and personal lives/experiences of doctors and their intention to stay, and if so how?

1.4 Research Methodology

This study adopted a qualitative methodology, based on in-depth, semi-structured interviews. This approach was specifically selected as it allowed the researcher to uncover more nuanced findings than more frequently used quantitative approaches (Sofaer, 1999; Bansal *et al*., 2018; Einola and Alvesson, 2021). The qualitative research process played a crucial role in helping the researcher to gain clarity about important 'how' and 'why' questions and gather information on the values, language, and beliefs of the study participants. This approach also allowed the

participating doctors to express their opinions in their own voices (Sofaer, 1999; Cassell *et al.*, 2018). An additional factor in the researcher's choice of methodology was the fact that qualitative approaches often offer a greater number of opportunities to contribute to policymaking and policy implementation than quantitative approaches (Hennink *et al.*, 2011).

A total of 31 hospital doctors were recruited for this study through a multi-tiered recruitment strategy, and the researcher had no direct relationship with participants prior to interviews. The sampling was primarily purposive (Tongco, 2007) but also involved elements of snowball sampling (Parker *et al*., 2019). This approach produced a diversified sample of junior hospital doctors from different demographic groups, allowing the capture of a broad spectrum of experience and perceptions. An interview guide was formulated to encompass both organisational (on-the-job) and community-related (off-the-job) factors. During the interviews, participants were asked about their personal backgrounds and work-related circumstances, including working conditions and practices. Additionally, they were asked about their lives beyond the confines of their professional responsibilities, including their connections with family, community, hobbies, and social obligations. The questions also prompted discussions of participants' experiences during the COVID-19 pandemic, and the questions in general tended to explore how all these factors collectively influenced doctors' levels of embeddedness, and, in turn, influenced their views regarding intention to stay.

All interviews were recorded and fully transcribed, and a thematic analysis was then carried out (Braun and Clarke, 2006). This process began with an open coding exercise which was followed by categorisation and theme formation in accordance with the approach elaborated by Mitchell *et al.* (2001). NVivo, a qualitative data analysis programme, was used to organise the data and assist with analysis. Further details on the methodology of this thesis are provided in Chapter 4.

1.5 Contributions to Knowledge

This thesis contributes to an underexplored dimension of the healthcare management literature by focusing specifically on doctor retention and examining why Irish hospital doctors intend to stay in their jobs (Mitchell *et al.*, 2001). To the best of this researcher's knowledge, this is one of the first studies to focus on intention to stay amongst hospital doctors in the Irish context and so it offers an empirical contribution. The focus on the intention to stay, rather than the common reasons why hospital doctors leave is an important distinction in enabling a more textured understanding of the factors that lead doctors to remain in the healthcare system.

This study also contributes to the literature by empirically exploring the lived experiences of junior hospital doctors in Ireland during the COVID-19 pandemic. It focuses in particular on how these experiences impacted their intention to stay. By presenting first-hand accounts from these doctors, the study delves into their professional and personal experiences during the pandemic. This empirical evidence adds depth to the understanding of the experiences, challenges, and realities faced by junior doctors in times of an unprecedented global health crisis. The first-hand perspective participants provide is also crucial to help establish how crisis situations like this play a role in doctors' decisions to stay. Understanding the factors that impact retention during a crisis can provide new and interesting insights as well as inform the development of targeted support strategies and policies.

The study further adds to the body of literature by filling gaps related to doctors' specific experiences during later waves of the pandemic, and specifically the third and subsequent waves of COVID-19, during which the study was conducted. This study therefore helps to address the limitations identified in earlier research (Byrne *et al.*, 2021) which suggested a need for further exploration of the experience of doctors during subsequent waves of COVID-19. In essence, the timing of the current study allowed participants to recall pandemic events with clarity and, significantly, to assess how the situation evolved throughout all stages of the

pandemic. Furthermore, by including both Irish and international doctors in the small study sample, this research addressed the limitations identified by Humphries *et al.* (2021), who called for additional research involving international doctors working in Ireland as this approach would ensure a comprehensive understanding of the experiences of migrant doctors throughout the pandemic. Overall, this study contributes to a deeper and more comprehensive understanding of the impacts of the COVID-19 pandemic on junior doctors' professional and personal experiences.

Prior healthcare research on hospital doctor turnover/retention has utilised a more deductive and quantitative approach which has focused heavily on evaluating hypotheses through empirical investigation. The use of theory has, perhaps surprisingly given the hypotheses testing dominance, been somewhat limited in the doctor turnover literature (Seathu Raman *et al*., 2024). Job embeddedness theory is understood, in this study, as being the antecedent to intention to stay, and it is therefore viewed as foundational to the development of practices that may enhance the retention of hospital doctors. Through the use this theory, this study employs a broad but useful lens to assess a widely recognised problem and make a fresh contribution to the healthcare literature on this topic (Mitchell *et al.*, 2001). The application of job embeddedness theory to doctors' retention has been limited to a single study (Valle *et al.,* 2016), which was a quantitative study that focused on only one medical specialty (hospital doctors in paediatric emergency medicine). This PhD seeks to address a deficit in the existing body of research by identifying and highlighting salient factors that relate to how the organisational and community embeddedness of hospital doctors, together with dimensions of fit, links, and sacrifice, relate to doctors' intentions to stay.

This thesis makes a core contribution to the recognition, development, and expansion of the community embeddedness dimension of job embeddedness theory by shedding light on factors that contribute to the retention of hospital doctors. Community embeddedness, which can also

be described in terms of off-the-job factors or life outside of work (Feldman *et al.,* 2012; Zhang *et al.,* 2012), is found, in this study, to be the most influential factor in hospital doctor retention within the Irish public healthcare system. Therefore, drawing on the work of Mitchell *et al.* (2001), this research delves deeper into the aspects of community embeddedness and explores the dimensions of fit, links, and sacrifice which possess contextual relevance for job embeddedness theory. The study highlights the prominent role of community, encompassing all three of these key dimensions. Firstly, based on community fit, it shows that hospital doctors consider their surrounding community as crucial to their individual needs and interests. It also suggests that they perceive their community as offering the opportunities and environment which they desire to have in their lives. The study also highlights the significant relationships, ties, and connections doctors have established with people outside of their work environments. These links are the connections they have to their family members, working spouses, and extended families. Other links also emerge as significant, such as attachment to bonds with friends, neighbours, and support networks, alongside active involvement in activities within their communities to which doctors often feel a strong sense of attachment. Typically, such connections make it more difficult for them to act as a free agents in the labour market. Consequently, the accumulated effect of these fits and links results in many tangible and intangible resources that doctors are reluctant to give up if they choose to leave their current jobs within the Irish public healthcare system.

The contribution to knowledge produced through this analysis is important, since research on community embeddedness, or off-the-job factors, is relatively scarce (Sessa and Bowling, 2020; Treuren and Fein, 2021). Over the past decade, there has been limited attention directed towards community embeddedness in comparison to organisational embeddedness, and, indeed, some studies have purposefully omitted community embeddedness from their work (Halbesleben and Wheeler, 2008; Sekiguchi *et al.,* 2008; Hom *et al.*, 2009; Ng and Feldman,

2009), while others have suggested that it is a weak predictor of retention (Crossley *et al.*, 2007; Mallol *et al.,* 2007; Ramesh and Gelfand, 2010). However, excluding community embeddedness is inconsistent with Mitchell *et al.*'s (2001) original conceptualisation of the relationship between work and non-work factors that keep an individual rooted in place. Indeed, a large body of empirical organisational research indicates that it is challenging or even impossible to understand people's careers without comprehending how their lives outside of work shape and are important to those career decisions (Hansen, 2001; Voydanoff, 2004; Lee *et al.*, 2011).

Previous research in this area has predominantly originated from the United States, prompting calls for additional exploration of job embeddedness in other cultural contexts (Mitchell and Lee, 2001; Lee *et al.,* 2014; Sessa and Bowling, 2020). In particular, Sessa and Bowling (2020) proposed that further research is needed to explore the community aspects of job embeddedness, particularly with respect to different demographics and country contexts. Building on all of these recommendations, this study extends job embeddedness theory to Ireland and focuses on understanding the importance of community embeddedness in the Irish healthcare context, with a particular focus on the retention decisions of hospital doctors.

This thesis also offers some practical implications and contributions around the area of work-related policies and practices within Ireland's healthcare system. This study suggests that there is a need for the Irish public healthcare system to adapt its work policies to foster connections between hospital doctors and the communities around them. An organisation can also enhance its off-the-job embeddedness for employees by encouraging them to become more involved in their local communities (Halvorsen *et al*., 2010). In essence, this thesis underlines the importance of considering factors beyond the workplace/off-the-job factors in the public healthcare sector's work policies, and it proposes strategies that focus on enhancing non-work aspects, or life outside of work, for hospital doctors. These strategies may involve the

development or enhancement of activities or initiatives aimed at encouraging employees to become more embedded in their communities. Such initiatives could potentially include comprehensive onboarding plans and attempts to enhance work-life balance. Other examples of useful interventions might include providing on-site childcare and gym facilities (discussed in more detail in Chapter 6). Importantly, these initiatives should cater to doctors based on their different needs (e.g., nationality) since the dimensions of fit, links, and sacrifice are not perceived in the same way by all doctors as the findings and discussions later in this thesis illustrate. Initiatives designed to cater for diversity will have the potential to create or improve doctors' embeddedness in their surrounding communities (off-the-job factors), and this may have a knock-on effect on their retention, or, in other words, improve the likelihood of their intention to stay.

Although organisational embeddedness was found to have limited influence in doctors' retention decisions, there is a critical need for better and more consistent application of HRM policies and practices for all. There is a clear need to improve the experience of work for doctors and mitigate the negative impacts of current working conditions which are too often poor. Key among these initiatives should be a new focus on retention rather than merely on the attraction and recruitment of doctors. The current efforts invested in replacing junior doctors lost through high turnover remain vital, but there is a need for a strategic shift and conscious efforts to retain those junior doctors who are already in the healthcare system. This approach is considered essential to the system's long-term sustainability, because, to put it simply, improving working conditions and practices for junior doctors is a more effective strategy than just relying on new hires. A retention-focused approach is particularly relevant at the current time, due to the recent recruitment freeze implemented by the Health Service Executive (HSE) (MacRedmond, 2023), which necessitates a re-evaluation and prioritisation of HRM policies that focus on retention.

Moreover, there is a key need for greater uniformity in the application of HRM practices (e.g. remuneration approaches and performance management) at the organisational level. For example, there is a lack of standardised HRM practices across hospitals, mainly in performance management systems for junior doctors, and the absence of consistency in performance management systems, particularly for non-trainee doctors, hinders not only their career progression but also their day-to-day experience at work in terms of learning and development. Therefore, implementing standardised practices for all junior doctors, such as proper performance appraisal procedures and supervision, will help to ensure fair treatment and consistent performance management across all levels.

Another significant concern which needs addressing is the impact of frequent job rotations on junior doctors. The requirement for trainee doctors to rotate between hospitals every six months, with switches often necessitating geographical relocation, exacerbates significant challenges posed by Ireland's housing crisis and other related issues such as poor work-life balance. This situation is even more complicated for junior doctors with family responsibilities. Therefore, strategies and measures to improve the duration and distances involved in rotations are deemed essential to mitigate the adverse effects of current practices. These rotations also can be expected to have a negative impact on off-the-job embeddedness.

This study also emphasises the benefits of fostering stronger connections between junior doctors and consultants, as this is important in the early stages of doctors' careers. Access to consultants for support, guidance, and professional development is highly valued by junior doctors and is deemed crucial for their smooth transition from medical school/early years of working to senior clinical practice. However, due to challenges such as insufficient consultant numbers and the limited availability of consultants due to their own busy work schedules, involving senior registrars (SpRs) in providing supervision and guidance for junior doctors could offer additional support and strengthen workplace relationships. SpRs are doctors who

are currently being trained to be consultants, and this study's findings demonstrate that their workload is much more manageable than that of other doctors and consultants. Therefore, involving them in supervision may add value to their training while also benefitting junior doctors who will gain access to proper guidance if their consultants are not available. This additional support may contribute to a more supportive work environment.

Overall, creating an effective retention plan requires a multifaceted approach (Mitchell et al., 2001; Holtom and O'Neill, 2004). However, efforts to implement a new strategy which prioritises attention to the community (off-the-job) aspects of job embeddedness, alongside improving organisational (on-the-job) aspects, will necessitate a move beyond traditional methods which have primarily been focused on work-related factors. Such changes are highly recommended because they will be highly likely to improve retention plans and their outcomes.

1.6 Summary and structure of thesis

This introductory chapter has presented a background and rationale for this research. Additionally, this chapter detailed the research aim, objectives, and research questions that the study seeks to address. The study also outlined the important contributions that have emerge through the study.

This thesis is organised into six separate chapters. Following this introductory chapter, Chapter 2 provides an overview of the Irish public healthcare system. It outlines the history and challenges of the Health Service Executive (HSE), and it then explores the roles, identities, career pathways, working conditions, and practices of public hospital doctors. The chapter concludes with an examination of the impact of the COVID-19 pandemic on the Irish health system.

Chapter 3 begins with definitions and a conceptual understanding of retention and turnover, clarifying the crucial distinction between retention and turnover. It then reviews existing

literature on these topics and identifies gaps in current understanding by emphasising the importance of focusing on retention. It concludes by exploring the theory of job embeddedness theory and its significance to doctors' retention, providing the theoretical framework for this thesis.

Chapter 4 articulates the research methodology employed in this study. It begins with an overview of the underlying philosophical assumptions and interpretive frameworks underpinning the research. It then delves into the research design, with a particular focus on describing the chosen method, along with the rationale for its selection. Further, it outlines the sampling process, elucidates the data collection strategies, and addresses the ethical considerations integral to conducting this research responsibly.

Chapter 5 outlines the research findings on factors influencing the retention of junior hospital doctors in the Irish public healthcare system. Through thematic analysis, key themes that emerged from the data are discussed to provide an understanding of doctors' intention to stay. The discussion begins with an examination of the current working conditions of junior doctors, highlighting long-discussed challenges that contribute to high turnover. It then goes on to illustrate the factors that embed doctors into their organisation and community, offering a comprehensive view of the factors affecting retention.

Chapter 6 provides an overall discussion and a conclusion that sets out the findings and contributions of this thesis, as well as highlighting what they mean for both theory and practice. Specifically, it illuminates the multifaceted reasons behind doctors' decisions over intention to stay, underscoring the significance of understanding these factors if effective retention strategies are to be developed. This final chapter also addresses the limitations of this study and outlines directions for future research.

CHAPTER 2

The Irish Healthcare System

2.1 Introduction

This chapter provides an overview of the Irish public healthcare system and discusses some of the experiences that those working in it are likely to encounter. First, the chapter provides pertinent information regarding the background of the Health Service Executive (HSE) and the challenges it has encountered over the years. Next, it delves into the identity and role of Irish public hospital doctors, before providing a description of the regulatory bodies who oversee them. The next section then discusses some of the intricacies of working as a junior doctor within the Irish public healthcare system. It provides insights into the pathways available to doctors together with some of their working conditions and practices. Finally, the chapter discusses the effects of the COVID-19 pandemic, and, in particular, the response of the health system towards it, together with the experiences of hospital doctors in coping with the pandemic.

2.2 Understanding the Irish public healthcare system

On 1st January 2005, the Health Service Executive (HSE) was established as a single national authority to coordinate the provision of personal, health, and social services in Ireland and to coordinate their delivery within the public healthcare system (Heavey, 2019; Health Service Executive, 2023). The Health Service Executive (HSE), employs approximately 100,000 staff, making it the largest employer in the state, and it has a current operating budget of €12 billion (Health Service Executive, 2023).

The responsibility for overseeing and implementing publicly funded health and social care services is delegated to the Health Service Executive (HSE), as a government agency under the oversight of the Department of Health (OECD, 2019). (Health Service Executive, 2023). The Health Service Executive (HSE) is divided into four administrative areas (see Figure 1): HSE South, HSE West, HSE Dublin Mid-Leinster, and HSE Dublin Northeast. These areas are made

up of seven public hospital groups that provide acute care for patients (see Figure 2): the Ireland East Hospital Group, the Dublin Midlands Hospital Group, RCSI Hospital Group, University of Limerick Hospital Group, South/Southwest Hospital Group, Saolta Hospital Group, and the Children's Hospital Group (National Doctor Training & Planning NDTP, 2023).



Figure 1: Map of HSE Administrative Areas (Burns, 2009)

Hospital Group	Hospitals
Children's Hospital Group	Children's Health Ireland at Crumlin, Tallaght, Temple Street, Connolly
Dublin Midlands Hospital Group	Coombe Women & Infants University Hospital Midland Regional Hospital Portlaoise Midland Regional Hospital Tullamore Naas General Hospital St. James's Hospital St. Luke's Radiation Oncology Network Tallaght University Hospital
Ireland East Hospital Group	Mater Misericordiae University Hospital National Maternity Hospital National Orthopaedic Hospital Cappagh National Rehabilitation Hospital Our Lady's Hospital Navan Royal Victoria Eye & Ear Hospital St. Columcille's Hospital St. Luke's General Hospital, Carlow/Kilkenny St. Michaels Hospital, Dun Laoghaire St. Vincent's University Hospital Wexford General Hospital
RCSI Hospital Group	Beaumont Hospital Cavan General Hospital Connolly Hospital Louth County Hospital Our Lady of Lourdes Hospital, Drogheda Rotunda Hospital
South/Southwest Hospital Group	Bantry General Hospital Cork University Hospital Cork University Maternity Hospital Lourdes Orthopaedic Hospital Mallow General Hospital Mercy University Hospital South Infirmary Victoria University Hospital South Tipperary General Hospital University Hospital Kerry University Hospital Waterford
University of Limerick (UL) Hospital Group	Croom Orthopaedic Hospital Ennis Hospital Nenagh Hospital St. John's Hospital University Hospital Limerick University Maternity Hospital Limerick

Table 1: Public Hospital Groups in Ireland

In practical terms, the first interaction between a patient and the public healthcare system often occurs via a local primary care physician or a general practitioner (GP), who can either direct the patient to the accident and emergency department of a public hospital or refer them to a specialist, depending on the specific needs of the patient (Heavey, 2019; Health Service Executive, 2023). It is important to note that, although the Health Service Executive (HSE) is publicly funded healthcare in Ireland, itis not universal. This means that some patients are required to pay for the services (OECD, 2021) while others receive reduced or free access via medical cards due factors such as income, age, health background (Heavy 209; OECD, 2021). Private health insurance holders, who constitute 47.6% and of the population, often receive faster treatment and preferential admission to hospital services, highlighting disparities between public and private healthcare systems (Pope, 2023; Connolly and Wren, 2019). Overall, the healthcare system is mainly funded by taxes, with out-of-pocket payments and private insurance contributing smaller shares (Heavy, 2019, Wren et al., 2015).

2.3 Health workforce issues

It is noteworthy that the healthcare system in Ireland is regarded positively by economically disadvantaged countries or developing nations. However, when compared to its counterparts within Europe the perspective is markedly different (Heavey, 2019). In 1987, Ruth Barrington (1987) opened her political history of the Irish healthcare system with the question 'How did we come to have one of the best health services in the world?'. During the period known as the Celtic Tiger years, before the 2008 global economic crash, the Irish economy saw significant growth (Battel, 2003). There was a substantial concurrent increase in public expenditure allocated to the healthcare sector between 1998 and 2008, with the figure rising from €3.6 billion to over €16 billion (Heavey, 2019). However, the picture created by these figures is scarcely believable from the viewpoint of today's Irish healthcare system (McDaid *et al.*, 2009; Heavey, 2019; N. Humphries *et al.*, 2019; Irish Medical Organisation, 2022).

In response to the crisis, the Irish government made several decisions which had major implications for the health system. There was a spending cutback of €16.4 billion in the years between 2008 and 2013, which was enough to reduce net government expenditure by €6.3 billion or 13%. (Williams and Thomas, 2017). For example, in 2011 alone, €2.2. billion was taken out of public spending, leading to an overall health budget reduction of €746 million (Nolan *et al.*, 2015). Reductions in funding meant that, for the first time in years, statutory funding in Ireland, as a proportion of total health expenditure, dropped below the Organisation for Economic Co-operation and Development (OECD) average. Today, Ireland's level of funding is comparatively low when compared to other European countries that rely on tax-based health financing (Nolan *et al.*, 2015; OECD, 2021).

Some of these budget reductions were achieved through cuts in health workers' wages and reductions in the number of employees, as well as optimal use of existing staff, voluntary redundancies, and the non-replacement of retiring staff. There was a drop of 13% in staffing levels, and salaries for newly appointed hospital consultants decreased by 10% in 2011, followed by an additional reduction of 30% in 2012 (Public Service Pay Commission, 2018; Humphries *et al.*, 2019). The use of agency and locum staffing was also reduced, and many temporary contracts were terminated. Overall, there was a reduction of 10,000 in the number of health workers between 2009 and 2012, and an additional gross reduction of 4,000 full-time equivalent positions was required to meet 2013 employment ceiling targets. Between the years 2013–2015, further pay cuts for health workers, increased working hours, and other related reforms were implemented as part of a Public Service Agreement. These cuts and adjustments were deemed essential to gain efficiencies that would support efforts to reduce unit costs, notably in medicines and human resources; provide the groundwork for a hospital payment system; and reallocate services across different levels of care (Nolan *et al.*, 2015; Burke *et al.*, 2021).

Overall, the Irish healthcare system has undergone significant change since the global financial crisis occurred. This situation has resulted in Ireland's healthcare system being unable to maintain its positive outlook when compared to its European counterparts. This has also led to significant challenges and poor conditions for both healthcare workers and the general population. Particularly for hospital doctors it has also brought significant challenges and difficulties in their working environment and practices. The strain of operating in a system under pressure for a prolonged period has also heightened the retention issues among doctors. This situation clearly undermines the efficiency and effectiveness of healthcare delivery and signals a critical need for reform to address these issues. Additionally, the Irish Medical Council is the legal body responsible for the regulation of doctors. It is tasked with safeguarding the public by encouraging and guaranteeing high standards of professional behaviour, as well as assuring the standards of professional training, education, and competency among medical doctors (Department of Health, 2014).

2.4 Ireland's public hospital doctors: who are they and what do they do?

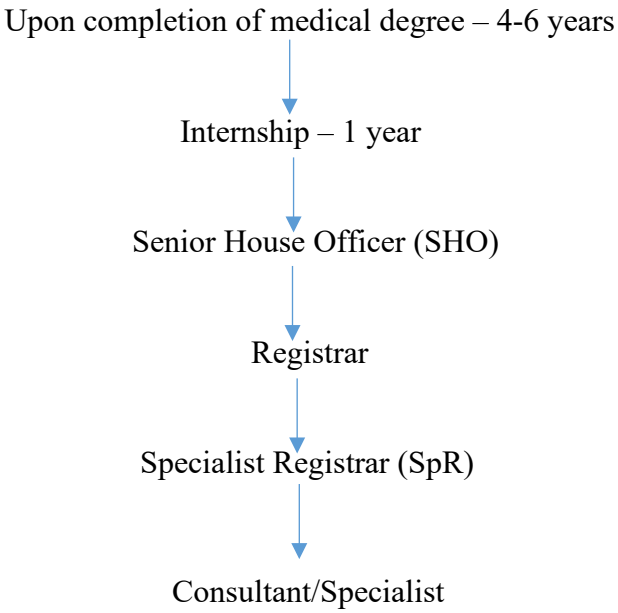


Figure 2. The pathway for doctors in Ireland's public health system

In Ireland, public hospital doctors are classified into different categories based on their levels of experience and chosen specialties (Health Service Executive, 2023, McGowan *et al.,* 2013). 'Junior doctor' is a collective term which refers to hospital doctors who are employed as interns, senior house officers, registrars, senior registrars, and specialist registrars, and these doctors are commonly known as non-consultant hospital doctors (NCHD) (Department of Health, 2014). Within these groups, the term intern describes hospital doctors who have just completed their medical degrees and are in the early stages of their careers they work in a learning environment where they are supported and supervised by senior non-consultant hospital doctors and consultants. The intern year builds their skills, knowledge, competencies, and confidence, providing them with the foundation of future practice as a medical doctor in their chosen specialism. On successful completion of an internship programme, an intern doctor will receive a Certificate of Experience from the Irish Medical Council (IMC) which will enable them to apply for general registration or trainee specialist registration as a medical practitioner with the IMC (National Doctor Training & Planning (NDTP), 2023).

Another category of non-consultant hospital doctors/junior doctors is the Senior House Officer (SHO). SHOs are supervised in their work by consultants or registrars. They are normally employed either in training posts or stand-alone posts (non-training posts). Doctors in this group have gained some experience, usually through the internship programme, and so they have a better understanding of clinical needs, procedures, and patient management. They commonly choose a specialty in which they are interested and work in that field (National Doctor Training & Planning, 2023).

Further up the hierarchy after the SHO level are the registrars. This group is made up of non-consultant hospital doctors/junior doctors who have completed a minimum of 24 months' practice after their internships. Progressing from the SHO to registrar level is contingent upon one's accumulated experience and demonstrated proficiency within a certain specialty.

Registrars are supervised in their work by their consultants, and they generally play an important role in patient care since they are expected to hold more advanced clinical skills and knowledge within their chosen specialties. Registrars can be in training or even occupy stand-alone posts (National Doctor Training & Planning, 2023).

Finally, specialist registrars (SpR) are non-consultant hospital doctors/junior doctors who are currently undertaking their higher specialist training (HST). These doctors have advanced further in terms of their specialism and clinical experience and knowledge, and they are taking their final steps on the path to specialisation, also known as the pathway to becoming a consultant. These are close to the full completion of their postgraduate training programme. At this stage of their careers, SpRs still work under the supervision of consultants but they generally have a higher level of autonomy and responsibility than other NCHDs. They are more involved in complex patient care, advanced medical procedures, and decision-making within their specialty than doctors at earlier stages, and they may, simultaneously, be taking on some teaching and research roles. Upon completion of this HST programme, they will receive a Certificate of Satisfactory Completion of Specialist Training (CSCST) which will allow them to register as specialists on the Medical Council Register. This will subsequently make them eligible for consultant posts within the Irish healthcare system (National Doctor Training & Planning (NDTP), 2023). Hospital consultants are not like junior doctors, who are only allowed to work within hospitals: consultants may hold contracts that permit them to work in private practice, for which they earn private fees on top of their normal salaries.

At the most senior clinical level within the health system, consultants are senior doctors who possess the highest levels of expertise and experience within the medical workforce of Irish hospitals. They play a vital role in the healthcare system by providing exceptional medical care, key leadership in both management and clinical service provision, and guidance to other healthcare professionals, particularly non-consultant hospital doctors (NCHD)/junior doctors.

Their extensive training and experience enable them to make prompt and critical decisions that directly impact on patient care. In addition to having responsibility for direct patient care, consultants also have responsibilities in relation to leadership, teaching, and research, as well as administration (NDTP, 2023).

There are significant differences between junior doctors and consultants pertaining to their roles, responsibilities, training, and level of experience. Typically, junior doctors are still in the early stages of their medical careers, and they are usually undergoing training programmes (discussed in detail below). They frequently work long hours and are required to perform on-call duties. They provide direct patient care under the guidance and supervision of their consultants. As they gain experience, junior doctors gradually assume more responsibilities and autonomy, working towards becoming consultants – a process that involves completing specialty training, passing relevant examinations, and acquiring sufficient clinical and leadership experience. Consultants, on the other hand, are the most experienced senior doctors who have completed several years of specialised training in their specific area of expertise, thereby reaching the pinnacle of their clinical careers. They typically possess a great deal of clinical experience which permits them to have a high degree of autonomy, leading to more control over their work schedules, and they often provide advanced medical care, making complex clinical decisions. Consultants also often serve as leaders within their departments. They are generally involved in providing leadership and engaging in teaching and research activities, in addition to patient care.[1]

[1] This study sample does not focus on the experiences of hospital consultants. The description of consultants' roles here is merely intended to facilitate an understanding of the hierarchical structure within the public hospital system and to differentiate them from junior doctors).

2.5 Working as a junior doctor/non-consultant hospital doctor (NCHD) in the Irish public health system

The work of NCHDs within the public system is typically structured by two main pathways: one involves a formal training pathway, while the other follows a non-training pathway. There are more than 4600 NCHD posts in the Irish health system. Around 80% of NCHDs are engaged in the training pathway, registered under the specialist trainee division of the Ireland Medical Council register, indicating their roles in training positions (Kelpie, 2011). Conversely, the remaining 20% of NCHDs, approximately one-fifth - about 900 posts are not on training schemes (Department of Health, 2014).

2.5.1 The postgraduate training pathway

After completion of an intern year, NCHDs who are eligible for entry into the postgraduate medical training can then proceed to a specialist training programme. This is the stage where all trainee doctors are required to be registered in the trainee specialist division of the Medical Council register. While engaged in this training programme, doctors are generally employed within the public health service as senior house officers and placed on specific rotations (SHO) (HSE MET,2011). The postgraduate medical training bodies are recognised and accredited by the Irish Medical Council to provide training within Ireland. Training bodies, such as the Royal College of Surgeons (RCSI), The College of Anesthesiologists of Ireland, and The College of Psychiatrists of Ireland, are responsible to the Council for the structure of the medical training programmes and their delivery, ranging from Basic Specialist Training (BST) to Higher Specialist Training (HST) Ireland (for more details on all colleges, see Health Service Executive, 2021). The training bodies oversee the entire process of BST and HST programmes, from selecting candidates, and managing and conducting training assessments, to monitoring their progress. BST is generally two to four years long, and, during this period, a trainee doctor

is employed under the supervision of a trainer and consultants who oversee the trainee doctor, providing feedback, conducting performance appraisals, and ensuring proper diverse learning and professional development. Upon completion of BST, doctors are awarded a certificate of satisfactory completion, which allows them to compete for a place in a higher training programme which is the HST. Entry to HST is generally highly competitive, but it is the final stage of the postgraduate training process which may take another two to seven years depending on the specialty (Irish Medical Organisation, 2011). During this time, the NCHD is employed as a Specialist Registrar (SpR) or as a Senior Registrar (SR) in the case of the psychiatry specialisation.

Those NCHDs who are on the training pathway usually have a clear assessment pathway, structured rotations, and career progression opportunities (Department of Health, 2014; National Doctor Training & Planning (NDTP), 2023). Doctors who wish to become GPs participate in a similar training process and are required to complete their higher specialist training in general practice, which involves two years of hospital-based training followed by two years of training under the supervision of a GP trainer.

2.5.2 Non-training pathways/stand-alone posts

NCHDs who are not pursuing the structured training pathway do not participate in this process, either due to their personal choice or due to their inability to meet the eligibility criteria for enrolment in the training programme. The eligibility criteria are established by the Irish Medical Council (IMC) and various training bodies, and doctors may be excluded for various reasons, including, but not limited to, the following:

- Not having completed their medical degrees in Ireland, the European Union, or selected countries.

- Not holding a degree from an English-medium institution or an institution with an approved syllabus.
- Not having completed a recognised internship.

These doctors are typically in the general division of the Irish Medical Council register (working outside of training programmes). Doctors occupying these posts are not part of the career pathway for specialist training and higher specialist training to the consultant level (Humphries *et al*., 2014). These doctors occupy hospital posts at senior house officer or at the registrar level (highest level). They work as hospital doctors but do not have a structured training programme to follow, and they are known for working in stand-alone or service posts (Humphries *et al.*, 2014). With general registration, NCHDs practice independently but may not represent themselves as holding specialist or trainee specialist registration, which is only available to trainee doctors (RCSI, 2022). These posts are less popular among doctors who have received their education in Ireland or the EU, as most of them seek to go on the training pathway. Non-training pathway doctors are typically employed in all public hospitals, with a greater proportion placed in smaller non-specialist/smaller hospitals (which commonly tend to have less trainees and posts filled by these non-trainees). Doctors in these posts are also commonly known as international medical graduates (IMG), as a large proportion of them are from non-European Union countries (Department of Health, 2014; Cronin *et al.*, 2019). These doctors typically undertake basic or routine hospital clinical activities and treatments, but there is usually no formal assessment process in place for them. In other words, they often find themselves lacking the structured supervision they would gain in a formal training programme.

Doctors who are in this pathway have the option to explore alternative routes for career advancement but this is on their own initiative. First, they can complete all membership exams in order to further their professional development independently (RCSI, 2022). Additionally, they can access external support systems meant to help doctors maintain their professional

competence, such as The Continuous Professional Development Support Scheme. This scheme facilitates access to educational activities for non-trainees (i.e., courses, seminars, conferences, and webinars organised by the training bodies). It offers non-trainees, who don't have the opportunity to get into a training scheme a way to enhance their clinical knowledge and skills while fulfilling some of the Medical Council's legal requirements for their own professional competence. These courses cover some content that is similar to the Basic Specialist Training/Higher Specialist Training versions. It is important to note that this initiative is external and is meant to benefit non-trainees by granting them access to courses while they are not on a specialist training programme. However, the application process, eligibility criteria for successful enrolment, and the payment of the associated annual subscription fee are entirely the responsibility of each individual doctor, and so involvement requires personal initiative. No support or guidance is provided, and there is no ongoing structured supervision or guidance associated with the scheme (Health Service Executive, 2021a). However, based on some recent changes in Irish legislation, doctors who are initially not eligible to enroll in a training programme can apply for one upon completion of a certain number of years in Ireland or a change in citizenship status. These changes affect doctors who have lived in Ireland for at least five years or have become an Irish citizen/obtained stamp 4 who may become eligible to apply for training programmes.

2.7.1 Key issues related to problematic working conditions

The austerity measures adopted after the financial crisis have resulted in reduced healthcare funding, staffing levels, and hospital resources, and they led to an overall deterioration in the working conditions for health staff (Burke *et al.*, 2014; Humphries *et al.*, 2019) and especially hospital doctors. The Irish public healthcare system are generally seen as especially under-resourced and working in difficult conditions.

High workload

Public healthcare hospital doctors are frequently expected to juggle high work volume with unpredictable workflow and time urgency for task completion leading to an overwhelming work-life imbalance situation (McGowan *et al.*, 2013; Lloyd, 2014; Hayes *et al.*, 2019; Humphries *et al.*, 2020a). This high workload is typically linked to understaffing, which results in an insufficient number of doctors being available to manage the workload in public hospitals. In this context, hospital doctors were found not only to have to handle their clinical duties but also to complete significant amounts of administrative work/paperwork (McGowan *et al.*, 2013; Humphries *et al.*, 2020; IMO, 2021). It has been claimed that the number of inpatients and outpatients in hospitals is frequently higher than the recommended norm, which is often considered to be unmanageable, and can lead to doctor interactions with patients being rushed (McGowan *et al.*, 2013; Wall, 2023).

Long working hours accompanied by non-compliance with European Working Time Directive (EWTD) regulations

To meet their high workload demands, doctors were found to work in excess of the mandated 48 hours per week, with 80–90 hours per week being sometimes considered necessary to cope (Flinn and Armstrong, 2011). These additional hours were reported to be necessary, not only to manage patient load, but also to follow up on tests and appointments, as well as organise and complete the administrative functions associated with doctors' daily work routines and their on-call commitments (McGowan *et al.*, 2013; Hayes *et al.*, 2017, 2019; Humphries *et al.*, 2020). The long working hours imposed on many doctors have resulted in Ireland's public healthcare system failing to comply with the European Working Time Directive. The European Working Time Directive outlines that, to foster professional competence, the acceptable working time for public health service executives should be no more than 48 hours a week on-

site. In essence, two pivotal rules govern doctors' working hours: firstly, there is a strict requirement for 11 hours of rest for every 24 hours, and, secondly, there is a mandatory provision for 24/48 hours of rest every weekend/fortnight. This limits an employee's work to an average of 48 hours per week. Since Ireland's public healthcare system has yet to successfully implement the European Working Time Directive in all its hospitals, and due to its continued violation of the directive, the European Commission has issued the Irish system with an official warning.

In relation to on-call duties, it is mandatory for hospital doctors to work no more than 24 hours on-site and on-call at their hospitals. On-site time refers to the time when doctors are available in their hospitals. Many urban/tertiary hospitals (offering highly specialised medical care) are able to comply with this requirement, which sees doctors working 24 hours on-call and receiving the following day off with 11 hours of uninterrupted rest as they may have more resources to support this (Health Service Executive, 2014; Foley *et al.*, 2017). However, the key challenge affecting this situation is the availability or scarcity of sufficient doctors. Some hospitals, specifically smaller/peripheral hospitals and even some tertiary hospitals, restrict the scope of this sort of 24-hour roster based on their service offerings and staff numbers. This means that doctors are required to be on call for a night and then report to work as usual the following day, without a day off. In such cases, doctors are sometimes required to work off-site for on-call duties, meaning they do not have to be physically present in the hospital after 5pm but can be recalled when their assistance is needed during the night. The fact that doctors are allowed to go home (off-site) and are only recalled when their assistance is needed, does not offer a clear solution, as the nature of their work hours during these shifts is highly unpredictable, depending on the patient load/cases on a given night. In some cases, patient loads may result in doctors having a demanding and prolonged set of night-time duties and then having to continue working on the subsequent day from 9am to 5pm to fulfil their work

obligations. Since off-site doctors don't have an off day, they are on call the day after (Health Service Executive, 2014; Humphries *et al.,* 2014; Foley *et al.,* 2017)

Poor training programmes

Due to the removal of training grants (essential for doctors to access postgraduate training programmes) as part of Ireland's austerity measures (Kearns, 2010), there are only limited national training schemes available for hospital doctors, and this makes it hard for many of them to have structured career pathways (Tyrrell *et al.*, 2016; Brugha *et al.*, 2021). National training schemes, also known as postgraduate training opportunities, are viewed as essential in that they help fulfil the basic requirement for doctors to become specialist consultants within the Irish healthcare system (Degen, *et al.*, 2014; Chevillard, 2020). Without sufficient postgraduate training opportunities, doctors' career progression can become slow and stagnate, which can create significant negative impacts (Bruce-Brand *et al.*, 2012; Chalikonda, 2023).

It is important to note that, although junior doctors are technically doctors who are in training, a substantial number of junior doctors are not formally enrolled in a structured training programme due to their ineligibility to apply for the postgraduate scheme. Hence, many junior doctors remain at this level for over a decade. An audit revealed that 37% of registrar NCHDs are not currently working in approved training posts (Health Service Executive, 2007). Although a breakdown by nationality is not readily available, it is widely believed that most of those doctors who are not in training posts are typically international doctors (Tyrrell *et al.*, 2016). Thus, a large number of international doctors who are working in Ireland's public health system are not accessing formal postgraduate training and, therefore, these cohorts of doctors may have even more difficult career pathways than their Irish counterparts, with limited opportunities to progress towards becoming consultants (Bidwell *et al.*, 2013; Tyrrell *et al.*, 2016). Beyond limited access to formal training, there is insufficient protected education time

for doctors, which inhibits their efforts to keep up with the required clinical knowledge and latest evidence-based practices. This can lead to inadequate preparation for future skill development and new roles throughout their careers (Degen *et al.*, 2014).

Job rotation challenges

Generally, junior doctors are required to rotate their work positions every 6 months during their training period. For doctors who are in training posts, these rotations take place each January and July. These rotations are deemed necessary for trainees, as they provide opportunities to gather valuable experience within their chosen specialties (Health Service Executive, 2023; National Doctor Training & Planning, 2023). Non-trainees typically work in contract-based roles for a similar duration of 6 months to 1 year. If their contracts are not renewed for the subsequent term, non-trainees will need to relocate to find new employment opportunities, which may mean moving to a different hospital or county. Doctors generally view these frequent moves as disruptive for several reasons. Firstly, the necessity of physical relocation often entails moving households and may require changes in a spouse's work arrangements, as well as transferring schools for children, thereby affecting the entire family's stability and routine. Secondly, the process of becoming accustomed to a new working environment and colleagues on a regular basis is considered challenging. Moreover, doctors often find that, by the time they have settled into their new hospitals and have, in many cases, established very good personal connections with colleagues, it is already time for them to move again. Building a sense of attachment to their roles and settings is therefore always challenging since they are always navigating change (McGowan *et al.*, 2013; Humphries *et al.*, 2015).

The need to switch roles regularly is aggravated by the national accommodation crisis in Ireland (Healy and Goldrick-Kelly, 2018; Reed, 2023), which has meant that relocations have become even tougher for doctors. Doctors are confronted with substantial and regular obstacles

when they must look for accommodation so frequently, and it can be nearly impossible at times to find suitable accommodation at short notice. Some doctors who have no place to stay when their new rotation begins temporarily reside in hotels or B&Bs while they are seeking suitable alternatives at the start of their rotations (Reed, 2023). Some also incur additional relocation expenses, such as the need to pay two sets of rent for one time period, due to these rotations. Finding a second residence is nearly impossible given the current housing crisis, and some doctors must commute very long distances on a daily basis if they wish to spare their families from frequent relocations and the associated burdens. Studies have found that the situation facing doctors may be worsening, as doctors typically work long hours (i.e., 70-80 hours per week), and any need to spend additional hours commuting, can result in significant stress and discomfort (Humphries *et al.*, 2020; Reed, 2023).

Poor emotional well-being

Intensified working conditions, accompanied by problems arising from the structure of working processes in the Irish healthcare system, may be resulting in many adverse effects, both on doctors' physical and mental well-being. For example, doctors have been found to experience high levels of stress and burnout in the form of emotional exhaustion, depersonalisation, and fatigue (McGowan *et al.*, 2013; Nason *et al.*, 2013; Hayes *et al.*, 2019; Collins and Beauregard, 2020; Humphries *et al.*, 2020). Crucially, as Flinn and Armstrong (2011) showed, there can be significant negative impacts on doctors' cognitive function and clinical decision-making performance resulting from conditions such as long hours of work in a stressful and challenging work environment. In these conditions, doctors can find it difficult to focus and may even miss some critical information. According to a benchmark survey by the Irish Medical Organisation (IMO) in year 2011, 61% of junior hospital doctors were rated as having a low level of morale (Chalikonda, 2023). It is distressing to note that doctors must frequently prioritise their professional obligations over their own personal well-being, as the

current state of affairs can exert significant pressure on them. This situation has elicited widespread concern as it is clear that the prevailing circumstances often demand excessive levels of commitment from junior doctors (McGowan *et al.*, 2013; Humphries *et al.*, 2020b).

Voluntary turnover (outward migration amongst hospital doctors)

The migration figure for Irish doctors has been increasing in recent years and that a significant number of junior doctors are indeed planning to leave the healthcare system in the near future (McEntee *et al.*, 2006; Humphries *et al.*, 2019). It is clearly demonstrated (see Table 2) that the proportion of interns who leave the Irish public healthcare system has increased. For example, in 2015, out of 668 doctors who completed their internship, 315 of them, which is equivalent to 47%, were not registered with the Irish Medical Council (IMC), indicating they were no longer working in Ireland. This trend has shown a significant increase from 2015 to 2022.

		Y+1					
Year	Interns	Further Training in Y+1		Non Training Y+1		No Record Y+1	
2015	668	258	39%	95	14%	315	47%
2016	695	238	34%	112	16%	345	50%
2017	724	230	32%	134	19%	360	50%
2018	728	213	29%	132	18%	383	53%
2019	730	232	32%	252	35%	246	34%
2020	965	259	27%	248	26%	458	47%
2021	832	194	23%	138	17%	500	60%
2022	805	99	12%	200	25%	506	63%
Average		29%		21%		50%	

Table 2: Number of interns in the public health system in subsequent years upon their internship training (National Doctor Training & Planning, 2023)

It is worth noting that when a hospital doctor within the Irish public health system desires to leave their job, they often relocate to another healthcare system or country. This is due to challenges faced by doctors in terms of job mobility within the Irish public health system. To put it simply, changing jobs between different public hospitals isn't a straightforward process. This is because trainee doctors are bound by fixed job rotations that are determined by the training body throughout their training programme, so their ability to select their preferred hospital in which to work is limited for them. Additionally, they are not permitted to apply or work in private hospitals as their training programme does not allow for such opportunities. Those who are non-trainee doctors often occupy service positions (HSE, 2011), which are also known as stand-alone posts. These doctors work under job contracts (6 months to 1 year), which are subject to renewal by their respective hospitals. However, when these doctors' contracts are not renewed, their options may be restricted, primarily because the job openings for non-trainee/service posts in each hospital are limited because most of these posts are filled by trainees, as these doctors are typically hired in smaller non-specialist hospitals. Consequently, their opportunities within the Irish healthcare system tend to be rather limited. Moving every 6 months to a year within Ireland presents its own set of external challenges as noted earlier. Private hospital openings for junior doctors are generally scarce, with few locations being available for placement (National Doctor Training & Planning, 2023).

The Irish workforce crisis, initially attributed a shortage of doctors to the global financial crisis, but has now evolved into a situation where scarcity is no longer related to shortages of doctors but rather to a shortage of doctors who are willing to remain in the public health system under the conditions that are being offered to them (Humphries *et al.,* 2018). This situation has not only led to a significant shortage of doctors, which has resulted in growing dependence on foreign-trained doctors to fill the vacancies created by those who have left (OECD, 2021). This reliance has escalated from 13.4% in the year 2000 to 42% in year 2017 (Bidwell *et al.*, 2013;

Cronin *et al.*, 2019), resulting in Ireland being among the top three high-income countries with a heavy reliance on international recruitment (contrasting sharply with the EU average of just 11.3%). This means that approximately four in ten doctors working in the Irish system are foreign-trained. In the last 20 years, Ireland has been recruiting several thousand doctors from South East Asia and Africa (Brugha *et al.*, 2021). Ireland has the highest number of medical graduates – with a rate of 24.4 medical graduates per 100000, which means, Ireland surpasses Australia (15.9), the United Kingdom (12.9), Germany (11.7) and Canada (7.9). Ireland produces the most doctors among the Organisation for Economic Cooperation and Development (OECD) countries, at 22.1 medical graduates per 100000 population in comparison to the OECD average of 12.5. However, despite this, Ireland still ranks below average for doctors who remain practising (OECD, 2019).

Although it is common for medical doctors to seek international experience, many complete specialist training abroad with a view to returning to their homelands upon completion (Dubois *et al.,* 2005; Humphries *et al.*, 2017). However, this appears less evident in Ireland. This is because many doctors who leave with an intention to return at a later stage ultimately decide not to. The decision not to return to Ireland is often made after a period when doctors see little or no evidence of improvement in working conditions within the Irish Health Service Executive (HSE). This can lead to a decision to permanently stay in the destination country (McDermott *et al.*, 2015; McAleese *et al.*, 2016; Humphries *et al.*, 2017). It has been demonstrated that the longer doctors stay away from Ireland, the less likely they are to return (Public Service Pay Commission, 2018).

2.8 COVID-19 and the Irish public healthcare system

COVID-19 emerged as a public health emergency in early 2020 (O'Leary *et al.*, 2021). As of March 22, 2020, the World Health Organization (WHO) reported 267,013 confirmed cases of COVID-19, with 11,201 deaths in 184 countries (Xiang *et al.*, 2020). The virus had a widespread and devastating impact and highlighted the importance of stringent preventive measures and public health interventions (Kennelly *et al.*, 2020; Xiang *et al.*, 2020). In Ireland, the first reported case of COVID-19 occurred on February 29, 2020. A lockdown was announced to 'flatten the curve' of COVID-19 infection on March 27, 2020 (Pollack, 2020, p.714). Hospital doctors represented the frontline response to COVID-19, and they were primarily responsible for assessing and treating patients. Their roles required them to have particularly close contact with patients, which typically increased their risk of contracting COVID-19 (Xiang *et al.*, 2020; O'Leary *et al.*, 2021).

The pandemic constituted a significant difficulty for the Irish public healthcare system, given its suboptimal state even prior to its outbreak, when it was already operating with restricted resources and struggled to fulfil the needs of the population and provide a good working atmosphere for healthcare staff (McGowan *et al.*, 2013; Brugha *et al.*, 2020). For example, hospital bed occupancy in 2019 was 90%, which was above the European average of 75% (OECD, 2019). Furthermore, there were already long waiting lists prior to COVID-19. In January 2020, there were 556,770 patients on waiting lists for their initial outpatient hospital appointments (NTPF, 2020). In terms of hospital beds, there were 2.9 beds per 1,000 inhabitants in Ireland as of 2018 (OECD, 2021). Indeed, prior to the COVID-19 pandemic, policies pertaining to the provision and employment of healthcare services during crises of its type were not well developed. Therefore, Ireland was in a state of inadequate readiness before the pandemic arrived, and the pandemic occurred at a time when the health system was arguably already under considerable strain (Kennelly *et al.*, 2020; Byrne *et al.*, 2021; O'Leary

et al., 2021). Consequently, the probability of the situation deteriorating further was relatively high.

2.8.1 The health system's response to COVID-19

In January 2020, the National Public Health Emergency Team (NPHET), which comprised around thirty medical science and health service experts, was given responsibility for dealing with the COVID-19 virus. NPHET worked closely with the HSE National Crisis Management Team to manage the Health Service Executive (HSE)'s response. With the help of relevant bodies, the Health Service Executive (HSE) released daily updates (Health Service Executive, 2023b) regarding the acute hospital activities related to COVID-19. These updates typically provided a concise overview of the impact of COVID-19 on Ireland's public hospitals and critical care units, and offered valuable information in relation to COVID-19. To help suppress the transmission of the COVID-19 virus and reduce the burden placed on hospitals and their staff, a range of actions linked to key initiatives were undertaken, and these initiatives are detailed below.

Funding

In terms of funding, there was a substantial enhancement of investment, with €435 million of funding in the early months of the pandemic, along with additional spending increases shortly afterwards around online mental health services (Kennelly *et al*., 2020).

Increased ICU bed capacity

As the pandemic surged, there was a significant increase in hospital admissions. Due to the inadequate number of ICU beds prior to the COVID-19 pandemic, many public hospitals took steps to increase their ICU capacity or even identify additional beds that could be utilised for COVID-19 patients. Additionally, on March 24, the government announced that private

hospitals would collaborate with the public healthcare system to address the crisis. As a result, the number of ICU beds increased, reducing the available resources for the general population.

Recruitment of additional healthcare workers

There was also increased staffing to maintain and enhance workforce capacity, which had been a prominent issue long before the pandemic. Measures taken to increase staffing included an international recruitment campaign, 'Be on call for Ireland', was a campaign which encouraged emigrant and retired healthcare professionals to return to work in Irish hospitals. This Irish Medical Council initiative led to 397 doctors being recruited, of whom about one third were retired doctors returning to work while others returned from abroad (260 of them returned after having migrated). Several other recruitment initiatives were used, such as increasing staffing by extending part-time staff hours, maximising agency usage, redeploying personnel, and encouraging those on career breaks to return early.

Collaboration of private and public hospitals

Collaboration between Ireland's private and public hospitals was enhanced in response to the COVID-19 pandemic, through a mechanism which saw the government enter into an agreement with the Private Hospitals Association to utilise their facilities for both COVID-19 and non-COVID-19-related patients. As per the new arrangement, 19 private hospitals operated as if they were public hospitals for a period of three months. Patients were treated in these facilities until this agreement lapsed at the end of June 2020. Other actions taken to address the situation included bringing forward exams for final-year medical students to enable them to join the workforce earlier, hiring student nurses as healthcare assistants, reassigning healthcare workers from the private sector, and providing other external staffing supports as needed.

GP/specialist operational changes

Changes in medical practice requirements were also made, such as designating GPs as the first point of contact and adapting non-Covid healthcare services to ensure the continued delivery of urgent elective procedures, while postponing non-Covid medical treatment check-ups. A number of community hubs were also established, which allowed patients to be seen by a GP who could then refer them to acute hospitals as appropriate. Some of these changes resulted in GPs providing the majority of their consultations over the phone or via video link, and this in turn reduced the risk of hospital doctors contracting COVID-19 which arose when suspected patients attended a hospital.

Changes in the utilisation of non-COVID-19 healthcare

Changes in the utilisation of non-COVID-19 healthcare were essential. These changes included postponing a significant number of non-Covid medical appointments, including check-ups and non-urgent medical examinations. This resulted in many of these appointments being postponed, and, in some cases, operations were also delayed. Additionally, the use of technology, such as telemedicine and phone consultations, was maximized, mainly in specialties such as psychiatry and mental health units so that healthcare services could be provided efficiently, and in-person contact could be reduced.

In general, at policy level, there was great support for these steps and Ireland's response to the COVID-19 was comprehensive and timely in many respects (Kennelly *et al.*, 2020; Byrne *et al.*, 2021). Notable aspects of Ireland's Covid-19 response included transparency, which involved a commitment to an open data policy, as well as the utilisation of both conventional and social media to inform the community. Additionally, the Department of Health and the Health Service Executive (HSE) were conducting frequent updates. Importantly, in relation to hospital doctors' working conditions, research has shown that the adoption of these measures

brought ‘significant transformations to the hospital work environment’ (Byrne *et al.*, 2021, p. 2). Specifically, the reconfiguration of hospital services has been found to have resulted in improved staffing levels, mainly due to the cancellation of non-essential care and the redeployment of hospital doctors to hospital-based roles. This led to an increase in the number of doctors available on the hospital floor, resulting in better facilitation of sick leave/call cover, improved morale and relationships, and increased availability of clinical support, as there were more consultants present on a daily basis. The availability of consultants was especially beneficial for junior doctors, who are commonly in training and often need someone from whom to seek advice, opinions, and oversight of their jobs and decisions. Doctors reported these positive impacts, even though the COVID-19 pandemic had placed the country and healthcare system in a perilous situation which brought significant uncertainties, anxiety, and increased risks to the health and safety of junior hospital doctors (Kennelly *et al.*, 2020; Lynch, 2020), the

COVID-related changes implemented during the first wave of the pandemic therefore had some positive impacts. In fact, the phrase ‘it took a pandemic to make change happen’ has been noted in the Irish health system (Byrne *et al.*, 2021 p. 4). Yet, overall, even though the pandemic led to some positive changes, there is considerable uncertainty about the sustainability in the pandemic’s subsequent phases of the hospital reconfigurations which were initially implemented. These issues are further explored and addressed in this thesis.

2.9 Summary

This chapter provides a concise overview of the Irish public healthcare system, detailing its evolution, structure and challenges faced by the health system. It also discusses the impact on healthcare workers, and particularly doctors, within the public hospital framework. The Health Service Executive (HSE), which is the Ireland’s public healthcare provider, has undergone

significant transformations due to the global financial crisis in 2008. These changes have resulted in many challenges including funding reductions, staff shortages, and the pressing need for systemic reform. Furthermore, these complexities and pressures have further impacted the roles and experiences of hospital doctors. In addition, the outbreak of COVID-19 pandemic further complicated an already strained system putting additional pressures on doctors. However, it is worth noting that the response to COVID-19 highlights the system's resilience and adaptability, as the pandemic catalysed some positive changes to work systems and doctors' work experience. These adaptations are commendable, but they also raise questions about the long-term sustainability and the future direction of healthcare in Ireland.

It is clear that the Irish public healthcare system stands at a critical juncture. The ongoing poor working conditions, along with the lessons learnt from the pandemic, provide a compelling case for comprehensive healthcare reform in Ireland. Such reforms should not only aim to address the immediate concerns faced by the health system, such as the need for a short-term solution to high doctor turnover, but should also address the systemic issues that have long plagued the system. These efforts should include seeking to comprehend and turn the page on less explored areas explored throughout this thesis. Overall, the journey of the Irish public healthcare system has been marked by long term struggle, and slight achievements have underscored the importance of shaping a sustainable health system.

CHAPTER 3

Literature Review and Conceptual Framework

3.1 Introduction

This chapter critically discusses the existing literature as relevant to the research questions of the thesis. The chapter provides conceptual and definitional clarity around turnover, retention and where intention to stay fits. Then, the literature on intention to stay is reviewed which highlights the potential value and utility of adopting this focus rather than solely a turnover lens. In so doing, the earlier turnover research is considered before identifying and then delving into the utility of job embeddedness theory to address the research questions. As part of this section of the chapter, the key issues and gaps with this theory are also identified

3.2 Conceptual underpinnings and definitions

Intention to stay refers to an employee's intent or inclination to remain in their job or within their current organisation (Mobley, 1977). In other words, 'intention to stay' is the employee's perception of the probability or likelihood of continuing in their current job or staying with their present organisation (McCloskey and McCain, 1987). The concept specifically focuses on employees' thoughts and attitudes regarding their decisions to remain in their organisations (Sheridan, 1992; Presbitero *et al.,* 2016). Typically, when an employee finds their job fulfilling, and they believe in the values of their organisation, and perceive the benefits of remaining within it, they are more likely to have a strong intention to stay in their job (Mitchell *et al*., 2001).

Retention refers to the number of employees who remain/stay in an organisation and the capacity for the organisation to retain them (Lee *et al*., 2004, Buckley *et al.*, 2022). It can also be defined as 'a strategic approach adopted by organisations to keep productive employees from seeking alternative employment' (Carbery and Cross, 2019, p.62). In essence, employee retention is the ability of an organisation to hold onto valuable employees. This is typically

achieved by taking actions that motivate and encourage employees to stay with the organisation for the maximum period of time (Mitchell *et al*., 2001; Shakeel and But, 2015).

Turnover**,** on the other hand, is a 'dynamic concept concerned with the movement of individuals across the boundaries of a social system' (Price, 1977, p. 487). In practical terms, it represents the ratio between the number of employees who have departed from an organisation during the period under consideration and the average staffing level (Price, 1977). Turnover most commonly represents '*voluntary turnover*', whereby employees leave the organisation voluntarily, irrespective of their specific reasons for leaving (Mobley *et al.*, 1979). This term encompasses voluntary quits, and it excludes promotions, job transfers, and other internal moves within employing organisations. Additionally, the terms '*turnover intention*' or '*intention to leave*' refer to situations where employees strongly contemplate quitting their jobs (Carbery and Cross, 2019; Zhang *et al.*, 2019). In other words, they refer to an employee's inclination or intention to voluntarily leave their job or organisation. Turnover intention can also be used to describe the probability that an employee will leave their job within a certain time period (Chao *et al.*, 2015; Buckley *et al.*, 2022).

3.3 A review of the literature – intention to stay

Employee intention to stay has been a significant subject of discourse in the field of management (Price and Mueller, 1981; Bluedorn, 1982; Lee *et al.*, 1996). This concept refers to the likelihood of an employee remaining with an organisation. It is a social psychological concept as it deals with an employee's perception and consideration of staying (Price and Mueller, 1981; Halaby, 1986; Iverson, 1992).This intention is a critical determinant of their continued membership of, and future actions within, an organisation (McCloskey and McCain, 1987). Therefore, employees' intention to stay with an organisation is crucial for that organisation's progress and success. Typically, to achieve an effective and efficient workforce,

it is essential to secure and manage competent human resources/human capital, since they form the most valuable resource in any organisation (Mello, 2011; Das and Baruah, 2013).

The connection between intention to stay and employee retention is rooted in the predictive nature of intention to stay. According to research, March and Simon, 1958; Mobley *et al.*, 1979; Price, 1983; Sheridan, 1992; Lee *et al.*, 1996; Mitchell *et al.*, 2001; Holtom and O'Neill, 2004; Holtom *et al.*, 2008, intention to stay is a precursor or a strong predictor of actual retention. This means that, when employees express a strong intention to stay with an organisation, it is highly likely that they will indeed stay and improve retention. From a managerial perspective, a high rate of retention is more important today than ever before (Holtom *et al.*, 2008), as high retention facilitates effective human resource planning, ensures organisational stability, supports growth, enhances revenue, and is essential to achieve competitive advantage (Maertz Jr and Campion, 1998; Steel, Griffeth, and Hom, 2002; Bugajski *et al.*, 2017).

There are many different approaches and initiatives which are commonly taken by organisations in relation to improving employees' intention to stay, and they can include compensation and rewards, job security, ensuring a positive work atmosphere and relationship with peers, and maintaining a safe and healthy working environment (Sheridan, 1992; Mitchell *et al.*, 2001; Das and Baruah, 2013). Walker (2001) identified seven factors that can improve employees' intention to stay, namely, compensation and appreciation for the work performed, provision of challenging work, chances to be promoted, a welcoming atmosphere within the organisation, positive relationships with co-workers, a healthy balance between work and personal life, and good communication. Ghosh *et al.* (2013) revealed that creating a sense of belonging, opportunities for development, freedom, and an overall environment which makes an employee feel that they are valued and unique is key to improving intention to stay. Likewise, Zhang *et al.* (2019) stated that providing adequate organisational support and an appropriate working environment does influence employees to stay.

Additionally, research suggests that employees with high job satisfaction, organisational commitment, and personal loyalty are more inclined to stay within their organisations (Chew and Chan, 2008; Ghosh *et al.*, 2013). In particular, committed employees are found to be less likely to quit as they have reasons and a desire to stay (Lee *et al.*, 2004; Reitz and Anderson, 2011). Factors such as opportunities for future employment and recognition at work are other proven factors that improve employees' intention to stay (Yang *et al*., 2021). Overall, it is evident that, if suitable and appropriate employee retention strategies are adopted and implemented by an organisation, employees will be more likely to stay in their jobs (Mitchell *et al.*, 2001; Holtom *et al.*, 2008).

3.4 Literature review of hospital doctor turnover and retention[2]

Hospital doctors play a pivotal role as the cornerstone of the healthcare sector, providing specialised care and services to patients, and this makes them a crucial component of the human resources in healthcare (Khan *et al.*, 2018). Improving the intention to stay among hospital doctors is fundamental, as poor intention to stay results in a low retention rate which leads to numerous negative consequences for the healthcare system and poses a threat to health equity (Xu *et al.*, 1995; Cleland *et al.*, 2020; Martinussen *et al.*, 2020). Therefore, retaining a sufficient number of doctors is important, as it significantly correlates with increased productivity (Dewa *et al.*, 2014); helps maintain an experienced, knowledgeable, and sustainable medical workforce (Waldman, 2010; Humphries *et al.*, 2015); and contributes to overall improved access to healthcare thanks to greater continuity of treatment (Freeborn *et al.,* 2002).

[2] Part of this section has been published in a systematic review paper: Seathu Raman, S. S., McDonnell, A. and Beck, M., 2024. Hospital doctor turnover and retention: a systematic review and new research pathway. *Journal of Health Organization and Management*, *38*(9), pp.45-71.

Several scholars worldwide have examined the issues related to this area of research. However, most of their focus has been on turnover among hospital doctors (why they leave) rather than on their intention to stay (why they stay) (e.g., Sharma *et al.,* 2012; Ali Jadoo *et al.*, 2015; Humphries *et al.*, 2015; Tsai *et al.*, 2016; Valle *et al.,* 2016; Zhang *et al.*, 2017; Humphries *et al.,* 2018; Oh and Kim, 2019; Martinussen *et al.*, 2020a; Zhang *et al.*, 2020), from the first empirical study published in 1997 by Lachman and Noy (1997) to a surge of published studies in the field developed from 2008 onwards. The majority of the research took place in European countries, with notable studies conducted in Ireland (McGowan *et al.*, 2013; Humphries *et al.,* 2013, 2018, 2019, 2020, 2021; Pflipsen *et al.*, 2019; Brugha *et al.*, 2020; Brugha *et al.*, 2021; Walsh and Brugha, 2021; Byrne *et al.*, 2021). Studies have also emerged in several Asian countries and the Middle East, Australia, and Africa (Luboga *et al.*, 2011; Zhang and Feng, 2011; Ali Jadoo *et al.*, 2015; Fengfan Zhang *et al.*, 2017).

Studies have found that the most significant factors contributing to turnover among hospital doctors are organisation-related factors, particularly poor working environment, culture, and practices (Luboga *et al.*, 2011; Bruce-Brand *et al.*, 2012a; Sharma *et al.,* 2012; Gauld and Horsburgh, 2015; Humphries *et al.*, 2015, 2018; Lambert *et al.,* 2018). For example, working in poor healthcare conditions, which are commonly understaffed, and being overstretched with high workload and long hours, have been cited as the most significant factors affecting doctors' decisions to leave (Sharma *et al.,* 2012; McGowan *et al.*, 2013; Humphries *et al.*, 2015; Humphries *et al.,* 2018; Lambert *et al.,* 2018). According to a study conducted in Taiwan by Tsai *et al.* (2016), there is a clear and independent relationship between work hours and turnover intention. The study found that hospital doctors working 60-88 hours per week exhibited a significantly higher intention to leave their current hospital. This finding is corroborated by another study , which demonstrated that high working hours are associated with increased turnover. Specifically, doctor's on-call hours, in addition to their standard hours,

heightened these consequences. Extended hours, combined with high work demands, result in job strain, contributing to doctors' turnover intention (Heponiemi, Presseau and Elovainio, 2016). In particular, hospital doctors were found to struggle in managing their workload and hours, especially when other job challenges were factored in, such as clinical demands (patient load and care, decision-making, treatment plans), academic demands (examinations, research, acquiring new knowledge, training and development), and administrative demands (paperwork, patient records). The situation deteriorates further when these demands are coupled with poor or limited resources, as they further reduce doctors' capacity to manage their workload and hours, which inevitably creates a negative impact on employees' intention to stay (Heponiemi, Presseau and Elovainio, 2016; James and Gerrard, 2017; Lambert, Smith and Goldacre, 2018; Duan *et al.*, 2019; R. Brugha *et al.*, 2021; Byrne *et al.*, 2021). Additionally, research also indicates that this intensified situation appears to be more detrimental amongst acute speciality doctors, such as those working in surgical, emergency medical, and intensive care areas (Wang *et al.*, 2015, p. 201; Tsai *et al.*, 2016; Wu, Wang and Chen, 2018). In other words, battling a climate of negativity significantly impacts doctors' decisions to leave.

Some studies which focused on doctors' pay and rewards and their relationship to turnover (Zhang and Feng, 2011; Tsai *et al.*, 2016; Lu *et al.*, 2017; Zhang *et al.*, 2017; Lambert, Smith and Goldacre, 2018; Pantenburg *et al.*, 2018; Wu, Wang and Chen, 2018; Oh and Kim, 2019; Pflipsen *et al.*, 2019) have indicated that those factors are relevant but do not tend to be a major determinant of turnover. Such matters have not generally been shown to effectively moderate the adverse effect of long working hours on voluntary turnover (Tsai *et al.*, 2016). In particular, Tsai *et al*. (2016) noted that pay and rewards were wholly insufficient and inadequate to compensate for the workload, long hours, and the skills that doctors contributed.

Some studies have also revealed the consequences doctors face due to their poor work climate, which often leads to other issues such as unsafe working environments, workplace violence

(Heponiemi *et al.*, 2014; Ali Jadoo *et al.*, 2015; Duan *et al.*, 2019), high levels of workplace bullying (Walsh, 2013; Clarke *et al.*, 2017; Lambert *et al.,* 2018a), and frequent incidences of medical disputes, especially where doctors were predominantly unsatisfied with the response of the hospital system towards these situations, which led to doctors feeling undervalued and insecure (Wang *et al.*, 2015, p. 201; Zhang *et al.*, 2019). Additionally, poor working relationships, lack of teamwork, low levels of work engagement, and poor communication and interaction with peers also emerged as factors that contribute to doctors choosing to leave (Walsh, 2013; Pantenburg *et al.*, 2018; Smith *et al.*, 2018; Wu *et al.,* 2018; Duan *et al.*, 2019; Martinussen *et al.*, 2020a). Notably, these aspects were seen to create a poor working atmosphere, resulting in reduced or absent harmony within the unit/ward/hospital (Clarke *et al.*, 2017; James and Gerrard, 2017).

The next most discussed factors related to the poor quality of management, supervisory support, and leadership styles within the workplace. Significant studies have demonstrated the effects of a lack of proper management support, and weak supervision, which often led to doctors feeling not valued and recognised (Fengfan Zhang *et al.*, 2017; James and Gerrard, 2017; Roy *et al.,* 2017; Lambert *et al.,* 2018; Martinussen *et al.*, 2020). Studies mainly highlighted situations where doctors did not receive adequate performance feedback or evaluation (Ochsmann, 2012; Brugha *et al.*, 2020; Byrne *et al.*, 2021; Ruairi Brugha *et al.*, 2021). These deficiencies indicate a significant absence of supervisory support and mentoring, particularly in the form of informational support (work-related information, appraisals, feedback), material support (assistance, time, guidance), and emotional support (care, acceptance) from senior doctors/consultants. Such gaps in performance evaluation indicate that hospital doctors are not receiving the necessary developmental support needed for their professional growth, which in turn negatively impacts doctors and can lead to withdrawal from work.

Similarly, a lack of training, education, and career advancement opportunities has been shown to cause doctors to consider leaving their jobs (Zhang *et al.*, 2016). Specifically, inadequate training, programmes, and career pathways, including both formal postgraduate training (mandatory to becoming a consultant) and informal training, provided through informal teaching, supervision, guidance, mentoring, and coaching, have led doctors to seek opportunities elsewhere. For example, several studies conducted in Ireland (McGowan *et al.*, 2013; Tyrrell *et al.*, 2016; Humphries, Crowe and Brugha, 2018; Ruairi Brugha *et al.*, 2021) have stated that hospital doctors were dissatisfied with their training programme and even went so far as to suggest that 'training is non-existent' (Pflipsen *et al.*, 2019, pg. 1398) as the offering was so poor. This led to a high level of frustration and dissatisfaction among doctors, which served as a strong antecedent for turnover. These findings are further supported by other studies from Finland (Heponiemi *et al.*, 2014), Germany (Degen *et al.*, 2014), Uganda (Luboga S *et al.*, 2011), and Poland (Domagała and Dubas-Jakóbczyk, 2019), where doctors were found to have an intention to leave due to the poor quality of training and professional development available to them.

Furthermore, research has shown that job satisfaction is a significant explanatory factor for hospital doctor turnover (Pathman *et al.*, 2002; Fuß *et al.*, 2008; Williams *et al.*, 2010; Bruce-Brand *et al.*, 2012b; Sharma, Lambert and Goldacre, 2012; Heponiemi *et al.*, 2014; Ali Jadoo *et al.*, 2015; Roy, van der Weijden and de Vries, 2017; Pantenburg *et al.*, 2018; Zhang *et al.*, 2019). In particular, low job satisfaction has regularly been shown to result from poor organisational factors, such as high workload (Hayes, 2016; Hayes *et al.*, 2019), excessive working hours (Ochsmann, 2012; Tsai *et al.*, 2016), workplace violence, bullying, and low job control (Degen *et al.*, 2014; Heponiemi *et al.*, 2014; Ali Jadoo *et al.*, 2015), poor work-life balance, poor relationship with peers (Bruce-Brand *et al.*, 2012b; Pantenburg *et al.*, 2018), lack of training and development (Degen *et al.*, 2014; Tyrrell *et al.*, 2016; Pflipsen *et al.*, 2019),

poor pay satisfaction (Singh and Loncar 2010), safety concerns, and work/life balance conflicts (Ali Jadoo *et al.*, 2015; Humphries *et al.*, 2020). Most of these studies examined the direct relationship between job satisfaction and turnover, and some evaluated the impact of work-related stress and burnout on these issues. For instance, high levels of stress and workplace burnout were found to be associated with lower satisfaction, which in turn increased turnover (Pathman *et al.*, 2002; Fuß *et al.*, 2008; Zhang and Feng, 2011; Zhang *et al.*, 2017).

The high job demands placed on hospital doctors, and their efforts to cope with these difficulties, have been shown to result in burnout, decreased job satisfaction, and increased withdrawal behaviours (Tziner *et al.*, 2015; Roy *et al.,* 2017). Similarly, poor health and wellbeing, particularly deteriorating mental health, depression, and high level of anxiety (Hamidi *et al.*, 2018) along with sleep deprivation, (Machi *et al.*, 2012; Tziner *et al.*, 2015; Weaver *et al.*, 2020) have been identified as significant explanatory variables. However, it is important to note that research suggests that doctors' low level of satisfaction arose specifically from these organisational aspects of their working lives and did not reflect their views of on patient care (Pathman *et al.*, 2002; Wang *et al.*, 2015; Pantenburg *et al.*, 2018). In fact, many doctors reported being highly satisfied with their level of overall patient care and doctor-patient relationships due to the meaningfulness of their contribution, intrinsic interest, the appropriate level of challenges (seen as a positive opportunities for learning and skill-building), self-fulfilment, and social status received. On the other hand, strong professional commitment – mainly, commitment toward their profession as a medical doctor – was shown to result in higher job satisfaction (Lachman and Noy, 1997), which in turn improves doctors' intention to stay; however, this study is now quite dated, and there is very limited further research exploring this issue.

External factors relating to economic and political factors that contribute to less favourable working conditions for hospital doctors have also been found to result in turnover among

hospital doctors (Roy, van der Weijden and de Vries, 2017; Wen *et al.*, 2018; Gutacker *et al.*, 2019). Specifically, research has scrutinised the role and influence of economics and politics, which some doctors perceive to be distorting the aims of their profession and creating less positive conditions for doctors. For instance, the lack of government funding and/or limited healthcare expenditure have been seen to severely impact the provision of adequate resources, resulting in insufficient hospital beds and subsidies (Gutacker *et al.*, 2019; Zhang *et al.*, 2019; Brugha *et al.*, 2020, 2021). In Ireland, the austerity measures implemented following the 2008 global financial crisis have had a lasting impact on doctors. Low funding and resources resulting from cuts have forced doctors to work in an intensified, stretched, and understaffed healthcare system for an extended period. Consequently, many view the Irish public healthcare system as an undesirable place in which to work (Flynn and Armstrong, 2011; McGowan *et al.*, 2013; Tyrrell *et al.*, 2016; Humphries *et al.*, 2019, 2020). This perception has had an inevitable negative impact in the form of voluntary turnover (Humphries *et al.*, 2013, 2015, 2018). Likewise, UK government initiatives, such as the medical revalidation system, provided greater assurance to the patients and the public, but had a negative impact on doctors, contributing to an increase in the number of doctors choosing to leave their jobs.

Institutional issues such as poorly defined governance structures and poor work policies typically affect the long-term availability of jobs for hospital doctors, including permanent and consultant positions. Also, uncertainty about future work contracts and rural placements, together with limited funding and limited placement opportunities for professional development, have all been reported as contributing to increased doctor turnover in several jurisdictions (Smith, 2008; Sharma et al., 2012; Zhang *et al.*, 2017; Humphries et al., 2018; Lambert et al.,2018; Byrne *et al.*, 2021; Brugha *et al.*, 2021).

Additionally, some international doctors working in different countries face significant difficulties due to certain regulations. In particular, doctors who require a visa/work permit

often encounter real challenges during both initial application and subsequent renewal stages. For instance, in Ireland, this process can be extremely difficult, and the nationality of a doctor can impact their eligibility for many government training courses and related schemes (Bidwell *et al.*, 2013; Humphries *et al.*, 2013, 2014; Clarke *et al.*, 2017, 2017). Facing many obstacles and being ineligible and unsuitable for training programmes can obstruct a doctor's career pathway, and this has been identified as a contributor to turnover. When doctors face these challenges and find it difficult to overcome them in a timely manner, they often choose to move to countries where these regulations are much more straightforward for international doctors, such as Australia and New Zealand.

Furthermore, hospital doctors' socio-demographic factors, such as age, gender, and marital status, have received considerable research attention. Research indicates that younger doctors are more likely and willing to leave posts, with the reasons commonly cited being openness to change, actively seeking better job and/or training opportunities, and a desire to travel, alongside having a strong interest in practicing medicine abroad (Heponiemi et al., 2008; Ali Jadoo *et al*., 2015; Lu *et al*., 2017; Oh and Kim, 2019). Conversely, older doctors have been shown to be less likely to leave because they experience greater work stability, enhanced promotional opportunities, and higher income levels. This cohort of doctors were also found to have stronger personal ties and higher job satisfaction. Some of them were also reluctant to leave their jobs at this stage as they were nearing their retirement period, which meant that seeking a job change at this stage wouldn't be ideal and would potentially have a negative impact on their retirement plans (Lachman and Noy, 1997; Wang *et al*., 2015; Pantenburg *et al*., 2018). However, older doctors did appear to be associated with increased turnover within fast-paced, highly specialised clinical and acute departments (e.g. surgery and anaesthetic) – whereby a higher proportion of these doctors were likely to look to leave as they got older (Wang *et al.*, 2015). It has been suggested that this trend may potentially be in response to

deteriorating performance, owing to the value of doctors' skills (e.g. surgery skills) becoming diminished or reduced over time (Sherwood and Bismark, 2020).

Gender is another factor that can affect intention to leave. Research has indicated that male doctors appeared to have a higher interest in leaving (Ali Jadoo *et al.*, 2015; Brugha *et al.*, 2021), while women, especially those who are married with childcare responsibilities, were found to have lower intention to leave. These findings relate to the fact that women are likely to have more social obligations and are therefore less geographically flexible and mobile than their male counterparts. Female doctors were also found to be more inclined than their male counterparts to leave due to work-family conflicts generated by the suitability of work to their family demands. One relevant factor here is the impact of overtime, which has been shown to be an important turnover predictor amongst female doctors due to the restrictions it can put on time available to spend with family (Ochsmann, 2012; Wu *et al*., 2018). Marriage appeared to have a wider impact, in that married doctors (both men and women) were found to have less intention to leave. This may be due to a dual career effect. Similar findings were found amongst those with children – hospital doctors with children were less likely to leave roles, particularly if they were currently living close to family members such as grandparents which was a heavily cited factor of influence (Wu et al., 2018; Brugha *et al*., 2021).

Conversely, a positive work environment characterised by high morale, enhanced work flexibility, effective supervision, supervisory support, and proper recognition has been shown to reduce turnover (Lachman and Noy, 1997; Brugha *et al.*, 2021). Specifically, the probability that doctors will show an intention to leave is reduced by one and a half times if they have leaders who they characterise as having a professional, supportive leadership style (Martinussen *et al.*, 2020).

While extensive research exists on hospital doctor turnover, and considerable attention has been paid to understanding turnover and the push factors that lead doctors to leave their jobs (Holtom *et al.*, 2008), there is limited understanding of why doctors intend to stay. Although the literature on turnover has been making significant contributions to the understanding of why hospital doctors leave their jobs, it offers a limited understanding of the other side of the story, or, in other words, the reasons why doctors stay. Some studies have investigated hospital doctors' reasons for staying. For example, Luboga *et al*. (2011) explored hospital doctors' intention to stay, but a substantial portion of their study focused on accumulated reasons for doctors' dissatisfaction with their work, which may lead to turnover, since a majority of the sample expressed an intention to leave their jobs rather than stay. Lachman and Noy (1997) investigated doctors' retention of hospital membership until retirement, but while their study shed light on critical aspects of long-term commitment, it primarily focused on retirement, tenured positions, and long-term commitment, meaning that further research is needed to fully comprehend the reasons why doctors choose to stay.

Another study by Brugha *et al.*, (2016), conducted in Ireland, has explored factors associated with reasons why foreign doctors migrated to Ireland and their intention to remain, return to their home countries, or migrate to other countries. While this study uncovered factors that motivate foreign doctors to consider staying in Ireland, its scope was limited to this group, and, rather than focusing specifically on staying, it explored the three broader dimensions of staying, returning home, and migrating further. Likewise, a few studies have identified factors that can help reduce employee turnover (Valle *et al.*, 2016; Smith *et al.*, 2018; Martinussen *et al.*, 2020; Brugha *et al.*, 2021); however, these studies still focused on the issue of turnover and turnover intentions. While other studies have investigated pull factors that result in employee retention, they have mainly included a broader range of medical professionals, such as general

practitioners, dentists, and laboratory medical personnel, rather than focusing solely on hospital doctors (Ibrahim *et al.*, 2019).

Therefore, further extending the literature by specifically exploring the reasons why doctors intent to stay is important, since turnover and retention are different concepts, with distinct psychological, emotional, and normative factors involved, for employees who remain or intend to stay in their present jobs or within an organisation, compared to those who are in the process of quitting (Lee *et al.*, 1996; Mitchell *et al.*, 2001; Reitz and Anderson, 2011). For example, an employee's decision to stay in their current job is not necessarily solely based on the absence of factors that contribute to turnover, and the reasons they stay in their current job within an organisation are not the opposite of the reasons why they might quit (Reitz and Anderson, 2011; William *et al.,* 2014). Hence, the factors influencing retention and turnover are not directly interchangeable and they typically involve distinct and complex considerations (Herzberg, 1966; Holtom *et al.,* 2006).

3.5 Towards a new model of turnover

Since March and Simon (1958) proposed a participant determination model of turnover in 1958, many different models of turnover have been proposed (Mobley, 1977, 1982; Mobley *et al.*, 1979; Bluedorn, 1982; Lee and Mitchell, 1994; Price, 2004). There have also been many theoretical advances since then due to some significant reviews of the turnover literature by Hom and Griffeth (1995) and (1998). Over the course of several decades, the extensive body of literature on employee turnover has focused on investigating reasons why individuals choose to leave their jobs (Schwab and Heneman III, 1972; Lee *et al.*, 1996, 2017; Mitchell *et al.,* 2001; Voutsina *et al*., 2013; Arshad and Puteh, 2015; Hom *et al*., 2019; Bolt *et al*., 2022). At times, research in this area has been hampered by generalisations about the psychological processes involved in quitting (Lee *et al.*, 1996) which have become key constructs in this field

of study. Among these key constructs, job satisfaction and organisational commitment have emerged as prominent factors. It is widely recognised that employees who experience low levels of job satisfaction or poor commitment are more likely than others to consider quitting their jobs (Carsten and Spector, 1987; Allen and Meyer, 1990). Conversely, employees who exhibit a high level of job satisfaction and commitment to their organisation are more inclined to remain in their current employment, even when other opportunities arise. However, as mentioned in Chapter 1, these approaches only offer partial explanations for employee turnover, since committed and satisfied employees may quit their positions due to other reasons. This is because the decision to quit or stay in a job is often preceded by other dimensions over and above attitudinal factors (i.e., satisfaction), which can include factors such as jarring events or consideration of alternative pathways. To put it simply, there are many factors why people voluntarily leave – some are personal, and some are influenced by the organisation. This perspective acknowledges that decisions to quit or stay in a job are not solely driven by negative experiences but also involve a series of cognitive evaluations and assessment/decision-making processes (Mitchell *et al.*, 2001; Halvorsen *et al.*, 2015).

Though prior studies provided a solid foundation of understanding and yielded significant findings, the existing literature predominantly concentrated on the broad question of why people leave (Lee *et al.*, 1996). Even though the unfolding model of voluntary turnover theory claimed to consider reasons why an employee might quit or stay in their job, some criticism has emerged regarding a lack of emphasis on 'stayers', as the empirical investigations have focused more on studying/examining 'quitters' (Donnelly and Quirin, 2006). This approach has left a gap in our understanding and has led to neglect of the equally crucial issue of why people stay in their jobs and/or within organisations. According to Mitchell *et al.* (2001) there was a need to consider a switch from the heavy emphasis on turnover and instead explore a more interesting and useful avenue by asking why employees stay (a question which is seldom

asked). Therefore, Mitchell *et al*. (2001) developed a theory called '*job embeddedness*' to provide a total paradigm shift and place a fresh focus on the broad array of factors that influence a person to stay in a job, and, more specifically, cause employees to become embedded in their jobs. This approach emerged to provide a more complete explanation of the factors involved in employee retention.

3.6 Job embeddedness theory

Job embeddedness theory is considered to be a theory or framework for understanding retention, and it attempts to take into account '*a broad constellation of psychological, social, and financial influences on employee retention*' that help to explain why employees remain in a job/organisation (Mitchell *et al.*, 2001, Halverson *et al*., 2015, p. 1104). In general, job embeddedness theory focuses on the process of retention, or why an employee remains in their present job. In other words, it is conceived as 'higher-order aggregate of forces for retention' (Coetzee *et al.,* 2018, pg. 97). The focus on retention, and not turnover, is important and it forms the foundation for a potential alternative conceptual framework through which to view hospital doctor retention issues. Indeed, job embeddedness is widely regarded as an '*anti-withdrawal construct*' (Reitz and Anderson, 2011), as its key focus is on the factors that keep an employee in their current job rather than the steps/processes they go through when they leave.

3.6.1 Origins and core concepts

The different perspectives offered by job embeddedness theory suggest that this theory's approach may lead to different understandings and solutions. This is mainly the case because the accumulated reasons and motivations that affect why an employee chooses to stay in their job are not the reverse of those that shape why the same employee might choose to leave (Terence R. Mitchell *et al.*, 2001; Holtom *et al.*, 2008). In other words, the factors contributing

to an employee's decision to stay in their current job can fundamentally differ from the absence of turnover factors, and, in fact, turnover factors may not necessarily apply. It is essential to avoid conceptualising retention and turnover factors as if they are at opposite ends of a continuum. This is a simplification that could mislead. For instance, an employee's reasons for job dissatisfaction may be distinct from their reasons for job satisfaction (Mitchell *et al.*, 2001; Reitz and Anderson, 2011; Halvorsen, Treuren, and Kulik, 2015; Hom *et al.*, 2017). An employee can be dissatisfied with hygiene factors (i.e., pay and working conditions) but satisfied with the intrinsic rewards of the job itself. This 'two-factor theory of motivation' (Herzberg, 1966 pp.1-3) suggests that factors that play a role in an individual's decision to stay in an organisation differ from the factors that influence their decision to leave. The reasons a person stays in a job are not the 'reverse' of the reasons a person leaves their job (Reitz and Anderson, 2011).

This theory originates from two fundamental questions posed by Lee and Mitchell, (1994), in their Unfolding Model of Voluntary Turnover. These questions concern the nature of shocks, and they seek to identify the jarring events that cause employees to quit and why some shocks lead employees to quit whereas some shocks do not. The answers to these questions are influenced by external forces, including off-the-job factors/non-attitudinal variables and the attachment employees have towards certain aspects of their job that would still keep the employee in the job/organisation. These could be family pressures or community commitments as well as an employee's attachment to network groups through their jobs or company activities such as football team. Ultimately, leaving a job/organisation often entails employees giving up some perks, routines, or projects to which they may have developed an attachment. Generally, the research focus was on whether employees were satisfied or dissatisfied with aspects of their job. However, the discussion has evolved to focus on understanding why employees can't leave/choose to stay and the many things that keep people entrenched in their jobs. These

enquiries about the factors that constitute reasons for employees to stay are addressed well through job embeddedness theory (Mitchell *et al.*, 2001).

The most important aspects of job embeddedness theory are the connections an employee has with other people or the community, how they integrate into the organisation or community, and what the employee would give up by leaving the organisation or community. Job embeddedness theory encourages the investigation of an employee's organisational embeddedness ('on-the job'), as well as their connections to the environment where they live, which can be understood as 'community embeddedness ('off-the-job' factors). As Mitchell *et al.*, (2001) argue, both on-the-job and off-the-job embeddedness are important as they interweave to create an overall 'web' of attachments where the person works and lives. The more complex or the stronger the attachments are which a person has, the harder it will be for them to leave their job. Generally, employees with good job fit are those who feel that they have good job responsibilities, experience a sense of commitment, and have strong interpersonal networks and friendships in the job alongside the surrounding community. Similarly, employees whose children are in good childcare/local schools and heavily engage with local activities are likely to face more disruption to their 'web' if they leave, than a person with a less complicated or dense web (lower job fit, a smaller network, and fewer friends in the community) (Holtom *et al.*, 2002, pp. 319–320). The strength of 'embeddedness' in organisations and communities is a function of three components, which can be understood as 'fit', 'links', and 'sacrifice' (Mitchell *et al.*, 2001).

3.6.2 Measurement approaches

According to the original theoretical concept, job embeddedness is recognised as a causal indicator construct, which means it is defined by its indicators. In this model, the indicators cause the construct; therefore, any changes in the indicators lead to changes in the construct.

Specifically, the dimensions of fit, links, and sacrifice are viewed as causes that collectively define and measure overall job embeddedness.

3.6.3. Fit dimension

Fit can be defined as the perceived compatibility of an employee with their organisation and community (Mitchell *et al.*, 2001). It can arise in a situation where an employee perceives themselves as being similar to, and 'fitting' with, their organisation and community. There are two main types of fit. First, on-the-job fit refers to the overall compatibility between an employee and their job role and their perceived compatibility with job requirements, knowledge, skills, and abilities, as well as with their personal and organisational values. This type of fit may include supervisor-subordinate fit (how well a person manages his or her relationship with their immediate supervisor) and person-job fit (a person's skill set and knowledge matching the requirements of the job) (Holtom *et al*., 2006; Reitz and Anderson, 2011). Second, off-the-job fit refers to how well employees feel connected to elements outside their work, such as family commitments, their surrounding community, and the general environment, including factors such as climate, schools, weather conditions, hobbies, religious beliefs, and entertainment. Off-the-job fit commonly occurs when an employee's life outside work, or in their community, aligns with the person's interests, values, and goals (Clinton *et al*., 2012; Mitchell *et al*., 2001, Zhang *et al*., 2012). The job embeddedness concept posits that the better the fit, in organisational and community terms, the more probable it is that the employee will stay with their job and within an organisation.

3.6.4 Links dimension

Links refer to the extent of an employee's associations with other people or activities. Links are characterised as formal and informal connections or relationships with other individuals and with the activities that take place in both the organisation and the larger community (e.g.,

membership of professional associations, community groups) (Mitchell *et al*., 2001; Reitz and Anderson, 2011). On-the-job links refer to an employee's connections within their workplace, which may include working within a team and having strong professional associations that generally make it harder for them to quit their job (Mitchell *et al*., 2001). Meanwhile, off-the-job links are defined as an employee's connections outside their workplace, which could involve community groups, institutions, or extended family (Halvorsen *et al*., 2015; Holtom *et al*., 2006). While these links may vary in number and strength, the greater the number of connections or links an employee has with the community and organisation, the greater the degree of job embeddedness an employee possesses. This means an employee who is highly embedded has typically secured many links. Research on the link dimension of job embeddedness shows that a strong connection with family and co-workers strongly affects how attached an employee is to his or her job (Prestholdt *et al*., 1987). The more links an employee has to the organisation and the community, the more deeply embedded they will be and the more likely they will be to stay.

3.6.5 Sacrifice dimension

Sacrifice refers to what an employee will have to sacrifice in terms of both organisation and community if they choose to leave/stay in their job. In other words, sacrifice relates to how easily links and fit can be disrupted (Holtom *et al*., 2006). It represents the perceived cost of material or psychological benefits that are forfeited by organisational departure, and sacrifice is therefore also known as 'switching cost'. Examples of switching costs include job-related pensions, retirement plans, and stability. On-the-job sacrifice is described as the actual or perceived psychological, social, or material cost associated with leaving an organisation (Lee *et al*., 2004; Mitchell *et al*., 2001). Typically, when an employee departs an organisation, job-related losses occur, which can include the loss of favourite co-workers, intriguing projects, and monetary and non-monetary advantages. Off-the-job sacrifice is defined as the actual or

perceived psychological, social, or material cost of leaving a community to facilitate relocation to a new work environment (Mitchell *et al*., 2001). Importantly, this component of the job embeddedness paradigm has been influenced by the earlier turnover theory provided by March and Simon (1958), which indicated that an employee's decision to leave or stay in their current job was impacted by their perception of how easy it would be to switch from their current employment to perceived career alternatives.

Although these three dimensions are interconnected and function together within the job embeddedness framework, each has a distinct theoretical mechanism explaining its individual impact. For example, strong links outside the workplace with friends, family, and the surrounding community influence staying (Zhang *et al*., 2012), as building social capital within the workplace can also do (Halvorsen *et al.*, 2010). These situations illustrate the power of links that promote intention to stay by inducing normative pressures, both on and off the job. For the fit dimension, its impact primarily depends on an individual's affinity towards their living environment, including to aspects of it such as culture, locale, and climate. This means that, as long as this affinity exists, it is reasonable to assume an individual is less likely to engage in turnover intention unless changing jobs does not require them to change their place of residence. The impact of on-the-job fit depends on the attractiveness of the workplace, when factors such as atmosphere and working conditions are perceived as a good fit by the employee (Mitchell *et al.*, 2001; Holtom *et al.*, 2008; Zhang *et al.,*2012). Research indicates that the importance of fit to intention to stay/retention should not be underestimated, especially among millennials. Furthermore, research has shown that pay and perks alone are not the only preferences that affect dimensions of fit, as employees also need to feel connected to the mission, vision, and values of an organisation and to feel that their work is contributing to something larger (Lee *et al.*, 2004a). As such, the dimension of links largely depends on an employee's number of connections while fit is conceived of as a 'cognitive belief rather than

an emotional response' (Cable and Parsons, 1999, p. 24). Lastly, decisions to leave require individuals to weigh the sacrifices they might have to make if they choose to leave. These sacrifices can be work-related, when an employee has to consider giving up a familiar organisational culture, investment made, or out-of-work factors such as their children's school (Lee *et al.*, 2004; Cunningham *et al.,* 2005). This dimension depends greatly on the nature of the benefits and resources an employee has accumulated over time, as the process can be quite complex. Turnover theories have found that the higher the perceived cost of leaving, the more likely it is that this cost will discourage the employee from leaving/making sacrifices. Therefore, job embeddedness does not reflect one's affinity with a particular organisation or job, but simply constitutes the totality of elements, both on-the-job and off-the-job, across the three dimensions of fit, links, and sacrifice, which serve to bind an individual to a particular job/organisation (Mitchell *et al.*, 2001; Lee *et al.*, 2004; Feldman *et al.,* 2012).

In general, job embeddedness theory includes everything that defines an employee's situation and experiences, including things that happen inside and outside of work. Those who are more embedded in, bound to, and have a good fit with their organisation and local community have a larger number of links in their webs, and so they have a higher level of loss or sacrifice associated with leaving. They are therefore less likely to leave an organisation (Mitchell *et al.*, 2001; Reitz and Anderson, 2011; Lee *et al.,* 2014).

3.7 Review of literature on job embeddedness

Job embeddedness was first introduced within management literature as a tool for predicting employee turnover, which was known to be a key factor in understanding 'why people stay in their jobs' (Mitchell *et al.,* 2001, p. 1102). In particular, the departure from the traditional approach, which often investigates reasons for employees leaving, to investigating the accumulated reasons for retention/employees staying, is noteworthy. In line with this approach,

researchers have investigated the predictive validity of job embeddedness and discovered that it can uniquely explain variations in employee turnover. Notably, many studies have explored job embeddedness, yielding intriguing findings. Some have also conducted meta-analyses (Jiang *et al.*, 2012) and several review papers (Holtom *et al.*, 2008, 2008; Lee *et al*., 2014) were published on this topic. Collectively, these studies concluded that job embeddedness is a strong predictor of employee retention and turnover (Mitchell *et al.*, 2001; Lee *et al.*, 2004a; Crossley *et al.*, 2007; Mallol *et al.,* 2007; Clinton, 2012; Hussain and Deery, 2018)

Among the several different studies, Mitchell *et al*. (2001) and Holtom *et al.* (2004) discovered that job embeddedness was a predictor of the intention to leave and voluntary turnover after the effects of gender, satisfaction, commitment, job search, and perceived alternatives were controlled. Lee *et al.* (2004) state that employees who are highly embedded will be motivated to continue working in their jobs and workplaces, and thus tend to produce high performance. One prominent discussion which has arisen around job embeddedness focuses on the unique effects of combining on-the-job and off-the-job embeddedness, where studies have revealed mixed results. While some studies have emphasised that on-the-job embeddedness negatively impacts turnover (Mallol, Holtom and Lee, 2007), other studies have shown that off-the-job embeddedness is also negatively related to turnover Lee *et al.*, (2004b).

3.7.1. Moderators and mediating mechanisms of job embeddedness

Mitchell *et al.*, (2001) posited that job embeddedness and turnover outcomes may vary by context or based on different sample attributes. Likewise, Johns (2006) highlighted that contextual factors could impact relationships between variables and specifically identified turnover research as particularly suitable for analysing context effects. Subsequently, Holtom *et al.* (2008) have proposed that contextual factors can be categorised at three levels: national, organisational, and individual. Based on the national level, many studies examining job

embeddedness have been conducted in several countries including United States, Europe, China, and India. Ramesh and Gelfand (2010) explored and broadened this area of research across cultures, specifically focusing on the generalisability of the job embeddedness model across different cultures. They examined turnover, primarily drawing contrasts between patterns in individualistic cultures (United States) and collectivist cultures (India). In this study, they demonstrated that job embeddedness is a viable concept that transcends western borders. They established the predictive validity of organisational job embeddedness in explaining actual turnover in India, even after controlling for numerous variables such as job satisfaction, organisational commitment, job search, and job alternatives. This finding further expanded the generalisability of the job embeddedness model by supporting its application in a different culture, adding to the growing body of cross-cultural research. The research found that job fit was more important to turnover in the United States than in India. Additionally, the study found that community links (social relationships) were emphasised more by participants from India than the United States, which linked to actual behaviour in relation to turnover. Hence, individualism-collectivism is an important cultural characteristic which may moderate the links between job embeddedness and turnover criteria (Ramesh and Gelfand, 2010). Similarly, Mallol *et al.* (2007) sought to develop and test the application of job embeddedness in Hispanic and Caucasian cultural contexts. They found that Hispanics exhibited different levels of job embeddedness from Caucasian workers. Their study suggested that Hispanics showed higher community embeddedness due to cultural influences, but the study did not show stronger organisational embeddedness.

Additionally, Lee *et al.* (2004) found that off-the-job embeddedness predicted turnover and absences, while on-the-job embeddedness predicted organisational citizenship and job performance. On-the-job embeddedness moderated the positive effect of volitional absences on turnover, the negative effect of job performance on turnover, and the negative effect of

citizenship on absences. In this study, it was specifically suggested that future research should expand its scope, further investigating why employees stay or leave, as this could enrich knowledge on retention and go beyond the current limited understanding. In fact, the author mentioned that this area of research had the potential to be particularly fruitful and interesting.

Giosan *et al.* (2005) discovered that, to boost employee embeddedness, employers should concentrate on improving organisational and supervisory support, offering training and opportunities, and establishing clear guidelines for new and remaining employees, along with encouraging the use of benefit programmes. The authors also found that, when individuals perceive fewer job alternatives, they are more likely to decline to leave the organisation, as leaving is considered to constitute a significant sacrifice in these circumstances. Similarly, another study revealed that the relationship between job search and turnover was much stronger when employees had more job alternatives and lower levels of job embeddedness (Swider *et al*., 2011).

On the other hand, Bergiel *et al.* (2009) found that job embeddedness fully mediated the relationship between compensation, supervisory support, growth opportunities, and employees' intention to quit. However, as this study only focused on convenient samples, the authors suggested that future research should look into obtaining diversified samples to achieve better generalisability (Bergiel *et al.*, 2009). Additionally, Wheeler *et al.* (2010) found that participants who perceive effective human resource management (HRM) practices and high-quality leader-member exchange (LMX) relationships have higher levels of job embeddedness. Swider *et al.* (2011) discovered the relationship between job search and turnover was more pronounced among employees who exhibit lower job satisfaction and embeddedness, and also have a greater number of alternative job options in the market. Meanwhile, Chen et al. (2010) suggested that, within an organisational context, open-mindedness and organisational

commitment positively affect knowledge workers' job embeddedness. However, their empirical findings did not establish a connection between job autonomy and job embeddedness.

Correspondingly, job embeddedness also affects the social environment at the individual level, which plays a role in retaining employees. In particular, a study by Allen (2006) showed that on-the-job embeddedness mediated the relationship between investiture socialisation tactics and turnover, by assisting newcomers to develop more links (e.g. helping them to build relationships at work, reduce uncertainty, and find structure in the new environment). This provides positive social support and makes newcomers develop a sense of competence, reducing turnover in the long run. According to another study by Felps *et al.* (2009), when multiple co-workers are actively seeking new jobs, it can make a focal employee more likely also to consider leaving their current position, as the viability and desirability of doing so become more apparent, especially since their immediate co-workers serve as natural comparisons. This 'social contagion' or 'turnover contagion' effect on turnover intentions can be quite powerful as individuals are heavily influenced by the behaviours and attitudes of their peers (Wang *et al.*, 2016; Porter and Rigby, 2021)

Moreover, some studies, such as that conducted by Harris *et al.* (2011), have used conversation resource theory (COR) to explain how leader-member exchange predicts organisational embeddedness. This study found that organisational embeddedness is a predictor for job satisfaction, turnover intentions, and actual turnover. Indeed, organisational embeddedness was discovered to be an intermediary mechanism that mediates the outcome of leader-member exchange relationships. Likewise, Wheller *et al.* (2010) suggested that employees are motivated to invest abundant resources into effort and performance to varying degrees. They found that individuals with high levels of negative effectivity and who experience shocks are less likely to remain embedded and are consequently more likely to search for a new job and engage in counterproductive behaviours. This state of embeddedness helps to buffer negative

events and reduces the probability of searching for a new job or engaging in counterproductive work behaviours. Another study by Holtom et al. (2012) found that individuals who have high levels of negative affectivity and experience shocks are less likely to remain in an organisation as they portray a low level of embeddedness. Specifically, the finding showed that embeddedness mediates the relationship between negative shocks and job search behaviours as well as counterproductive work behaviours. In a similar vein, scholars looked at individual aspects of job embeddedness also indicated demographic characteristics, particularly, gender to play a role in job embeddedness. Specifically, those study shows that men and women interpret embeddedness differently, and that as a result the relationship between job embeddedness and turnover is weaker for women compared to men (Peltokorpi *et al*., 2015). This finding was in contrast to that of Jiang *et al.* (2012) who found that embeddedness and turnover intentions were stronger among female participants in their study; therefore, paying necessary consideration to demographic factors is crucial in job embeddedness, as men and women respond to job fit, value relationships, and evaluate the risks at work differently.

Furthermore, several conceptual papers (e.g. Cohen, 2006; Holtom *et al.*, 2006, 2008; Johnson, 2007) on job embeddedness have made crucial recommendations for integrating job embeddedness into a comprehensive retention plan. Yao *et al.* (2002) clarified the concept of job embeddedness, discussed its relationship with other constructs, and highlighted methodological concerns. Meanwhile, as many job embeddedness studies have focused on domestic settings, Shen and Hall, (2009) applied job embeddedness into an international framework, and found that expatriates who feel more embedded in their jobs – meaning they perceive strong links with work, colleagues, and community were found to be less likely to leave or even explore other career options. This study also found that proper repatriation support, such as assistance in adjusting to work and country, can enhance employees' overall job satisfaction which in turn result in better retention. Other studies on individual factors

(Gong *et al.,* 2011) have included a study on the role of local dialect usage. This study found that the frequency with which individuals speak their local dialect is connected to how they identify with an organisation or community. This identification, in turn, influences their decision to stay with the organisation by enhancing their job embeddedness.

While many empirical findings suggest that embeddedness is beneficial and that employees often seek to cultivate it, there are also negative perceptions associated with it. In other words, scholar have equally articulated the potential 'dark side' of job embeddedness (Allen *et al.*, 2016). In particular, some studies have shown that embeddedness can act as a buffer, preventing negative workplace events from leading to quitting behaviour, such as being stuck in an unhealthy environment. This means, that, even though employees perceive their workplace as unfavourable – involving poor conditions, and abusive supervision, which is commonly associated with quitting – many do not quit. This is possibly due to employees feeling stuck, since it isn't straightforward for them to leave; however, these employees may go on to exhibit low performance or more counterproductive work behaviours (Holtom *et al.*, 2012; Allen *et al.*, 2016; Greene *et al*., 2018). Hom *et al.* (2012) considered this group of employees as 'reluctant stayers', as they are the cohort of employees who desire to leave but cannot due to various situations. Highly embedded employees were also shown to exhibit high levels of aggressive behaviour towards their co-workers as well as their family members and friends when they experienced bullying at work. This reaction can be seen as a coping mechanism as they seek to regain control and assert dominance in their environment (Burton, 2015).

3.7.2 Measures: the composite measure vs the global measure

As Crossley *et al.* (2007) pointed out, the composite measure of job embeddedness developed by Mitchell *et al*. (2001) has theoretical and statistical limitations. To address these issues, they created an alternative seven-item 'global' JE measure that evaluates overall attachment to the

organisation, of the type expressed in sentiments such as 'I feel attached to this organisation' and 'it would be difficult for me to leave this organisation'. According to Crossley *et al*. (2007), this global measure has two theoretical advantages. First, it allows participants to incorporate information from their own judgement, because its items assess general attachment to the organisation rather than specific aspects, whereas composite measures may omit some aspects that may be important to the individual or even include some irrelevant factors. Second, a global measure could reflect the unique value that an individual may assign to different factors when developing their overall perception. For example, some participants may view community-related factors as more important than job-related factors when forming perceptions of embeddedness. In this scenario, when utilising a global measure, an individual could report their embeddedness perception by primarily evaluating community-based factors, whereas, when factors are combined additively in a composite measure, the final score of embeddedness is the average of job-related and community factors, which may fail to account for the unique weightings of these factors. Thus, the global measure they developed could predict employees' intentions to leave their jobs and actual turnover, even after accounting for the impact of the composite measure and organisational attitudes. Therefore, Crossley *et al*. argued that their global measure provides a concise alternative to the original composite measure. However, their global measure does not include items that explicitly refer to factors occurring outside the immediate work environment, which is to say the off-the-job factors that were important elements of the initial theory. In response to this limitation, Crossley *et al.* (2011) argued that community embeddedness is indirectly covered in their global measure. This is because the instructions for the measure ask respondents to evaluate job embeddedness as a whole, considering factors that are both work-related (e.g. links at work, job fit) and non-work-related (e.g. family, hobbies).

Compared to the global measure, the composite measure is theoretically richer and contributes more insights because it explicitly incorporates non-attitudinal and off-the-job components. Zhang *et al.* (2012) and also Mitchell *et al.* (2001) argue that the job embeddedness construct places emphasis on non-attitudinal characteristics, and particularly the component of links. While fit and sacrifice capture individual perceptions, the composite measure emphasises the cognitive content of specific facts. For example, employees might recognise a cognitive alignment between their skills and their jobs, even though they might have less attachment towards their organisation (e.g. feeling that their job utilises their skills and capabilities well, even though the organisation is less positive). In this case, the global measure captures a more general reaction, which may combine emotional and attitudinal components.

Additionally, non-work factors and their importance have been emphasised by many scholars (Steer and Mowday, 1981; Hom and Kinicki, 2001; Price, 2001), and the construct of job embeddedness is the first attempt to represent a broad overview of off-the-job influence on employee retention on a significant scale (Mitchell *et al*. (2001). For instance, Price (2001) argues that kinship responsibility is a significant predictor of turnover, with its measure including items such as marital status, childcare responsibilities, and surrounding community. On the other hand, Lee *et al.* (2004) suggest that kinship responsibility is conceptually and empirically similar to the links component of community embeddedness. However, job embeddedness extends the content of kinship responsibility, because off-the-job embeddedness additionally contains fit and sacrifice related to community.

Based on research conducted on organisational and community embeddedness, community embeddedness has been shown to be limited with inconsistent findings and can even be considered to be an unstable predictor of turnover (Mitchell *et al.*, 2001). In a sample of healthcare workers, all three dimensions of community embeddedness – community links, fit, and sacrifice – were negatively associated with turnover. However, only community links (and

not fit and sacrifice) were negatively associated with turnover in a sample of grocery store workers (Terence R. Mitchell *et al.*, 2001). Besides that, other studies (e.g. Crossley *et al.*, 2007; Mallol *et al.*, 2007; Ramesh and Gelfand, 2010) based on three dimensions (fit, links and sacrifice), did not reveal a significant relationship between community embeddedness and turnover. Two studies (Terence R. Mitchell *et al.*, 2001; Lee *et al.*, 2004b) found a significant negative relationship between total community embeddedness, averaged across the three dimensions, while other relevant studies did not find any relationship between total community embeddedness and actual turnover (Allen, 2006; Crossley *et al.*, 2007; Mallol, Holtom and Lee, 2007; Ramesh and Gelfand, 2010).

Next, there is also inconsistency in findings based on links. Some studies have found a negative relationship between links and turnover (Mitchell *et al.*, 2001; Lee *et al.*, 2004b), yet other studies have not found any such association (Crossley *et al.*, 2007; Ramesh and Gelfand, 2010). Exceptionally, (Mallol *et al.*, 2007) found an association between organisational links and turnover, but not community links and turnover.

Based on the findings of prior research (Holtom *et al.*, 2008; Hom *et al.*, 2010), there are some conceptual and measurement issues related to links. Firstly, more links do not necessarily translate into higher embeddedness, as some links may result in overload and conflict. Also, more community links may increase turnover by exposing individuals to more job offers or information about other positions. Therefore, it shouldn't be concluded that more links equate with higher embeddedness. This is because certain links are more important than others. Research has indicated that not much attention has been paid to comprehending the quality and depth of links (Price and Mueller, 1981; Hom and Kinicki, 2001). Therefore, further research is required to shed light on the depth of links and how both organisational and community links relate to characteristics such as size, strength, range, network density, centrality, network

constraint, and structural equivalence, to produce different effects on job embeddedness (Terence R. Mitchell *et al.*, 2001).

Hence, focusing merely on the number of links is not a sufficient strategy for measuring the objective connections that embed employees. Research suggests that future research should assess the depth and quality of the way people are connected. Four key areas have been suggested, including the number of weak ties (weak connections), and the extent of structural holes (limitation in characteristics, network/connection range and status) (Zhang, Fried and Griffeth, 2012).

Job embeddedness theory has inspired recent interest among scholars who are seeking to gain new insights into the retention process (Mitchell *et al.*, 2001; Lee *et al.*, 2004a; Ng and Feldman, 2009; Hom *et al.*, 2010; Feldman, Ng and Vogel, 2012; Burton, 2015; Allen *et al*., 2016; Greene *et al.*, 2018) and the results and findings are encouraging; however, the construct remains underdeveloped (Jiang *et al.*, 2012). Although there are a few exceptions, the scope of most research has been limited to empirical testing of potential outcomes of job embeddedness. There is still a need for further development in the conceptualisation and measurement of the theory.

Moving forward, this research further develops the understanding of job embeddedness theory by utilising the composite and global measures as foundational guides. Specifically, it explores a less examined area within job embeddedness which is the qualitative measures to expand the theoretical framework through a new lens of investigation. By offering a sentiment-driven perspective, this study seeks to contribute comprehensively to the understanding and application of job embeddedness theory. In particular, the study delves deeper into both on-the-job and off-the-job embeddedness by focusing on organisational and community embeddedness and their dimensions of fit, links and sacrifice (see Figure 3) for hospital

dcotors. Importantly, rather than merely quantifying these dimensions, the research explores their qualitative aspects, offering a more in-depth, extensive and nuanced understanding of this area. This approach not only contributes to a richer theoretical development but also enhances the understanding of the core constructs of embeddedness – fit, link and sacrifice quality over quantity.

3.8 Organisational embeddedness and community embeddedness

3.8.1 .Organisational embeddedness

The concept of job embeddedness has evolved over time. Ng and Feldman (2007) introduced the concept of organisational embeddedness as a measure to comprehend the totality of organisational forces that keep people in their current employment. Organisational embeddedness refers specifically to the extent to which employees feel connected to and integrated in their organisation. In other words, it focuses on the social and relational connections individuals have within specific organisations beyond the scope of their job alone. It recognises that employees' ties to their organisations play a significant role in their decisions to stay in their jobs (Ng and Feldman, 2007). Organisational embeddedness encompasses *'fit'*, which assesses an individual's abilities and interests along with organisational requirements and rewards – the greater the perceived compatibility, the greater the individual's integration within the organisation. *Links* relate to the level of individual relationships and activities of an individual within their workplace (i.e., friendships, task interdependence). The more connections someone has within an organisation, the more likely they will be to stay. Lastly, *sacrifice* relates to the total losses an individual would experience by leaving their organisation. This includes tangible employee benefits such as retirement benefits, sick leave, and education loans, and so this component involves individual risk assessments. The greater the perceived

cost of departing, the deeper the individual's commitment to the organisation, which will make them stay to enjoy and appreciate the perks (Ng and Feldman, 2009).

3.8.2 Community embeddedness

The concept of community embeddedness, which focuses on non-work-related aspects of an employee's life and their relationship with the surrounding community, similarly emerged as an extension of the main theory of job embeddedness. Community embeddedness explores the extent of the social connections and involvements individuals have with the communities in which they live (Ng and Feldman, 2014). This concept is meant to include 'non-work factors', as it includes elements not directly related to a person's job. Community embeddedness reflects the fact that individuals could be strongly embedded or choose to stay in their jobs, not specifically because of job or organisational reasons, but also because of non-work factors which reflect communities' influences, including relationships, interactions, and institutions, as these dimensions play an equally important role in shaping an employee's attitudes and behaviours (Mitchell *et al.*, 2001; Ng and Feldman, 2014). An employee's connection and attachment to the broader community can be evaluated through *fit*, which refers to the degree to which individual personal characteristics, values, and goals align with those of the community. *Fit* can also relate to the compatibility between the individual and the community in terms of shared beliefs and norms. When an individual perceives a high level of fit with a community, they experience a sense of belonging and form an identity which results in them being more likely to stay in their job due to their engagement with the community and its activities. *Links* refer to the individual's relationships and connections within the community, most notably, the social ties and networks an individual has with their friends and family, as well as with institutions like schools and church activities. Generally, stronger links indicate a higher level of integration in the community. Finally, *sacrifice* represents what an individual is willing or not willing to forgo if they choose to leave the community (i.e., family, children's

school). The higher an individual perceives their level of sacrifice to be, the more likely they are to not give up their job based on their level of embeddedness in their community.

3.9 Job embeddedness in healthcare research

Author & Date	Research Design	Sample	Findings
Reitz, Anderson and Hill (2010)	Cross-sectional survey	357 registered nurses	JE was significantly related to nurse retention. Typically, the more embedded nurse feels in their job (through fit, links towards organisation and community) the more likely they will stay.
Mitchell *et al.* (2001)	Cross-sectional survey	700 grocery store employees & 500 hospital employees (150 nurses, 350 non-clinical staff members).	JE was demonstrated to be a better predictor for voluntary turnover compared to other factors (i.e., job satisfaction, organisational commitment, job search behaviour, and job alternatives), and the influence of JE on retention was shown not to be limited to a specific group, as it was found to have similar effects among nurses and other non-clinical healthcare workers.
Valle *et al.* (2016)	Surveys	183 Paediatric Emergency Medicine (PEM) physicians.	JE – a composite construct comprising elements related to individual links (work/family, career stage, hospital setting) to others and the organisation, fit perceptions (job fit) and perceptions of the sacrifices (salary, benefits) associated with job transition – was shown to correlate negatively with PEM physicians' intentions to leave their jobs.
Holtom and O'Neill, (2004)	Longitudinal (2time) survey	500 (150 nurses and 350 admin employees) in a community hospital in the US.	Organisational and community embeddedness were important factor for nurses. Job embeddedness predicts turnover more accurately than other indicators such as job satisfaction, organisational commitment, job alternatives, job search.
Sun *et al.*, (2012)	Cross-sectional survey	1000 nurses in five university hospitals in Heilongjiang province in China.	The study showed a strong relationship between the self-reported psychological capital, job embeddedness, and performance of the nurses surveyed. Nurses with positive attitudes readily relate to, integrate with, and are competent in their positions within the organisation and at work. As a result, nurses are more inclined to remain with their existing employer.

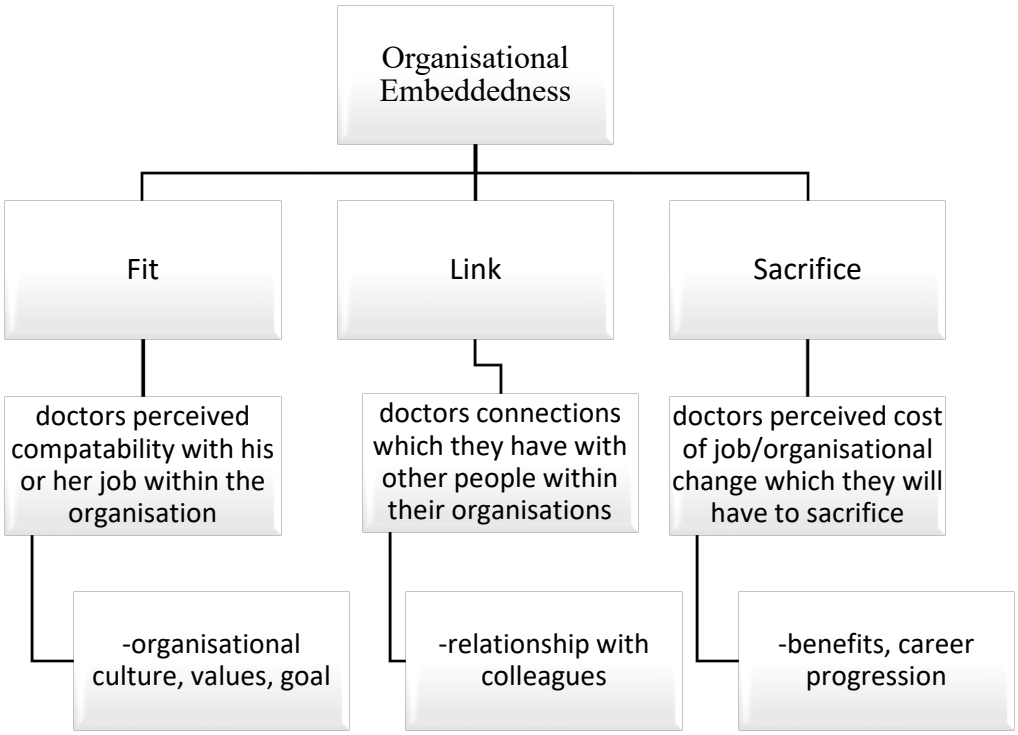
Hopson *et al*., (2018)	Mixed method study (survey and focus group)	584 nurses from a mid-sized, urban, community teaching, acute care facility.	The factors that best predicted job embeddedness were found to be older age, community links, and peer relationships. The study suggested that, by concentrating on elements that motivate nurses to remain in their employment, healthcare professional development practitioners may have an influence on retention.
Fasbender *et al*., (2019)	Hierarchical multiple regression and simple slope analyses	361 NHS nurses in the UK.	When off-the-job embeddedness was high (vs. low), there was a larger negative connection between job satisfaction and turnover intentions. Intentions to leave the job were strongly correlated with job stress, but this correlation was mitigated by high (vs. low) off-the-job embeddedness.
Halfer, (2011)	Longitudinal study	191 paediatric registered nurses,	Community embeddedness did not provide a salient reason for retention. Younger nurses, those who have low job fit – were more likely to leave.

Table 3: A summary of job embeddedness research in healthcare

Among the above studies, only one, the work by Valle *et al.* (2016), fully focused on hospital doctors. It illustrated that an individual doctor's links to others in the workplace, their fit with their job, and the sacrifice resulting from quitting their role and how all these impacts their decision to stay or leave. More specifically, this study found that, although doctors were not satisfied with the extra shifts (nights, weekends, and holidays) and the non-clinical work in their job (administrative aspects), they highly appreciated the fit with their job skills, and especially the intrinsic rewards that came with working as a hospital doctor (they strongly appreciated the meaningful impact of their contribution). Beyond this, no studies have specifically investigated JE in relation to the retention of hospital doctors. Meanwhile some other studies have focused on healthcare workers and specifically on nurses (Holtom and O'Neill, 2004, p. 200; Sun *et al.*, 2012; Hopson *et al.,* 2018; Fasbender *et al.,* 2019). But they have failed to acknowledge the crucial distinction between doctors and other healthcare workers, arising from the fact that ultimate responsibility for care lies with doctors alone.

Therefore, it is important to better comprehend job embeddedness within the healthcare context, and particularly in relation to hospital doctors.

As mentioned in Chapter One, this thesis adopts a qualitative approach to examining the level and nature of embeddedness among hospital doctors and its impact on their intention to stay within the Irish healthcare system. In order to do this study will independently investigate work-related (organisational) and non-work-related (community) factors. By investigating distinct aspects of organisational and community embeddedness, this research seeks to gain a profound understanding of their respective influences on doctors' retention in the context of intentions to stay in their jobs within their organisations. The implicit investigation of the interplay between doctors' work and non-work factors, understood in terms of both organisational and community embeddedness, will hopefully deliver in-depth insights into the factors that significantly impact on doctors' intentions.



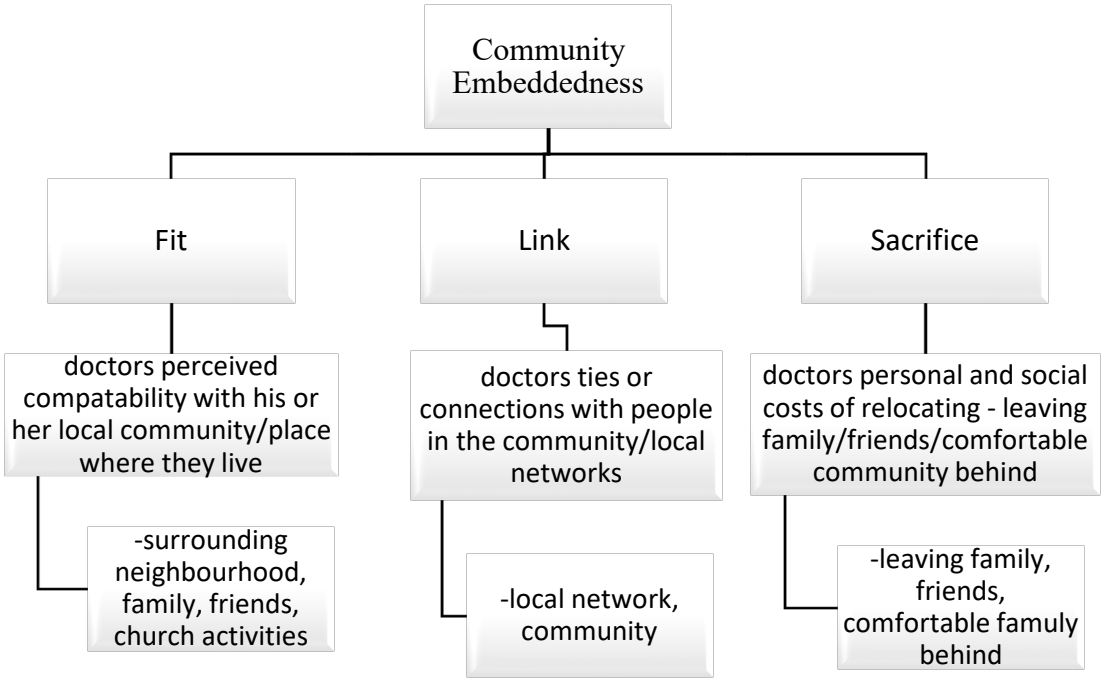


Figure 3: Visual presentation of job embeddedness theory

3.10 Summary

In conclusion, this chapter has comprehensively explored the multifaceted aspects of hospital doctor retention and turnover, illuminating the complexity of these phenomena through a detailed examination of the existing literature. It has highlighted the significance of understanding both concepts not as binaries but as part of a nuanced continuum where factors contributing to retention and turnover may differ and interact in complex ways. The review has highlighted the pivotal role of job embeddedness theory in enhancing our comprehension of why hospital doctors choose to remain in their positions, emphasising the importance of both work-related and non-work-related factors in influencing their decisions. Through exploring the dimensions of fit, links, and sacrifice, this chapter has articulated a clear rationale for the further investigation of job embeddedness theory within the healthcare context, especially concerning hospital doctors. The literature review has identified gaps in the current research, particularly the need for a more profound understanding of the reasons behind doctors' intentions to stay in their job. This exploration is critical for developing effective strategies to

improve doctor retention. As this thesis progresses, it aims to contribute to this body of knowledge by examining the level and nature of embeddedness among hospital doctors in the Irish healthcare system, offering valuable insights into how their retention can be enhanced through strategic organisational and community engagement.

CHAPTER 4

Methodology

4.1 Introduction

This chapter details the research methods used in this thesis and explains how the present research has been carried out. The first section discusses the philosophical underpinnings and paradigms that have shaped the study. The chapter then explains the key details of the study's research design, pilot study, sampling processes, data collection methods, ethical considerations, and data analysis process.

4.2 Philosophical underpinnings

The general orientation of this research is linked to an underlying philosophical position, which influenced the methodology utilised. According to Lincoln *et al.*, (1985, p. 105), research philosophies are centred around paradigms and can be defined as 'the basic belief system or world view that guides the investigator, not only in choices of method but in ontologically and epistemologically fundamental ways.' As Creswell and Creswell (2018) argue, paradigms in the human and social sciences help us understand phenomena. This research sits within the constructivist paradigm which focuses on the intention to understand 'the world of human experience' (Cohen *et al*., 2002, p. 36). This is appropriate given that the focus of this research is on the lived experiences of junior hospital doctors (Denicolo *et al.,* 2016). The central assumption of this paradigm is that reality is socially constructed, that individuals interpret their experiences subjectively, and that this leads to the emergence of multiple meanings (Young *et al*., 2009; Creswell and Creswell, 2018). Typically, the constructivist paradigm embraces a relativist ontology which posits that there is no objective reality but that realities are comprehensible and manifest 'in the form of multiple, intangible mental constructions, which are socially and experimentally based, local and specific in nature, and dependent in their form and content on the individual persons or groups holding the constructions' (Lincoln *et al*., 1985, p. 110). The constructivist paradigm relies on a transactional and subjective

epistemology (Cresswell *et al.*, 2019) and the participant and researcher have close and dynamic interactions (Lincoln *et al.,* 1985).

Methodologically, the constructivist view supports a hermeneutical approach (Bryman, 2016) which assumes that meaning is concealed and must be brought to the fore through deep reflection (Schwandt, 2000). This process can be stimulated through an interactive dialogue between the researcher and the participant. According to Guba & Lincoln (2005, p. 196), the researcher takes on the role of a 'passionate participant' and acts as a facilitator of multi-voice reconstructions during the data collection process to bring a subject matter to life. Within this study, data on lived experiences were gathered from participants who were junior hospital doctors in the Irish public health sector, and the researcher generated insights based on their unique and personal experiences, with the ambition of uncovering deeper meanings and perceptions through the analysis of semi-structured interviews.

In this study, a philosophical approach was applied that recognises the importance of understanding hospital doctors' organisational (on-the-job) and community (off-the-job) embeddedness through the lens of their individual lived experiences. This research angle specifically focused on the first-hand experiences of the doctors involved. In alignment with the philosophical orientation of this study, it is acknowledged that the reality of the participant doctors' experiences is socially constructed and is open to many reconstructions and interpretations, and so the researcher's role involves the interpretation and presentation of the participants' views or perceptions.

4.3 Research design

According to Barkin (2008), qualitative research evokes a narrative or analytical richness that brings out more detail and a nuanced understanding. In qualitative research, meaning is understood as 'an intricate fabric composed of minute threads, many colours, different textures

and various blends of material' (Creswell, 1998, p.13). Qualitative research involves an interpretive and naturalistic approach to studying subject matter in the real world setting (Denzin and Lincoln, 2011; Moser and Korstjens, 2017), and it allows for complex social phenomena to be viewed holistically, which typically suits the constructivist approach (Young *et al.,* 2009). Morrow (2007, p. 215) explained that the qualitative method 'begins inductively as the research works to understand the meaning of participants.' Exploratory research aims to uncover, describe, and better comprehend what lies behind a phenomenon, and it is usually carried out when little is known about a domain or situation, or when insight is lacking into a target populations' own opinions, thoughts, and behaviour associated with a topic (Stebbins, 2001; Gephart, 2004; Creswell and Creswell, 2018). This approach is considered particularly suitable when an ongoing issue or problem needs to be explored in further detail and when the researcher seeks to obtain a comprehensive understanding of an issue (Young *et al.,* 2009; Creswell and Creswell, 2018).

The qualitative approach implemented in this study looks to provide insights into the organisational (on-the-job) and community (off-the-job) experiences of hospital doctors, as well as doctors' experiences throughout the COVID-19 pandemic. It seeks to understand how these experiences, in turn, impacted doctors' embeddedness in their organisation and communities and their intention to stay (Mitchell *et al.*, 2001). Qualitative methodologies were considered best suited to this study, as they would support an in-depth understanding of the situation from the doctors' own points of view, in the context of their everyday life realities, and allow for discussion of the phenomenon at hand to unfold naturally (Gephart, 2004; Denzin and Lincoln, 2011). Qualitative analysis provided a suitable way to improve clarity around my research questions, which mainly focused on how and why questions, and it also allowed for the capture of a high level of detail. Importantly, qualitative research helped generate rich descriptions, insights, and understanding of human interactions, meanings, and processes

which would have been difficult to capture through quantitative research processes. Although quantitative research has been widely used in scientific research, it sometimes falls short in capturing the complexity of human communication. This can happen when it tends not to recognise the intricacies and dynamic nature of authentic communicative contexts (Damico, 1993; Tetnowski and Damico, 2001). In other words, quantitative research does not always support an understanding of the complex, dynamic, and multi-dimensional aspects of a phenomenon (Sofaer, 1999). Research using qualitative methods can produce details and descriptions of lived experience (i.e., emotions, perspectives, beliefs, values, actions, and behaviours) to help add context to participants' responses (Cypress, 2015). This was important in the case of this study, where the aim was to gather doctors' responses concerning the given situation from their own points of view. It is perhaps worth noting that there is growing emphasis on the importance of qualitative research findings in healthcare, as researchers and policymakers, along with healthcare professionals, are under growing pressure to apply their insights to real-world settings and assess their efficacy in bringing about desired changes, enhancing public health, and mitigating healthcare delivery inequalities (Sandelowski, 2004).

Additionally, given the limited qualitative research available on the retention of hospital doctors in the existing literature (Seathu Raman *et al.,* 2024) this study employed an exploratory approach to conduct a qualitative, in-depth analysis of the retention of junior hospital doctors in the Irish public healthcare system. Apart from being the less explored methodology, the qualitative approach is deemed suitable for this research as it serves the purposes of the study, which is to mainly obtain information from the personal views of participants, interpret their meaning, and relate them to themes (Morrow, 2007; Morgan, 2013). Moreover, by adopting a phenomenological approach, which seeks the meaning, structure, and essence of the lived experiences of a specific phenomenon, the researcher aims to gain a comprehensive/deeper understanding of doctors' experiences. Thus, the qualitative method is

the most appropriate choice for addressing the research questions, as it prioritizes capturing participants' perspectives and perceptions, which are central to understanding the essence of doctors' lived experiences.

Nonetheless, job embeddedness theory has predominantly been explored through quantitative research, with most studies utilising quantitative analysis (Ghosh and Gurunathan, 2015). However, integrating a qualitative approach into this traditionally quantitative framework offers an opportunity to investigate the less explored and understudied dimensions, thereby contributing to the theory's development and refinement (Bradbury-Jones *et al.*, 2014). Such an approach allows for a deeper understanding of contextual factors, particularly focusing on the three constructs of fit, links, and sacrifices. While quantitative studies often involve standardized variables applied across large populations, they may overlook context-specific factors that may influence job embeddedness. Some studies have highlighted the limitations of this approach, particularly the heavy reliance on questionnaires (i.e. self-report surveys) with convenience samples. However, it is due to the standardised questionnaires which may at times lead to invalid conclusions (Holtom and Inderrieden, 2006; Crossley *et al.*, 2007). Qualitative research addresses this limitation by providing richer, more detailed explanations of both work and non-work-related settings. Specifically, by examining the lived experiences of participants, qualitative research can identify gaps or limitations in the current theoretical framework and propose a new understanding, constructs, and relationships. Additionally, the identification of emerging themes can help explore new and useful dimensions of job embeddedness which may not be captured by quantitative measures. For example, qualitative findings (i.e. themes) may reveal factors that contribute to an employee's decision to stay that are not adequately captured by standardized surveys. In other words, a qualitative approach not only elucidates the reasons behind correlations but also adds depth to understanding of them, offering a more comprehensive perspective (Lee and Mitchell, 1994; Barkin, 2008; Morgan, 2013). This

underscores the importance of context and subjective interpretation in the study of job embeddedness. In addition, building on the discussion in Chapter 3, on measures, this study aims to extend theoretical development through a qualitative approach. By doing so, it will address the gap in the literature that has overly focused on quantifying constructs, such as the number of links or fit, without adequately exploring their quality (Zhang et al., 2012). This approach will enable a deeper understanding of the nuances related to fit, links, and sacrifice, moving beyond mere numerical assessment to provide richer insights.

The method of inquiry employed for this study was the qualitative in-depth, semi-structured interview technique (a one-to-one approach, conducted either face-to-face or online – more details on this study's data collection processes are provided in the section below). A semi-structured interview approach was preferred in this study, as the primary goal was to better comprehend participants' unique perspectives on the issue investigated rather than to arrive at a generalised understanding of a phenomenon. Moreover, this method of interviewing allows greater flexibility, enabling the researcher to explore pertinent topics that may emerge during the course of the interview, thereby further adding to comprehension of the issue investigated (McGrath *et al.*, 2019; Adeoye-Olatunde and Olenik, 2021). It is important to note that the initial plan was to conduct in-person face-to-face interviews. However, due to COVID-19 pandemic regulations (i.e., lockdown and social distancing), the study took an alternative approach that involved the use of online interviews. This method still enabled the researcher to comprehend doctors' thought processes, with the ultimate goal of generating research findings that illustrated or facilitated the interpretation of their experiences (Reeves *et al.*, 2008; Ruel, 2017). According to Merriam (2009), the primary objective of this research process is to understand how people describe or convey their experiences and the meanings that they attribute to those experiences. In essence, this method enables each participant to speak for themselves and reveal the meaning behind their thoughts/behaviours. It is hoped that, by

utilising this approach, this study has generated an in-depth/detailed understanding of hospital doctors' unique experiences and their attitudes towards their work and non-work experiences, as well as how these experiences shape their intentions to stay in their jobs.

4.3.1 Participants and sampling procedures

As discussed in Chapters 1 and 2, the study focused on a research sample consisting of junior hospital doctors from the Irish public sector, commonly known as non-consultant hospital doctors (NCHDs). To achieve a somewhat homogenous sample of junior doctors, certain inclusion criteria were employed. Participating junior doctors were required to:

i) be attached to the public health system Ireland/the Health Service Executive (HSE),
ii) hold a valid Irish Medical Council (IMC) registration,
iii) be either a trainee doctor who was pursuing a postgraduate training program or a junior doctor working in a non-trainee contract position,
iv) not be involved in any private sector or locum jobs, and
v) have a minimum of one year of experience within the Irish public health system (to ensure a reasonable level of experience and exposure to both work and non-work-related experiences).

These inclusion criteria were imposed to ensure that the study focused on choosing doctors who could provide targeted insights addressing the research study's questions, aims, and objectives (Young *et al*., 2009; Robinson, 2014).

Guided by these criteria, a multi-tiered participant recruitment strategy was employed, which was primarily purposive. This was followed by an opportunistic approach in the form of snowballing. Purposive sampling was mainly employed in order to choose participants who were very likely to provide relevant information (Kelly *et al., 2*010) This sampling method was deemed to be particularly suited to the aims and objectives of this study, as it allows the

deliberate and strategic choice of participants, moving away from random forms of sampling to ensure that specific kinds of participants are included, based on inclusion and exclusion criteria, to help shed light on the study's questions (Mason, 2010; Robinson, 2014). In line with this approach, the researcher identified people who would be most appropriate to the research based on the research objective (Tongco, 2007).

After conducting several initial interviews arranged through purposive sampling, snowballing sampling was then implemented. Snowball sampling mechanisms share the characteristics of networking and referral (Sheu *et al.*, 2009), and, in the context of this study, the doctors who had been interviewed in the first stage proposed or suggested colleagues or other junior doctors who matched the criteria deemed suitable for the research (Parker *et al*., 2019). This technique helped to improve the sample size, and it was especially helpful in providing ways to attract doctors from hard-to-reach populations, such as those who were not active on social media. In other words, this method helped the researcher to obtain data which would otherwise have been difficult to obtain without the involvement of participants to whom the researcher had no personal access. The significance of this method was heightened during the COVID-19 pandemic, when the junior hospital doctors who constituted the main focus of this research were at the forefront of the battle against the pandemic and were extremely busy and difficult to reach (Kennelly *et al.*, 2020). Hence, using the snowball method made it possible to identify a greater number of doctors who potentially fitted the research criteria than would have been possible through purposive sampling alone. Furthermore, the additional doctors interviewed thanks to snowball sampling also contributed to the study achieving data saturation. Overall, the use of purposive and snowball sampling techniques was highly effective in this study, as it allowed the researcher to identify a strong pool of potentially relevant respondents in a timely manner (see Table 1).

Participants were recruited through online platforms, including social media applications such as Facebook, LinkedIn, and Twitter, which were used to identify junior hospital doctors working within the Irish public health system. Several searches were conducted using terms such as 'NCHD Ireland/junior hospital doctors Ireland', and various doctors' groups were also identified (i.e., 'doctors4lifeireland', 'Irish Medical Org NCHDs', 'trainus4Ireland', 'Doctors in Ireland' groups). Training-focused and specialty groups on social media were also utilised to locate potential participants. The researcher subsequently reached out to these potential participants through direct messages on relevant social media platforms. In these messages, the researcher introduced herself, provided the background of the study, and requested the potential participants' email addresses if they expressed interest in discussing the research in more detail. Additionally, a call for research participants was posted on these social media platforms, garnering attention and shares from many users. All the people who responded to this call were then replied to individually, and those potential participants who were keen to participate were provided with more details about the research through email. As per the initial protocol, the potential participants who had been referred to the researcher by the other participants were subsequently contacted via email, and details of the study were shared with them. These methods were found to be effective and they resulted in the recruitment of sufficient hospital doctors (who were from diverse demographic backgrounds, specialties, and hospital locations). Following the initial contact made for the research study, several potential participants were approached, and a variety of responses were received. The number of interviews was not pre-defined prior to the data collection stage of the study. Rather, the sample evolved in line with the study until the data reached saturation point. While some participants expressed keen interest in participating, some declined, citing concerns about confidentiality, despite the assurances provided by the researcher. Among the participants who declined, several indicated a loss of interest in, or hope related to, being involved in anything related to their work, as they

perceived that their current employment with the Health Service Executive (HSE) in Ireland was temporary and thought that their career goals lay elsewhere. Some participants expressed the view that they had given up on the prospect of improvements as their working conditions were so poor and were continuing to deteriorate.

A total of 31 participants were recruited for this study, comprising a mix of trainee and non-trainee, Irish and international, female and male doctors of various ages, with different specialties, from rural and urban public hospitals across Ireland. This number was considered sufficient since qualitative research sampling often involves modest sample sizes, as the primary focus is to acquire comprehensive insights into individual experiences (Miles and Huberman, 1994) and richness and depth of data is prioritised over volume (Carey, 1995). Priority was given to interviewing a diverse sample size consisting of junior hospital doctors with varied backgrounds and experiences. The researcher also placed strong emphasis on achieving saturation which was achieved at 31 interviewees. At this stage, no new substantial information was uncovered in additional interviews (Young *et al*., 2009). Data saturation is generally deemed to have been achieved when there is no new data, no new themes, no new coding, and the ability to replicate the study has been reached (Guest *et al.*, 2006).

Following is the demographic of participants whom this study interviewed:

No	Age	Sex	Marital status	Children	Speciality	Job Status	Hospital	Nationality
1	34	M	Married	No	Obs-Gynae	Trainee	Urban	International
2	36	M	Married	Yes	Anaesthetist	Trainee	Urban	Irish
3	35	F	Married	No	Surgery	Trainee	Urban	Irish
4	31	F	Partner	No	Paediatrics	Trainee	Urban	Irish
5	34	M	Married	Yes	Psychiatry	Trainee	Urban	International
6	38	F	Single	No	Obs-Gynae	Non-Trainee	Rural	International
7	32	F	Married	Yes	Paediatrics	Non-Trainee	Rural	International
8	34	F	Partner	No	Obs-Gynae	Trainee	Urban	International

9	40	M	Married	Yes	Emergency Medicine	Non-Trainee	Urban	International
10	33	F	Partner	No	Psychiatry	Trainee	Rural	International
11	42	F	Single	No	Emergency Medicine	Trainee	Urban	International
12	33	M	Single	No	Anaesthetist	Trainee	Urban	Irish
13	39	M	Married	Yes	Surgery	Non-Trainee	Urban	International
14	34	M	Partner	No	Microbiology	Trainee	Urban	International
15	40	F	Partner	No	Surgery	Trainee	Urban	Irish
16	34	M	Married	Yes	Paediatrics	Non-Trainee	Urban	International
17	31	M	Married	Yes	Paediatrics	Non-Trainee	Urban	International
18	27	F	Partner	No	GP Trainee	Trainee	Rural	International
19	33	F	Single	No	Internal Medicine	Trainee	Urban	Irish
20	38	M	Partner	No	Surgery	Trainee	Urban	Irish
21	45	F	Married	Yes	Psychiatry	Trainee	Urban	Irish
22	32	F	Married	Yes	Psychiatry	Trainee	Urban	Irish
23	36	F	Partner	No	Psychiatry	Trainee	Urban	Irish
24	35	F	Single	No	Anaesthetist	Trainee	Urban	Irish
25	30	F	Single	No	Obs and Gynae	Trainee	Urban	Irish
26	29	M	Partner	No	Surgery	Trainee	Urban	Irish
27	26	F	Single	No	Internal medicine	Trainee	Urban	International
28	32	F	Married	No	Paediatrics	Non-Trainee	Urban	
29	40	F	Single	No	Surgery	Non-Trainee	Urban	International
30	41	F	Married	No	Paediatrics	Non-Trainee	Urban	International
31	27	M	Single	Yes	Anaesthetist	Trainee	Urban	Irish

Table 4: List of participants

4.3.2 Data collection: the interview process

Qualitative research involves using naturalistic and flexible methods for collecting data. This means that standardised research instruments are typically not implemented (Lodico *et al.*, 2010). This type of approach offers notable benefits in exploratory research, especially when

exploratory interview questions and probing techniques are used. When conversation-based research is conducted, participants' experiences, opinions, and perspectives are elicited (Young *et al*., 2009; Rubin and Rubin, 2011). In this study, the participants provided responses to interview questions using their own words. This approach yielded more meaningful and explanatory answers which could not have been anticipated by predefined responses. In line with the exploratory nature of this study, the in-depth, semi-structured interview method granted the researcher the flexibility needed to elicit deep and reflective participant responses. In order to encourage in-depth answers, the researcher was careful to listen intently to the participants and responded appropriately to their cues. Moreover, interviews were conducted with only the researcher and participant present to provide a comfortable environment for the participant. The questions were semi- structured, with formal and follow-up questions organised around a set of predetermined open-ended questions, and selective probing followed to cover the main questions set out in the interview guide.

According to Gray (2014), a standardised interview structure is advisable during an interview to maintain study reliability. Therefore, an interview guide (see Appendix) was developed and used. This interview guide provided an outline and protocol for the researcher to follow during the interview process. The interview guide was prepared by the researcher, and it was subsequently reviewed and approved by the supervising team. The interview guide was designed to align with the study objectives and aims (Pedersen *et al.*, 2016), and it consisted of both broad and specific questions that facilitated a natural conversation during the interview. However, although the interviews were part-guided, flexibility during interviews was paramount. This was because the study focused on gathering enough exploratory data related to doctors' lived experiences, which meant that doctors had to be encouraged to elaborate and provide examples rather than being cut short and encouraged to focus purely on the core of question asked.

It is also important to note that, before the interviews began, a couple of pilot interviews were conducted. According to Sampson (2004), pilot interviews are necessary as they can highlight any issues that might exist with the research tools and/or the interview questions, allowing the researcher to make any necessary adjustments before the main set of interviews begin. For this study, pilot interviews were conducted with three participants (not included in the main study sample or figures) to determine whether or not the study instrument and the interview guide were suitable, understandable, and appropriate. After the pilot interviews were completed, the interview guide was refined and improved, mainly through the introduction of additional questions which distinguished between participants' work and non-work experiences. It is crucial to highlight that the information obtained from the pilot interviews was only used to reflect on, evaluate, and enhance the interview protocols and implement necessary adjustments, which means that the information gathered from these preliminary interviews was not included in the data analysis phase.

Following the recruitment of participants, the interviews were conducted at a date and time agreed upon by the participant and the researcher. Interviews were conducted via Microsoft Teams. Login details and a link were sent to each participant's email. Before the interview began on the interview date, the study's objectives, informed consent, the interview process, and confidentiality details had been discussed, allowing the participant to ask any relevant questions. Upon completion of these steps, the interview commenced with guided questioning by the researcher, followed by additional probes and clarifying questions, which were used at the discretion of the researcher to improve the understanding of the answers shared.

All interviews began in the same way with all doctors. Questions tended to focus at the outset on the discussion of contextual information about doctors' personal backgrounds (i.e., about themselves, their educational backgrounds, length of service, descriptions of their roles and responsibilities, and their motivations behind choosing the Irish healthcare system).

Subsequent questions explored doctors' broader perceptions of the medical profession, encompassing the advantages, disadvantages, and overall job satisfaction they were experiencing.

The interview schedule also contained questions that were framed so as to explore organisational and community embeddedness (on-the-job and off-the-job) factors. The researcher transitioned into asking organisation-related questions which related to participants' current work experiences, including their working environment, conditions, the nature of their departments/specialisms, hospital size, job role, workload, working hours, task complexity, job-related challenges, and job quality after simple questions relating to the person being interviewed. Overall, these questions sought to establish an understanding of each participant's typical day at work and their perception of job manageability. In a similar vein, doctors were asked about their level of autonomy at work, the support they received (i.e., supervisory and management support), and views on remuneration and benefits, HR practices, and job status (i.e., contract/permanent). Relationships with co-workers and views on career progression were also explored. Participants were also asked to share their overall experiences of working during the COVID-19 pandemic and how they affected them personally and professionally. This was a constant feature across interviews.

Upon completion of the discussion of organisation-related factors, participants were encouraged to share insights into the community aspects of their lives, which encompassed non-work experiences. Specifically, they were asked to describe their situation outside of work (including commitments to family, children, friends, where they lived, etc.), as well as kinship responsibilities and personal commitments or obligations. The researcher also enquired about participants' integration into the community outside their work (e.g., through sports, religious activities, local interests, neighbourhood initiatives, non-work-related friends, childcare, school and housing). Participants were also asked to reflect on the importance of these non-

work elements of their lives and to evaluate the extent to which these factors were impacting their views on their jobs and careers.

All interviews concluded with an open question which asked, '*Is there anything that I have not covered today which you would like to add/share with me?*' This allowed interviewees to share final thoughts or remarks which they thought were necessary. Participants were then debriefed, and any questions they had about their interviews, or the research were addressed. Overall, an individual interview took between 45-60 minutes. The researcher felt that the qualitative, semi-structured, in-depth approach used in the interviews allowed for the discovery of new knowledge about doctors' views, thoughts, and experiences. This was particularly valuable because it enabled the capture of critical and reflexive viewpoints.

All interviews were anonymised and recorded in audio format, with participants providing signed consent. Subsequently, after each interview concluded, the researcher transcribed the audio recordings into electronic text documents.

4.3.3 Ethical considerations

An ethical code of conduct is an important element of any research project (Denzin and Lincoln, 2011). It is particularly crucial to take into account informed consent, issues of confidentiality, and possible repercussions for study participants while conducting a qualitative research study (Kvale and Brinkmann, 2009). To ensure compliance with the university's ethics procedure and code of research conduct, this study was proposed to and approved by the Social Science Ethics Committee at University College Cork (Log 2021-132) prior to the data collection process. To obtain the necessary approval for this study, the researcher completed an ethics approval process that required detailed application information including a project description; research objectives and sample research questions; and details of participants, recruitment methods, the data collection process, data storage, and several checklists regarding ethical practices; along with a statement of anticipated ethical issues related to the study and how the researchers intended to deal with them. Given that this research was conducted at the height of the COVID-19 pandemic, special consideration was given to ensuring compliance with relevant COVID-19 protocols and regulations. After submission and approval of the application, data collection commenced.

Participants were briefed on the nature of the study in advance of their participation, and it was made clear that their involvement was entirely voluntary and that they could choose to withdraw from the study at any stage without any negative repercussions (up to two weeks after their interview taking place). Prior to their interviews, participants were provided with an Information Sheet (see Appendix) outlining the study, which explained what would be involved in the study and encouraged them to ask questions in advance if they had any doubts. After this, participants were provided with a Consent Form (see Appendix). This consent form fostered mutual trust by assuring voluntary participation, confidentiality, and anonymity. All participants were only interviewed once. Participants were given a clear and informative

explanation of the rationale for the design of the study and the questions that were to be asked. Details on how the data would be analysed and evaluated were also explained by the researcher. Participants were also reminded about their option to withdraw from the study within a period of two weeks after the completion of their interviews, if they wished to do so.

All interviews were audio recorded, with signed consent from participants. At the end of each interview, it was made clear that the interview had concluded. Upon completion of each interview, the audio recording was then transcribed by the researcher. The transcription process was highly confidential, and participants could withdraw at any time during the specified period for any reasons without consequences. When transcription was completed, each audio recording was wiped and deleted from the recording device and only the elective text document was stored. All interviews were anonymised and identified with a code throughout the rest of the research process (i.e., P1, P2). All transcripts were electronically stored in a designated account on an encrypted personal computer which was password protected and used only for research purposes. Transcripts were solely available to the researcher and her supervisors.

Although this research involved human participants, the ethical issues that could potentially arise within this study were minimal due to the non-sensitive nature of the study. However, the anonymity and confidentiality of participants were ensured and maintained throughout the study. All information provided was treated with a high level of confidentiality, and all answers shared and identifiers were anonymised. Likewise, as one of the research questions sought to understand whether gender differences played a role in doctors' decisions to stay or leave, participants were recruited to represent various genders. The aim of the gender-related question was to understand how gender informed participants' perspectives in relation to their experiences, motivations, and embeddedness and their decisions to stay or leave. However, there was no inclusion of extremely gender-sensitive questions as the study was not centrally focused on, or differentiated by, gender. The main focus and anticipated contribution of the

study was to examine the lived experiences of doctors. The questions posed to organisational representatives were therefore related to the general work context and did not require more detailed gender representation. Gender-neutral language was used during most stages of the data collection process.

4.3.4 Data analysis

At the data analysis stage, the gathered data was organised into categories followed by themes and the findings were then established (Creswell and Creswell, 2018). For this study, data were first transcribed and uploaded using NVivo software (Version 12). Thematic analysis was used to analyse the interviews in line with Braun and Clarke's (2006) recommendations. Thematic analysis covers the process of identifying patterns or themes within qualitative research and, according to Braun and Clarke (2006 p. 78), 'it provides core skills that will be useful for conducting many other kinds of analysis.' Through the identification, analysis, and reporting of patterns or themes within the data, thematic analysis investigates the meanings and experiences that speak to each participant's reality. In this study, the data analysis process used six phases of thematic analyses (Braun and Clarke, 2006; Clarke and Braun, 2017).

It is worth noting that the researcher had some prior knowledge of the information and possessed initial thoughts regarding the data. The transcription process involved repeatedly listening to the audio tape to meticulously verify the accuracy of the transcriptions. This deliberate effort was particularly important because certain Irish native doctors had strong accents, and the researcher took great care to ensure that the words conveyed in the written electronic documents precisely mirrored the spoken content.

In the first phase, which is typically described as involving *becoming familiar with the data*, each transcript was read a minimum of two times. On the second reading, the researcher looked

for important meaningful ideas, statements, and early impressions/rough ideas that were then taken down and which could be used in subsequent phases.

The second phase involves *generating initial codes* – an inductive process was applied using first-order or open coding, which involved labelling each line of data with a code that captured its meaning (line-by-line coding). In this process, each line of the data was read and the phrase which appeared interesting was labelled with a code using NVivo software (Version 12) which was helpful in processing the large dataset. The process was mainly data driven, as it was carried out inductively across the whole dataset without any pre-set codes. As the researcher was conducting the coding, new codes were generated along the way and so sometimes existing codes were modified. Initially, full and equal attention was given to each data item in order to identify interesting/important aspects of the data/repeated patterns. This approach helped to break down the big dataset into smaller, more defined chunks of meaning.

The third phase of analysis was related to *searching for themes.* This phase took place when all the data had been open coded, and it involved the first-order codes being developed into second-order categories which were established by systematically combining initial codes with similar context to establish consistency and a high level of detail. In other words, the researcher looked for similarities and discrepancies across the codes to inform the development of sub-themes. For example, codes were examined and similar codes which clearly fitted together were then put together into a sub-theme. At this stage, when the researcher had some sense of the data flow, these sub-themes were then arranged/categorised into broader themes which were predominately descriptive and which seemed to be linked closely to the research questions. This process was conducted using the NVivo software and the results were then transferred into a Microsoft Excel sheet.

In the fourth phase, which was concerned with *reviewing themes*, all the themes were reviewed again to ensure that each theme had sufficient data to support it. Two levels of review and refinement of themes were employed. The first level involved reviewing the codes in each theme to ensure that they appeared to form a coherent pattern. At this stage, some themes were refined and reworked, while some new themes were created, and others were discarded. For level two, the themes were then grouped on the basis of the job embeddedness framework to provide an 'accurate representation' (Braun and Clarke, 2006, p. 91) of the themes. This process was informed by Vaughan's (1992) approach, which allowed for both concept and data-driven analysis of the initial first-order codes, informed by existing literature and the chosen theoretical framework. The themes were then aligned with the dimensions of the framework, which were organisational embeddedness based on organisational fit, links, and sacrifice, followed by community embeddedness based on fit, links, and sacrifice, with the goal of examining how the relevant dimensions (fit, links, and sacrifice) manifested in the data. In this phase, the themes were

rigorously reviewed and then processed to ensure their coherence and alignment, ultimately enhancing the analysis of how the dimensions of fit, links, and sacrifice within organisational and community embeddedness were related in the data.

Phase 5 involved *defining and naming the themes*. In this stage, the themes were defined and refined, and the meaning and story of each theme were elucidated to explain what was interesting about them and why. This process was useful because it provided a structure for the findings. Finally, in phase 6, the identified themes were written up for the purpose of presenting the findings.

First-order codes	Second-order categories	Dimensions
- Irish culture, norms and practices - Accessibility and travel convenience - Living conditions in Ireland - Community appreciation and recognition	Fit	Community Embeddedness
- A sense of belonging - Social support from family and friends - Community bonds: giving back to the local community - Engagement in sports, recreational activities, and social interactions	Link	
- Leaving family and identity behind - Feeling settled - High-quality educational and institutional resources	Sacrifice	
- Being a trainee doctor - Consultants as pillars of support - Transformation of the health system and working conditions during the COVID-19 pandemic	Fit	Organisational Embeddedness
- Supportive teamwork and a collegial relationship with peers	Link	
- Predetermined progression for trainee doctors - Reluctance to embrace change due to fear and familiarity	Sacrifice	

Table 5: Sample of coding structure

4.4 Ensuring the rigour of qualitative analysis

The researcher sought to capture individual research participant perspectives without interjecting personal bias or opinions (Creswell and Creswell, 2018). To achieve rigour, the research data collection began with clear research design (research questions and objectives). There was also a clear and comprehensive research plan, including a data collection method and coding strategy which was discussed and agreed with the supervising team. The researcher collected data from the participants, and the data were inductively analysed so that themes and patterns could be identified objectively without the introduction of any personal bias. The researcher sought to increase the reliability and trustworthiness of the research design, utilising best practices to identify a clear rationale for sampling decisions, determination of data saturation and comprehensiveness, and detailed engagement with study participants.

Importantly, the researcher used rich/deep descriptions and specific details to illustrate the results, using the participants' voices, which helped to establish validity of the study's conclusions. As a result, several initial codes became important in the final coding scheme. Furthermore, in order to prevent prejudices from having an undue impact on the study process and results, the researcher sought to be reflexive, via critical self-reflection. The use of computer-aided qualitative data analysis software (NVivo) helped facilitate transparency by creating a record of the researcher's actions through each of the coding cycles. The researcher's supervising team also actively engaged in checking the coding, the themes (transferred from NVivo to Excel), and the sample of transcripts to ensure intercoder consistency (O'Connor and Joffe, 2020; Braun and Clarke, 2022). This process validated the findings by providing regular feedback to confirm that they aligned with the researcher's analysis. As part of this process, some themes were further refined after the codes and themes were jointly reviewed. This process revealed a strong uniformity amongst all codes.

4.5 Summary

This chapter outlined the methodological approach of this research. As per the constructivist paradigm adopted, this study used an interpretive qualitative methodology consisting of in-depth, semi-structured interviews with public hospital junior doctors. The chapter also discussed the two different types of recruitment strategy which were utilised, namely purposive and snowballing approaches. The research design was also discussed, including information related to participants, data collection, analysis, and ethical considerations. Finally, the chapter outlined the steps taken to ensure rigour throughout the collection and analysis of data.

CHAPTER 5

Findings

5.1 Introduction

This chapter presents the findings of this research study, which set out to comprehend the factors that influence the retention of junior hospital doctors within the Irish public healthcare system. The objective is to uncover the reasons behind doctors' decisions to stay in their jobs, as this knowledge can be beneficial in addressing the retention challenges faced by the system.

This chapter will present the core themes identified through the data analysis as structured within the thematic framework. These themes serve to illuminate the intricate patterns and insights derived from the raw data, offering a detailed understanding of the intentions of junior hospital doctors to stay in their jobs. Verbatim quotes from the dataset are incorporated in the chapter to provide a clear and vivid context, and to illustrate the relationship between the raw data and the emergent themes. This chapter is organised into two sections: a findings section that reports the current working conditions of junior hospital doctors before focusing on matters around organisational and community embeddedness. Although the part relating to working conditions does not specifically answer the research question, this is important because junior doctors chose to share the challenges and difficulties they encounter in their roles and which have been long spoken about as a key reason for high turnover. It therefore provides important context before focusing on their level of embeddedness how organisational and community aspects are playing a role in their decisions to stay within the Irish public hospitals.

5.2 The working conditions of junior hospital doctors in the Irish public health system

The poor working conditions of hospital doctors and the need for a fit-for-purpose public health system in Ireland have become the subject of considerable academic and public discourse. These debates were centrally reflected in all interviews. In particular, interviewees highlight that there are several factors associated with the poor working conditions in the Irish public

healthcare system that contribute to significant challenges and difficulties for junior doctors in a hospital setting.

The most critical issue addressed by these doctors with regard to the poor conditions are poor staffing levels. This staffing concern is so critical that the respondents consistently conveyed their thoughts in quite stark and dramatic terms. For example, one respondent who expressed frustration about the scale of the issue and its impact on efficiency and quality commented that '*if there is one of you when should be 10 of you, the maths is never going to add up*' (P21,F,Irish). This situation reportedly extends to there being no robust plans in place to cover doctors' duties when there are planned absences, such as maternity leave. One doctor discussed a case of this kind in their own hospital setting: '*There will be a situation coming up in the next few weeks where somebody will be on maternity, and we won't have a cover. Bloody hope for the miracle till the last minute. And then I think it's all about the… it's a seesaw game, It's all inversely proportional, staffing, finances. More staffing, more finances, less staffing, less finances, so they are trying to balance, but they are not reaching that equilibrium, unfortunately*' (P29,F,International). Similarly, another junior doctor shared a concerning situation which arose when they were sick, and noted that '*[It's] a vicious cycle where you are sick, because we have less staff and we have to help with the burden, so, most of the time, if we are not feeling well, we still have to go, and that's a very bad thing (unless you are extremely sick that you just say I am not going to go). So, it's just not easy to be on sick leaves and it's very difficult to get that break*' (P12,M,Irish).

The frustration here reflects the perspective that, while management is more than likely hoping against the odds for a solution to emerge, there is no actual plan in place. Although the organisation is endeavouring to find a solution, no successful avenues for resolving the problem have been found to date, nor is there any confidence in this prospect amongst the interviewed doctors.

This issue associated with '*less manpower*' (P1,M,International) heavily contributes to increasing an already high workload. Doctors consistently reported that the '*workload is very, very busy*' and that '*the problem is always the workload, there's a lot of responsibility on your shoulders and a lot of expectations*' (P1,M,International). The same doctor commented that, in the '*short terms it's manageable, but in the long term it's not completely manageable*'(P1,M,International). Similarly, another interviewee suggested that it is '*actually crazy how much you do over the space of even 24 hours*' (P15,F,Irish), as, during this time, doctors are not only focusing on their clinical responsibilities but are also dealing with administrative tasks and paperwork which is not directly related to patient care: '*excessive non-clinical work takes a lot of our time and also drains our energy where we have no energy left for our clinical work*' (P11,F,International) *or* '*the staffing is so poor where we have to handle not only the clinical work but also so much of paperwork which then delays our own work*' *(P8,F,International).* This high workload also makes doctors work '*really unsociable hours*' (P4,F,Irish), whereby they easily '*work 64 hours in one week*' (P9,M,International), and they observed that '*because of the workload you never finish on time*' (P14,M,International). For the most part, doctors also '*struggle to get lunch and breaks*' (P27,F,International) because of the demands placed on them. Specifically, participants emphasise that '*we don't have protected break time, we don't have protected lunch time*' (P25,F,Irish), and so they therefore have to '*eat in between patients*' (P31,M,Irish), '*grab something quick at one o'clock*' (P15,F,Irish), or '*take breaks when we can'* (P25,F,Irish). One doctor mentioned that '*the workload is way too much, for me anyway. If I was to take a break, that would correspond to my working day being 15 minutes longer, so the workload isn't designed to take in breaks*' (P22,F,Irish). These accounts suggest that the high workload experienced by junior doctors is continuous, with limited breaks, because any breaks would cause them to fall behind with their workload, thus adding extra time to their day.

Doctors emphasised that their working lives are also made difficult by the on-call shifts and hours that often fall outside their regular working hours, including at weekends. Since the Irish healthcare system frequently falls short of complying with the European Working Time Directive (EWTD), doctors were often found to work beyond their mandated working hours. For example, some of them work straight through for almost two days without a reasonable break: '*You work from 9–5pm, then on-call.... You have a really crazy busy night and you still need to continue working the next day*' (P10,F,International) or '*I am actually working off-site for on call, which actually means I can go home and come in when there is a call. But it's not possible for my case, as I don't live nearby the hospital which doesn't allow me to get here within half an hour and the nights are usually crazy so imagine….. off site call gets plenty of sleep is not true…most of the night are super busy and I am still up the next day at 9am for usual shift* (P16,M,International). One of the worst factors, from the doctors' perspective is that these demanding shifts and unsocial hours are sometimes treated as uncompensated overtime, and this leads to a lot of dissatisfaction: '*We weren't getting paid for time at the end of our shift, so, if I was to finish a long day at 10.30, I never get paid – after an ED call at 10.30, it's at least 11 or 11.30 before I get out of the hospital, but you are not paid for that extra hour. It's not that you are staying for your own will or liking – it's work that's keeping you back – but you don't get paid extra for that hour, so that's another frustrating factor*' (P24,F,Irish). The demanding nature of the work environment led some doctors to reconsider their career and life decisions*:* '*[When] I am struggling through a 24-hour call, I am thinking "I am almost 40, really is this my life?"*' (P6,F,International).

Doctors also pointed out other aspects of their working conditions and practices that brought significant challenges. For example, many spoke about the frequent '*job rotations*' which create a lot of frustration due to the many instabilities that frequent moves linked to employment changes generate. This can include their need to purchase or rent property, deal

with changing pay schedules and living conditions, and cope with other financial impacts such as tax implications. Some doctors expressed major concerns regarding external challenges, primarily referring to Ireland's housing crisis and costs, which create increasingly severe difficulties for doctors who need to move frequently. These changes can also create difficulties with building relationships at work, due to the constant need to adapt to new settings, and so they can have adverse emotional and social impacts.

> *I actually had to stay in a hotel for weeks for two of my rotations, because there is just no house available for rent… I think you know the current housing crisis here. Then I was in a rented home for a year then I moved again. (P1,M,International)*

> *My training now is in (name of the hospital) but I need to go to (mentioned another hospital in a different county), so I will be moving for the next rotations, then perhaps move back here…. With the current housing crisis, it's just very hard. (P4,F,Irish)*

> *It can be quite annoying because you're changing every six months, you have issues with pay, your overtime is paid at different periods, like, it might be two weeks in lieu or, you know, later, a month later, and it can be, like, you can often find that you're just settling into a place and then you have to move on…. It can be a little bit, you know, unsatisfying, pretty much every six months you have to prepare your finances for a big hit in terms of tax.* (P2,M,Irish)

> *By the time your six months are over, that's when you get to know the team, you develop the rapport with everyone. And then you are like 'time up!' and go and start from*

scratch again, getting to know the team and getting comfortable in that environment. It's hard. It's not easy. (P10,F,International)

It seems that these rotations pose even greater challenges for international doctors who are not in the postgraduate training programme (due to ineligibility to enrol, discussed in Chapter 2), because they basically work on short job contracts (6 months-1 year). This situation leaves them with inadequate job security as the continuation of their jobs heavily depends on a renewal of the contract/availability of other jobs within the Irish public system. As a consequence, international doctors who participated in this study often expressed their frustration concerning the uncertainty surrounding their rotations and moves.

I can't buy a house because I don't know where I'm going to be next year…. Because it depends if they renew my contract. (P13,M,International)

It's not only I need to rotate, but being not sure if I will have a job next year is scary. Because I am not a trainee my contract depends if they renew it, otherwise I need to apply elsewhere, and there is not always jobs in paeds [paediatric] which I can apply. (P7,F,International)

For now, I commute everyday for 1.5 hours back and forth, sometimes 2 hours back and forth, because its very hard to get any rent near my hospital and I am just tired of looking for a house every year; moving with the current crisis its not happening… so I just commute and it's better to commute as I also don't want my family to keep moving like nomads each time I need to move. I am not sure if they will renew my contract next

year. If they don't, I plan to apply in (another county) which requires me to commute further daily (sigh). (P17,M,International)

The intense working conditions, characterised by increasing demands and pressures, have also resulted in some doctors experiencing poor emotional well-being, which they describe as '*too much pressure on one head*' (P1,M,International), or an experience of work being '*emotionally draining as well as physically tiring*' (P19,F,Irish). Respondents '*find that, after 24 hours of that, you can be just drained, our body is tired and, emotionally, it takes longer to get over it, you're still tired the next day, like*' (P12,M,Irish). Emphatic language featured regularly in interviews, with one participant noting that they are *'really, really tired. It's just been really, really tiring*' (P3,F,Irish), and another who felt '*so burnt out*' due to prolonged stress and overwork that they mentioned they '*couldn't sleep*' (P10,F,International). Often the job leaves these doctors so drained that they feel incapacitated, and this brings intense mental and emotional fatigue. The combination of this exhaustion and lack of time for daily activities, such as cooking, leads many junior doctors to feel that they are leading an unhealthy life, even though they preach healthy habits in their professional capacity:

Sometimes it is so draining that you can't think or you won't talk. When I am back home, since I am so exhausted. I don't have time to cook, I do take-away a lot since I am on foot for so many hours and worse if on-call, so I have no time and energy to make good food. I order take-away, eat, and go to bed. (P19,F,Irish)

I am having the most unhealthy life. But, in practice, we preach differently. It's just a confusing life we have. (P21,F,Irish)

One doctor noted that these pressures led her emotional well-being to deteriorate until she '*became very anxious and depressed and I had to start on, like, antidepressant medication for the first time in my life*' (P3,F,Irish). A similar sentiment was expressed by another doctor who

said that the extreme pressure and lack of proper support from management meant they '*reached a point where I just couldn't manage. I didn't want to get up to go to work anymore, I lost my purpose…. I reached a point where I just couldn't mentally because I started having depression*' (P6,F,International). This participant, an international doctor who lived alone without family support, found herself feeling particularly burdened. She believes that her circumstances would have been better if she had had her family present in Ireland with her: '*If you were in your house with – close to your own family, you know – it probably would have been different. Everything kind of started to just get, you know, become too much, and I just started to feel really anxious, and I never felt anxious before*' (P6,F,International).

Overall, participants overwhelmingly expressed the view that there is a widely held unspoken belief/expectation that doctors should possess an immense ability to manage high levels of stress. In other words, they perceive that the system is set up in a way that assumes doctors should be '*able to handle all the stress – you should be able to handle this, you're kind of always told what you should be able to do*' (P11,F,International). However, in reality, participants feel that they '*are not robots*' (P1,M,International) and the '*working hours, the physical, em, impact of the intensity of the job itself can be a disadvantage*' (P14,M,International). The belief that the situation is continuing to deteriorate was noted as significant for doctors' well-being, and one doctor even suggested that this creates a broader set of risks: '*It's dangerous for us, it's dangerous for the patient*' (P23,F,Irish). Some even mentioned the challenges and risks associated with trying to cope in such hard situations, which can occasionally lead to medical errors. For example, doctors mentioned that '*sometimes you're so stressed and mistakes take place*' (P11,F,International), patients are '*given the wrong dose by mistake*' (P12,M,Irish), or a '*patient came back sicker*' (P11,F,International) due to mistakes made by over-stretched doctors.

Another interviewee expressed views about the longer-term risks generated by the pressure and expectations placed on doctors:

> *Just say, let's say, doctors make any of these mistakes – we would never be forgiven and you would be in the newspaper for any of these mistakes and obviously our mistakes affect lives etc., but just little things, you, they, people, often don't realise. We are humans too, we need a balance of hours, we need to rest, we can't just go on and on without a break and ensure that all we do will be perfect. I have personally never done any major errors so far, but if the system does not recognise the importance of improving the current conditions, I might one day end up in the same boat.* (P8,F,International)

These comments suggest that in spite of doctors being held to extremely high standards, they are also human beings who can make mistakes if they lack appropriate rest, recuperation and work-life balance. This participant also indicated that there is an urgent need for recognition and improvement of these working conditions to mitigate the risk of errors that could potentially arise from overwork and stress.

However, although the participants recognised and voiced concerns about their poor working conditions, only a small fraction were contemplating leaving the Irish public hospital system in the near future. The majority indicated that, in spite of such negative issues, they remained inclined to stay in their jobs, making comments such as '*I will stay*' (P1,M,International), '*I highly doubt I will ever leave the country to go elsewhere*' (P3,F,Irish), '*Leaving Ireland at this stage is not what I will do*' (P31,M,Irish), and '*I have the option of leaving, but the question is do I really want to? For now, it's a no*' (P14,M,International). These statements further sparked the researcher's desire to understand the underlying factors that explain why many junior doctors choose to stay, despite the arduous circumstances. In particular, 26 out of 31participants strongly expressed their intention to stay, despite acknowledging that the current

working conditions are far from ideal. While they are well aware of the significant shortcomings and challenges they face within this system, they still prefer to stay rather than leave.

	Fit	**Links**	**Sacrifice**
Community Embeddedness	- Irish culture, norms and practices - Accessibility and travel convenience - Living conditions in Ireland -Community appreciation and recognition	- A sense of belonging - Social support from family and friends - Community bonds: giving back to the local community - Engagement in sports, recreational activities, and social interactions	-Leaving family and identity behind -Feeling settled -High quality educational and institutional resources
Organisational Embeddedness	- Being a trainee doctor - Consultants as pillars of support - Transformation of the health system and working conditions during the COVID-19 pandemic	- Supportive teamwork and a collegial relationship with peers	- Predetermined progression for trainee doctors - Reluctance to embrace change due to fear and familiarity

Table 6: An overview of the main findings

The remaining sections of the chapter explore the community and organisational embeddedness of these doctors and how these factors relate to doctors' intention to stay.

5.3 Community embeddedness

Community embeddedness describes the extent to which individuals are integrated into their communities or engaged in off-the-job activities (Mitchell *et al.*, 2001). This concept takes a comprehensive view of an individual's life outside of work, encompassing their perceptions, relationships, and connections within their broader social environment.

In this study, community embeddedness stands out as having an especially crucial role in influencing hospital doctors' intentions to stay within the Irish public hospital system. In other words, forces that exist outside the workplace appear to be significant for doctors' intentions to stay. Notable in this is that there is little organisational involvement in supporting or facilitating much of this non-work embeddedness but tends to be more organic and something at the sole responsibility of the individual.

Notably, even though doctors have limited time to spend on their life outside of work due to the issues discussed earlier such as heavy workload, long hours and weekend shifts, it was interesting to find that they still perceive that their life outside of the workplace plays a crucial role in their intention to stay.

This study also indicates that nationality, gender, and marital status appear to have some impact in terms of how doctors reflect on the three dimensions of fit, links and sacrifice.

5.3.1 Fit – Community embeddedness

In the discourse about community embeddedness, 'fit' is defined in terms of individual needs and interests that are congruent with an individual's community/surrounding environment (Lee *at al*., 2004). Fit therefore refers to forces outside the workplace and how relevant and suited an individual feels to the broader community in which they live (Mitchell *et al.*, 2001, Clinton *et al.,* 2012).

Theme 1: Irish culture, norms, and practices

Doctors who were Irish natives appeared to perceive that Irish cultural norms, values and practices fit their expectations and lifestyles. They referred to the extent to which the Irish culture is in harmony with the ways of life that they aspire to. They appreciated their cultural heritage, recognising it as their own rich tradition. These feelings were reflected in a strong and deep-seated affection towards continuing to live in Ireland, which they conveyed in warm terms

such as: '*it's the affection towards Ireland and the culture here*' (P4,F,Irish). These elements appeared to permeate daily interactions and societal dynamics in Ireland. Respondents consistently referred to a profound '*sense of identity... cultural identity and pride to be an Irish [person]'* (P20,M,Irish), expressing their belief that the culture they carry is important to them and would be difficult to replace in any other culture or environment: '*being Irish, I think the culture still holds me strong, it's just not the same anywhere else*' (P2,M,Irish), '*I don't know how easy it will be [to live elsewhere] because being born and brought up here I think Ireland is more than just a place. It's the way of life*' (P3,F,Irish).

Specifically, this cultural identity and societal values of being, for instance, '*very pro-Irish'* (P26,M,Irish) were understood to be distinct from other culture's practices. For example, some respondents' comments suggested that they see America, for example, as representing different values and perspectives: '*USA, it's just total opposite of our culture here*' (P4,F,Irish). Indeed, one doctor shared the challenges he faced in navigating the cultural intricacies during the early stages of his career in the US. Despite residing in America, he remained deeply engaged in the Irish cultural ethos and practices: '*I lived with a couple of Irish fellows in the States, so I never really kind of fully went [native], I didn't fully immerse myself I suppose. It wasn't that easy for me, But it seems that we had… we were kind of semi-fully immersed but there was definitely a more Irish culture there the whole time*' (P26,M,Irish). The residual '*Irish culture*' within which he lived in America further testifies to the profound impact and resilience of the Irish participants' cultural roots, even when residing in foreign lands. Some respondents even made direct comparison between the culture in Ireland and America, in comments that made clear their preference for staying in Ireland: '*….but never America. I guess the culture is totally different. We Irish embrace our own culture which I think [is] total opposite to America*' (P12,M,Irish). Some highlighted the complexity of the decisions involved in living abroad for them and their partners due to cultural and religious practices, despite being satisfied with their

jobs, saying they never felt any sense of belonging: '*I was very happy in New Zealand with my working conditions and things like that but we were not there for long term just because it was just not the same living elsewhere. Though we loved it there, we never felt at home... the culture played a big part. It was certainly different to what we have been used to…. Also as my partner is a staunch Catholic and she preferred here to New Zealand* (P23,F,Irish).

Meanwhile, international doctors, on the basis of their observation of Irish culture and their experience of living in Ireland, emphasised the sense of cultural values, norms, and practices which partly aligned with their backgrounds and expectations. This means that they generally find Irish culture to be a positive one, and this was reflected in comments which suggested that '*the culture here is very positive*' (P18,F,International) and '*the culture here really suits me'* (P6,F,International). In particular, they suggested that Irish culture is known for being a '*warm and friendly culture*' (P6,F,International). It is also associated with a great sense of hospitality and this makes it a welcoming culture towards people from different backgrounds and nationalities who are generally embraced by the local population: some participants noted that '*it's an immigrant friendly country'* (P5,M,International) or praised '*the Irish culture and its positivity and the Irish society was welcoming to foreigners*'(P28,F,International). Some also perceived that, the cultural practices in Ireland reflect a norm of being respectful of others' cultural identities, traditions, and practices, which produces a sense of inclusivity and acceptance in the wider cultural context: '*everyone respects your beliefs and I do think people do respect your culture too* (P6,F,International). This spirit of acceptance is particularly evident in comments from participants who referred to Irish people and Irish culture as being '*accommodating to different cultures*' (P5), noting that '*people really respect our own culture here*' (P1,M,International), and that '*this is a Christian country that's fine….. but they equally respect others and their belief and culture too*' (P13,M,International).

Likewise, international doctors expressed the view that the culture practices upheld in Ireland generally do not discriminate against other cultural norms in the form of racism, '*So, generally, here in Ireland the people they are accommodative. So I don't feel discriminated from that point of view*' (P10,F,International). Some respondents gave examples based on their personal experiences and observations based on other countries, which they found offered a clear contrast to Ireland: '*I have my family in UK as well but I think they are more racist there and I have visited Saudi Arabia as well, so compared to these place I feel Ireland is a good place and country to live for long term…. The culture is definitely different* (P17,M,International). One doctor specifically went as far as to mention the advice he received from his professor, whom he regards as his '*mentor'* and who advised him to *'go to Ireland, as the culture there is better than in the UK living wise'* (P1,M,International). Notably, this doctor has been living in Ireland for some time now and genuinely believes that his professor's recommendation was accurate, as he finds the cultural aspects of life in Ireland to be very appealing and well-suited to his needs and preferences, although difficult work conditions exist: '*[After] five years here, I strongly think my professor was right, culture here plays an important role for me, it's what I looked for in a place I live... even though I know the work isn't easy'* (P1,M,International).

Another participant intimated that their real motivation for remaining in Ireland is the culture: '*Yes, absolutely. Irish culture and people are main reasons I stayed here 'til today as they are very accommodating*' (P5,M,International), while a doctor who was born and raised in Ireland commented that, '*though I am Pakistani, I was born and raised here, I did my schooling here as I mentioned, the culture here is different. It is very accepting and respectful culture. I have never really been treated differently*' (P27,F,International). The repeated use of words like 'respect', 'accommodative' and 'everyone' is notable and suggests participants believe that acceptance and inclusivity are collective and foundational values within Irish culture.

In a similar context, language, as a fundamental component of culture, was also highlighted by international doctors as a key factor that makes Ireland an appealing choice. They perceive Ireland to be suitable as it offers the advantage of being an '*English speaking country'* (P5), which makes it easier for them to communicate and adapt without the need to learn a new language. One doctor shared their decision-making process by saying, '*I had two options: one is Romania and another one is Ireland. I chose Ireland because it is an English-speaking country*' (P9,M,International). This choice reflects their preference for a place where they can comfortably communicate. Others echoed this sentiment by noting some contrasting experiences. For example, one doctor commented that *'it's easy because it's an English-speaking country, it suits better... although I would have been interested with Czech Republic, the language was a problem... where I really couldn't socialise, so I prefer [being] here'* (P13,M,International). Another doctor who is ineligible for the postgraduate training programme, attempted learning German so he could move to Germany but his plan did not succeed. He explained that '*I did do German language A1 and A2 thinking I could go there for training, but to be honest it was tough, then I gave up as here I don't have such issues with language… so I thought it doesn't matter if I don't get the training now, I will give it some time and see if I can go into the alternative pathway*'(P9,M,International) – he therefore decided to postpone his career development plans.

Theme 2: Accessibility and travel convenience

On a more practical level, interviewees expressed appreciation for Ireland's ease of accessibility and the convenience of travelling *within* the county where they were based, which is relevant given the frequent job rotations. Job rotations are applicable to all doctors, regardless of whether they are in a training scheme or a non-training post. However, those in non-trainings posts may find themselves working across counties more frequently as their roles are typically based on job contracts (6 m-1 year). Therefore if their contract is not renewed as per terms,

they are obligated to leave the hospital and take up a post in a different hospital, which may be in a different county.

Generally, both cohorts of doctors (trainees and non-trainees) emphasised the relatively manageable travel time between counties and the country's overall geographical advantages. While there was frustration with the frequency of moves and the housing challenges, there was high appreciation for the relatively effortless travel domestically. Meanwhile, doctors who have been placed on job rotation in different counties mentioned that the feasibility of commuting between two counties weekly provides some personal convenience and comfort*: one noted that '[I'm] working in Limerick, but I commute every weekend to Cork. Its only a 1.5-hour drive to home*' (P5,M,International), another commented that '*the fact that I still can commute back in 3 hours make[s] it bearable*' (P23,F,Irish), and another participant noted that '*home is just 2 hours drive away so its fine'* (P4,F,Irish).

Some doctors who are non-trainees, and who are therefore required to rotate more often, expressed the view that they preferred not to relocate when their frequent job rotations required it, as they did not want to disrupt their family's well-being by uprooting them. Therefore, they chose to maintain their current residence and commute daily and, due to the favourable road conditions, this was manageable for them: '*I commute, I didn't move because I can sacrifice [some of] my time and energies but I didn't want my family to suffer with me in terms of changing our house, school and everything. So I just commuted from Dublin, like, one-hour drive one way, so a two hour drive, but it's on a motorway, so it's fine*' (P17,M,International).

'I am on contract, and, my next rotation, is in Portlaoise which is an hour and half from my place, but I will just drive daily…. My previous two rotations [between 2 years] were in Roscommon and Mullingar and I travelled daily. I am used to it now and the drive is not too

bad and the road and infrastructure is good here, so it's fine rather than moving every time with my whole family' (P16,M,International)

Some international doctors emphasised the geographical benefits of Ireland in respect to the convenience of easy travel for leisure activities within the country and to international destinations such as the United Kingdom, France, and Poland. This situation is particularly appealing to doctors who are often torn between the desire to return to their home country, arising from the difficult nature of their work, and their love of travel. Instead of opting to return home, they may embark on a drive to another county or take a flight to fulfil their passion for exploration and adventure: '*When work gets so tough… and when you bring yourself to a point where you are like "why don't I just go home" and there are things that go, but, but, you can go and drive to Cork and drive to wherever. I have been to the UK at least three times since I came. You can drive to the UK and see your friends in the UK. I went to France, I went to Poland, em, so, I am like, it's all here. It's all at your fingertips versus at home where, it's not that it's not possible, it's just more difficult*' (P6,F,International).

Some participants talked about the level of convenience and the appeal of their present location in terms which that suggested that, in Ireland, international travel is 'at your fingertips'. As one international participant put it, if '*Greece is 4 hours away, why would you want to leave?*' (P18,F,International). Another international participant conveyed her love of adventure and appreciation of the therapeutic nature of Ireland, when she stated that she was satisfied by its attractions. She explained that '*I love travelling, so I like to take the car and drive to the Cliffs of Moher and just go and have lunch there on my own. And I'll drive up to Donegal and just go and see something*' (P30,F,International), noting that places in Ireland are relatively easy to visit by car. This participant also signalled that opportunities to appreciate nature, as well as the solitude and rejuvenating qualities of these journeys, are important, commenting that opportunities to take a break from her hectic work life and engage in various activities are

important for her mental health: '*I just feel sometimes running away from work doing all these activities [is] still keeping me sane (laughs)*' (P30,F,International).

Theme 3: Living conditions in Ireland

Participants generally regard the practical aspects of living in Ireland as being preferable to those in other countries. This is especially true for Irish doctors who had lived overseas: '*I was living in England until I was 21. I did my undergrad degree in England, in Liverpool and then came over and did medicine in UCD and then I'm here now training as an anaesthetist [and] the living here is so much better than England*' (P31,M,Irish). Similarly, an Irish doctor commented that '*if I want to leave, it has to be UK since Aussie is too far away for me, and UK is a no-no for me as I don't prefer the living there…. You can say that, to some extent, the life here is better than UK in many aspects, even though I know we do have some housing crisis, but I won't deny that I feel the living aspect here is better'* (P2,M,Irish).

International doctors tended to express even greater appreciation for the living conditions in Ireland. They offered a very positive opinion of living conditions which they believe make Ireland a '*nice*', '*ideal*', '*suitable*', and '*peaceful*' place to live. This indicates a general appreciation of the country and a positive sentiment that Ireland offers the lifestyle they desire: '*Life here is good… peaceful and relax[ed]*' (P5,M,International) noted one participant. Others commented that '*[I] have to say I'm lucky because I really love Ireland, it's a place which suits me*' (P18,F,International) and that '*the lifestyle here fit to what I am looking for'* (P7,F,International). International doctors were able to compare places and highlight the disparities in living conditions that have led them to prefer Ireland as a good fit for long-term residence: '*Ireland is a good place and country to live for long term*' (P9,M, International). It was relatively common for participants to make direct comparisons between Ireland and their home countries and this tended to emphasise Ireland's superiority: '*I have to be honest that*

Ireland is much better in all levels if you compare it with [home country]' (P7,F, International). Despite recognising the challenges they face at work – such as difficulties getting into postgraduate training schemes which have resulted in them receiving frequent advice and encouragement from family members to look for options in other countries – some of these international doctors emphasised that the wider conditions beyond their workplaces, and the lifestyles they have, are factors that keeps them in Ireland. In other words, while career progression may be more attainable elsewhere, respondents valued the lifestyle, and overall well-being gained from high-quality living conditions to the extent that these, in part, could override their dissatisfaction with very poor working conditions.

> *Sometimes when people back in Pakistan ask me if I have gone into training yet, I tell them no. They will encourage me to look into UK/Canada or USA, but, to be honest, only the environment and lifestyle are actually stopping me. It's very positive living here which I think is more important for me in the long run rather than my career progression because I know I still can progress with exams alone…. Even [though] the pathway is not very straightforward.* (P17,M, *International*).

In addition to general living conditions, many international respondents highlighted basic necessities which are accommodated here in ways which they consider to be superior to elsewhere. These factors include socio-economic factors and government policies, as well as infrastructure and safety. Firstly, international participants expressed high regard and appreciation for the quality and standards of the Irish education system. In particular, they praised the system for its progressive and holistic approach: one commented that '*my daughter is getting a very high quality of education*' (P18,F, International), while another stated that '*schools are very good here, it is more [geared] towards nurturing education*' (P7,F,International). They especially emphasised their personal preference for the education

system here in Ireland over that in their home countries, citing its consistently high standards and expressing deep satisfaction with, and trust in, the education being provided to their children. This is evident in statements like '*I think I like the education system here its quite advanced and comprehensive*' (P28F,International), and '*schools are equal standard and the education is really good'* (P8,F,International). One respondent directly compared the Irish system favourably to that in India, where high costs are associated with obtaining good schooling, emphasising the value and affordability they perceive in their current setting: '*In India, we have to spend about 1 lakh which is about 1000 euro or more just for school every month. I am talking about a child, if you want a good school*' (P5,M,International).

Furthermore, international participants generally expressed positive appreciation and trust regarding their experiences with the way Ireland's government handled situations concerning administration and politics: '*in relation to politics, I think it's a very stable and neutral country*' (P1) and '*overall, as a country, I think Ireland is quite neutral in its political stance' (P30).* Respondents recognised that the government ensures a high-quality level of law and order in Ireland and, importantly, this included as a sub-theme the government's effective management, not just during normal times, but also through the COVID-19 pandemic.

Participants noted the efficiency with which regulations were implemented, vaccines rolled out, and strict security measures enforced during the pandemic, which ensured that healthcare standards were upheld:

> *I think the ministers were really managing Covid and the issues well in this country. Vaccine rolling, lockdown instructions, and you see they were serious about everything. Even [when] I go to work, I need to show my ID everyday – these sort of rules are important.* (P7,F,International).

> *I remember my parents were, here when Covid hit in the start of 2020 and I was always thinking of them as I was scared I will infect them… but, after some time, I realised that they were safer here than being in my own home country as things were really messy there. That's because I guess the government law were better imposed here.* (P17,M,International).

The government's stability and effective management of COVID-19 were particularly noted by international doctors who contrasted this with their home countries where political conditions were substandard or even chaotic. For example, one participant commented that, in their own country, '*there is significant economic and political instability there'* (P1,M,International), while another qualified their comments about Ireland by noting that '*I can really say this as I came from a country with very chaotic political condition '* (P28,F,International). For some doctors, this led to feelings of confidence in the ability of the Irish government as the country they chose to migrate to: '*I know we are in a safe country as we saw what took place during Covid'* (P8,F,International).

It is evident that many international participants believe the Irish government prioritises the well-being and safety of its citizens, and witnessing its steadfast and organised arrangements and responses during unexpected crises has really had an impact on junior doctors' sentiments. For international doctors, in particular, this underscores the significance of robust governance structures and agile strategies in preserving public trust and safety.

Another sentiment echoed by many international participants was the perception that living conditions in Ireland provide a safe environment for them and their families. They highly value the safety of the environment which for some stood in contrast with that of their home countries. For example, one participant talked about a simple activity they enjoy with their children which is not only pleasant but safe to undertake: '*I cycle with my daughter during the*

weekend. It's nice we get a chance to do all that here and be safe at the same time' (P16,M,International). They compared the busy and often unsafe conditions they had experienced at home, where similar activities are affected by challenging conditions like heavy traffic. This led to them being deprived of simple privileges. For example, one doctor remembered that '*back in my hometown, work was stressful, I had no downtime... traffic was crazy. It takes 2 hours to reach home, and we never get the privilege of going for a simple walk as the country is busy, and I live in the city, so walking is, like, not a thing there. No one really does that in my living area*' (P5,M,International), while another commented that '*it wasn't particularly safe as the infrastructure is poor*' (P13,M,International). Importantly, some women doctor also mentioned '*its not really safe for ladies at my place'* so '*for me its mostly home and work only'* (P28,F,International). Therefore, despite the tough days they have experienced at their hospitals and their high workloads, many international doctors cherished such opportunities and compared them favourably with their experiences elsewhere: '*But here, when I am home from a day where I have had a few surgeries, and my mind is totally cracked, I just go for a 30 min walk after the kids are in bed…. I get so refreshed*' (P13,M, International). Another international participant spoke about her passion for cycling and having the opportunity to be a member of a local cycling group: '*I am a member of Women Cycling Ireland, I cycle a lot during the weekend. I don't cycle much in Nigeria because the infrastructure isn't great and it's not very safe*' (P6,F, International). This doctor also drew a comparison between Ireland and her home country when she expressed reservations about cycling due to poor infrastructure and concerns about safety. She perceives Ireland as a more conducive place for such activities due to its safer environment. While such daily routines may seem normal or usual for the locals, they are highly valued by international doctors who come from entirely different environments and who have developed a newfound appreciation for what they experience here.

Theme 4: Community appreciation and recognition

Interviewees of Irish and international origin discussed the '*appreciation*' (P14,M,International) and elevated '*level of respect*' (P1,M, International) they receive and enjoy for being a hospital doctor in Ireland. Many noted that, '*they really look up to you when you say you are a doctor*' (P6,F, International), highlighting the sense of admiration and gratitude they receive from the public. They believe that their profession holds a unique status in the community which reinforces their sense of purpose and fulfilment in their careers. One person mentioned that '*it feels good when the community gives you appreciation. As a doctor you get appreciated everywhere*' (P16,M,International). This high level of respect, appreciation, and positive feedback from the community helps doctors to '*realise that it's an important job that we are doing for people*' (P22,F,Irish), and it even makes the hard situations and challenges they face at work more bearable. For example, one doctor explained that '*sometimes, my patients see me in shops and they come and greet me, like, even a small gesture – "hi doctor''....and they tell about us to their family and they thank us too. Those kind of people are the ones who make our difficult experience at work better*' (P14,M,International).

*S*ome participants also mentioned that their jobs as hospital doctors provide *'positive references and recommendations'* such as when they are looking for *'houses for rent'* (P14,M,International). They appreciated that *'[people] 'normally trust you and don't ask many questions if you work in the hospital as a doctor.... I think it's a community respect and trust'* (P10,F, International*).* This allows doctors to enjoy some practical benefits and social advantages linked to their jobs beyond the workplace.

Some interviewees linked such responses from the public specifically to the COVID-19 pandemic, during which more people across the community started appreciating the work and value of doctors and the social contribution they make. Some interviewees felt that the

pandemic prompted more reflection about the role of doctors and increased appreciation and respect for them. For example, one doctor noted that '*during Covid especially... I felt my role as a doctor was much more appreciated by the people around… more thank you we hear*' (P4,F,Irish), while another said '*I run to do grocery after work during Covid because I don't want my wife to be out as we have an 8-month-old. When they see [me] with my scrub in Dunnes or Tesco, they say thanks for the hard work and so on, you see… it could be a small conversation over the counter, but it's those things that make your day or entire week*' (P2,M,Irish). Another participant mentioned that 'what I do in the hospital is really, really respected by my community… and this was even more [so] during Covid... I am grateful and content for that for sure' (P3,F,Irish). Generally, people in Ireland not only value the work of hospital doctors but also acknowledge and highly respect their contribution and hold their important role in high esteem. This in turn, creates a conducive environment and atmosphere outside the workplace for hospital doctors.

5.3.2 Links – community embeddedness

In the academic discourse about community embeddedness, links are defined as the informal and formal connections that an individual forms with other individuals outside of their work environment, as well as their connections with institutions and community groups (Mitchell *et al.*, 2001). These links are not limited to immediate and extended family connections – they may encompass a wide range of ties such as affiliations with clubs, volunteer organisations and activities, and community groups (Halvorsen *et al*., 2015). Links that support community embeddedness are explored below in relation to four themes.

Theme 1: A sense of belonging

Interviewees, particularly those of Irish origin, exhibited a strong sense of acceptance, belonging, and attachment to the locality in which they were born and grew up, as well as to

their national society. This appeared to form an emotional bond that was perceived as an integral part of many shared experiences and traditions. It strengthened people's sense of being understood and appreciated.

> *We all have a strong sense of belonging to the place we were born. This place obviously has many meanings and complex emotions for me…. It's a lifelong connection I would say.* (P22,F,Irish)

Typically, Irish doctors demonstrated a profound and multi-layered bond with Ireland, whereby they experienced it not just as a physical space but also as a complex interplay of many social connections, local affiliations, and their personal history (also known as shared history), incorporating the relationships that they developed over time. It is a part of belonging and creates a personal attachment that holds a special place in their hearts because of the relationships and interactions they have with people: some stated that '*this is my home*' (P2,M,Irish) or that '*Ireland is home to me*' (P31,M,Irish), while other interviewees said that '*it's a home to me, there is no other place I could call home*' (P15,F, Irish), or '*I was born here, by default I just belong here… and it is just a place you feel the true connection with others*' (P4,F, Irish). Likewise, some even felt that they have a strong connection to their ancestral heritage in Ireland through '*their roots*' (P20,M,Irish) whereby they '*think in Ireland we are very connected to our roots, which of course I am proud of… [but elsewhere it is] kind of difficult to put down the roots*' (P2,M,Irish). Typically, Irish-born doctors expressed feeling rooted and connected to their place and people, which creates a sense of belonging and connection.

Conversely, some international doctors endorsed a sense of affinity towards Ireland, both the place and the people, despite not having been born here and having Ireland as their native country. They described this profound connection to Ireland as having been cultivated over an

extended period of time spent in the country, linking the individual to both the place and its people. It is significant for them that this bond has grown organically, fostering a deep sense of attachment and camaraderie despite their non-native origins. For example, one doctor who had come to Ireland at a very young age with their family and got '*educated here… went to college here*' explained that they had spent *'16 years now in Ireland'* and feel they are '*practically Irish'* in ways that are hard to express: '*it's so different. I feel connected to this place somehow… I do go home too, once every few years, but only feel home when I am back here*' (P27,F, International). Likewise, another doctor who had done their medical degree in Ireland and '*spent more than 12 years in Ireland now*' had built a sense of strong connection with the country: '*it's just a connection to this place as I have lived here long now…. I have my own circle of people and this place is definitely a home to me now*' (P18,F,International). Ireland and its people have given these doctors a profound sense of attachment. In other words, spending a significant portion of their life here, and the breadth and depth of the social circle they have built over time has helped create a strong connection to place. Some doctors also explained that their links had developed through family connections after their marriage to an Irish citizen. For example, one participant shared that '*I left my hometown to do medicine in Europe when I was 20 [years old], I am now 35 [years old] and have been living in Europe for 15 years. I am married to an Irish [person, so], even though I am not born here, through my wife and my son I have some sort of rapport to this place. I am close to my father-in-law and the rest of my wife family…. even though I still consider (mentioned their native country) being my home, maybe it is more of my first home and Ireland now second home for me right now'* (P5,M,International).

Additionally, Irish doctors expressed the view that their sense of connection and ties became more evident during the COVID-19 crisis. In many cases, the COVID-19 pandemic seems to have strengthened existing bonds and its related emotional and moral ties brought a lot of

meaning to their lives, including a sense of attachment. Participants mentioned that '*I feel [I] belonged here and I felt this even more during Covid*' (P26,M,Irish) and that '*Covid gave me a deeper sense of belonging... here*' (P20,M,Irish). Equally importantly, one participant who had moved to New Zealand upon completing their internship in Ireland before returning recently, mentioned that they '*moved back because I knew that was for temporary and I had been planning to move back anyway*'. Even though they had a good life in New Zealand, their main reason for returning back to Ireland was the '*baseline wanting to live here with family*', and they explained that this intention got even deeper and they became more inclined to return when the pandemic began: '*definitely Covid has made want to move back. I [am] glad I moved back to Ireland before Covid hit, otherwise it would have been so hard to come back. As I said, it is the baseline to be in our home, our place and our people. We are happy here now, and I certainly won't be moving out'*,.. '*It's not only we felt good to be back, our parents, friends and surrounding too…yes, it's the attachment'* (P23,F,Irish). Some interviewees reflected on how the COVID-19 crisis had impacted on their personal situations: '*when I saw the doctors coming back for the "be on call for Ireland", I did think if I would have gone somewhere, I will surely come back… It's the bonding you see… I have with my people here; I would have felt compelled to come back for sure…. I think, during a crisis like this we reflect more towards our personal situation and we feel that we really want to be there for people whom we really care*' (P3, F, Irish).

A few doctors also highlighted their personal and social connections within their local community, which bring tangible benefits that they enjoy. These connections include familiarity with long-established local cafés, gyms, and restaurants in their areas, as well as longstanding friendships and relationships with people they have known for a significant period of time, having grown up in the same area.

This is where I grew up, I was born in Cork. So I have huge connections to this area, very familiar, I have a favourite gym that I go to regularly. I'm part of a triathlon club, and I go to regular training with them. A lot of my friends outside medicine live close by, I have lots of friends in medicine who live close by, lots of cafés and restaurants close by,.. which I am familiar with and I think that's also built up on my surroundings. (P26,M,Irish)

I guess the familiarity… [being] familiar with the people around, your surrounding, and you know the people who serve you the coffee in the morning from the coffee shop… it's kind of your community. (P4,F,Irish)

Another one spoke about his religion in this context and the links this brings that were seen as highly valuable. Specifically, he spoke about being a '*Catholic*' and still having his '*good friendship with my church friends'.* While he emphasised that he is not a *'huge practitioner' of Catholicism,* he still cherishes going to church and appreciate the connections which he has formed from it: *'just meeting the people I know since small and these things. Sometimes it just reflects back to your own circle and surroundings' (P2,M,Irish).*

Theme 2: Social support from family and friends

Several doctors, predominantly of Irish origin, discussed the significant impact of social support provided by family and friends. They highlighted how some actions, decisions, and situations get prioritised based on reasoning connected to these relationships. They emphasised that the presence of family, as well as their family's well-being and proximity to them, are crucial factors that contribute to their career decisions. For example, when one participant referred to choices being made '*just due to family reasons*' (P2,M,Irish), they set this out as more important than work-related factors. Several interviewees stressed that family considerations were paramount over professional commitments, explaining that '*it's only because family is here*' (P19,F,Irish), or that '*my parents are here, family is here*' (P15,F,Irish). One participant, in discussing their decision-making process about whether to remain with the HSE, mentioned that '*my family is here, so it's very little to do with the HSE, it's more to do with the family. Work is secondary no matter what – at the end, family is the one who determines the rest*' (P12,M,Irish). Similarly, another participant noted that '*Even [if] I have no work reasons which makes me to stay... I highly doubt I will ever leave the country to [go] elsewhere. I want to work in Ireland just to be close to my family, so that's really the only thing that is keeping me in Ireland*' (P24,F,Irish).

Importantly, these Irish doctors linked the emotional support and stability they receive from their families to their decisions to stay in their jobs: one doctor stated that '*because my family is here, I am staying*' (P4,F,Irish). Participants emphasised the immense importance and value they place on family when making career decisions, mentioning, for example, that '*95% of the reason I'll stay is for family*' (P20,M,Irish). One doctor noted that '*I think so often to get out of here, but I ask myself each time, can I get the emotional support and stability outside which I get from my family… my circle now? It's hard to navigate*' (P22,F,Irish). Another explained

that '*I want to keep working in Ireland just to be close to my family, so that's really the only thing that is keeping me in Ireland. Nothing else*' (P31,M,Irish).

Similarly, respondents highlighted the importance of having a support system, such as family, filled with people who can provide assistance when needed, including childcare support. One interviewee mentioned that '*my dad collects them*' (P22,F,Irish), while another explained how important it was that '*my mum helps me with my children whenever I am on call*', because most of the parental '*caregiving duties'* fall to her, since her spouse '*works for a (mentioned a different country) company, so he works unsocial hours too and often away from town for work'* (P21,F,Irish).

Some also spoke about how these supports alleviate financial burdens. For example, one participant explained that '*[my] mother and mother-in-law's help and just keeping the cost down*' (P2,M,Irish) was important when childcare services are very expensive (often described as '*extortionate*' P2,M,Irish). These costs are much higher when there is no family support to offset them: '*It's essentially like paying a second mortgage*' (P2,M,Irish). In fact, this particular doctor openly acknowledged that there were times when they have contemplated moving to Australia for more favourable working conditions. However, having three children presents a significant challenge in several ways, especially in the absence a supportive family network overseas: '*the thought of leaving to Australia was certainly something my wife and I spoke about many times, but with three kids and having no family around is certainly a big deal…It could be as simple as dropping and picking them from the swimming lessons, we know now it's a call away to a family members or hers to get some help, but when you live alone in another country it's not going to be easy as we may assume it will be'* (P2,M,Irish) – this situation underscores the complexity of decision-making, particularly when family support plays as an important role.

Some doctors also shared that having a supportive network of people close by, such as family and friends, is important for doctors who are consistently dealing with a hectic work schedule. This network provides domestic support, moral support, and understanding, and it is often a collective effort that helps to facilitate their demanding schedules and responsibilities.

> *I realise every doctor has a load of people in their lives. A lot of people – for the most part, for most people – have made that doctor function or make the doctor function well, like, really, there's a lot of people in the background, like, just helping out, picking up things from town or all these jobs that you just never can do. Or even a wife at home who is handling most of the domestic household when the doctor is not even around.... And, yeah, very important… and though I don't see them very often, they make… they just help so much they really do.* (P15,F,Irish)

> *My whole support system, my mother, my sister, my partner – if I didn't have them, I wouldn't be able to do my job. They just support me and bring me through so much. And they are just a reminder that there's more to life.* (P24,F,Irish)

Irish doctors also stated that the whole COVID-19 experience was another factor that gave them a definite inclination towards staying close to family. For example, one said that '*family is the priority for me and when the pandemic took place, I got this even more into my head…*' (P15,F,Irish), while another said '*I think Covid really restricted me from going, I found it hard not to visit my mum and dad during Covid with the restrictions… especially, I am very close to my mum and not having the time to sit and talk to her in person... kind of impacted me personally*' (P26,M,Irish). Overall, individuals deeply value their family ties and consistently place their families above work in their life decisions. Furthermore, the influence of external events, like the COVID-19 pandemic, has led people to become more conscious of the importance of family in their decision-making processes.

International doctors who do not have their entire family, extended family, and friendship circle residing in Ireland spoke about their experiences regarding their immediate family members settling in Ireland and how well they have formed a sense of connection with the local

community as a support system. Several spoke about how much they valued their spouse's sense of ease and connection in Ireland, mentioning, for example, their '*wife feeling good here*' (P13,M,International) or even saying that '*my wife loves it here*' (P17,M,International). This is significant, as many of these international doctors' wives primarily take on homemaking roles, and their contentment serves as a valuable support for doctors, since the wife '*takes care of the children and the school stuffs and I know she is happy and comfortable doing it for me'* – thus they '*can focus at work better* (P13,M,International). Similarly, another female doctor mentioned that their husband's job allows him to play a substantial role in caring for their child, which is especially valuable for her given her own work is demanding enough: '*my husband isn't a doctor and he works in IT here and his job is very ideal for him and that [is] a big help for me.… He sends my son to creche and collects him, and also I know my husband's job allows him to be with my son most of the time which I can't…. That's a huge relief and support which I am grateful for*' (P7,F,International). This sort of positive experience and contentment extending to family members appears to play a crucial role in shaping and strengthening international doctors' support systems, despite the absence of a broader network of extended family and friends.

International doctors also held positive views of Irish people who, they claimed, assist in their assimilation. They spoke highly of Irish people, reflecting their favourable view of their '*kindness*', '*friendliness*', and '*welcoming nature',* which generates a web of connections: *'I like Irish people, I think they are kind*'…. *'I have many good friends now who are Irish'* (P18,F,International). Some even mentioned one-off experiences of positive interactions with Irish people in their community which make doctors feel comfortable and accepted: for example, one participant noted that '*people here are friendly, warm and welcoming. I would say one reason I feel comfortable to be here and happy is because of the people. Even on a busy can day at work, sometimes a small kind incident at Aldi parking lots with others change*

your day. It brightens up the day. Like, sometimes I won't have coins for parking.... and someone will just come without even me asking to help me. I guess this type of gesture is really nice' (P7,F,International).

International doctors found it easy to integrate into Irish society and felt familiar with their environments and the people with whom they interacted – one participant summarised their experience by saying that '*My integration with Irish people has been really, really good*' (P9,M,International). More specifically, this situation has also led them to be part of the community and receive many different types of support. For example, one interviewee noted that: '*My landlady is amazing. We will go to the beach together. Em, I have just integrated very well to be honest…. Sometimes I spend [the] weekend just venting out about work to her, and she is very supportive emotionally. She isn't a medical person but she gives great advices…I think I am just lucky*' (P6,F,International). Another participant spoke about getting childcare support from their neighbour*: 'I couldn't get creche for a year…. We was panicking every single day… and my neighbour who is a mum of two agreed to look after my son…. She don't have to, you see, but she stepped out to help us. It was such a relief to know he is in a safe place and he loves it too since they boys and my son get well very well too*' (P28,F,International). To some extent, doctors expressed positive feelings about how difficulties helped them to encounter and value community support.

In the same vein, international doctors, mentioned that they have a circle of people from their own ethnic group or nationality living in Ireland, and that this is helpful even if it is a small circle. One doctor commented specifically on the way this helped to compensate for supports they may miss from their home country: '*We have our community here. We meet often, do parties together and that make us feel like we aren't missing anything much'* (P13,M,International). This circle offers a balance with their integration into Irish life, by allowing engagement with their 'own' community and culture through attending cultural events

and participating in regular social interactions. This provides a sense of belonging, continuity, and support that adds to their experience of living in Ireland.

> *[From a] gathering point of view... yearly we try to attend, whichever city we are working in, the local [Eid Mubarak] gatherings – we have Eid celebrations twice a year. And so we try to attend that, whichever city we are living in. We try to see if there is any cultural event going on in Dublin or near the city, for we love to go and attend there.* (P7,F,International)

> *I continuously, regularly communicate and intermingle with my community. And I invite my friends to my side and we also go to them. So, we are quite… interaction is ongoing there.* (P17,M,International)

Generally, Irish doctors derive significant support from their families, including extended families, and social circles, while international doctors, on the other hand, tend to emphasise the importance of their immediate family members and local community in establishing connections, relationships, and links.

Theme 3: Community bonds: giving back to the local community

This theme was primarily observed among Irish doctors who spoke about commitment and dedication to their local community in the form of contributing to it thorough their daily work efforts. There appeared to be a strong sense of a duty to serve and give back to the '*the community which I belong to*' (P3,F,Irish). They felt a strong sense of camaraderie with, and care for, their communities, and these feelings resulted in sentiments like being '*honoured to be able to serve the people who are your community*' (P24,F,Irish). Typically, participants talked about the sense of connection and motivation they experienced when '*someone walks into the hospitals or I see a patient during a surgery they could have been my teacher, football coach, from my neighbourhood or someone I knew, so I am happ[y] to serve these cohort of people… really*' (P31,M,Irish). Their sense of satisfaction and fulfilment in serving 'their people' was heightened by their personal connection and a clear understanding of the impact

of their work on these individuals. It was suggested that these types of satisfaction '*aren't going to be there if I leave this place*' (P31,M,Irish). In a similar vein, another doctor explained that his motivation for pursuing medicine goes beyond financial reasons and involves a strong desire to contribute positively to his community to which he feels a powerful connection. Specifically, he acknowledged that, while there might be alternative paths that offer greater benefits such as working for a different healthcare system which offers better working conditions, he still works for the HSE as he strives to make a meaningful impact on his own community:

> *Why am I putting myself through all this. It's kind of to help, kind of, Irish people, to help the people…. I'd much rather be at home treating my community than working in some place in the States where I have no connection to.* (P26,M,Irish)

For interviewees from rural or less privileged parts of Ireland, the emotional value of giving back was most apparent, because they valued the opportunity to make a meaningful contribution to their local communities. These doctors spoke about facing many unique challenges and a lack of opportunities available to them while growing up. Often, pursuing their interests was difficult, and they expressed their gratitude for the opportunities they had found and emphasised the importance of giving back to their community:

> *I am the first generation who went to college in my family and extended family – my dad is a farmer and I really think it is important to give back to my community at this stage of life.* (P22,F,Irish)

> *It is really important to me what I do here … [I'm] from a small town in Kerry, em, very much a resource-poor part of Kerry. Education there, or in the part of Kerry where I was, was extremely limited…. Like, you know, the school I went to when I was in my teens was extremely small. In the first year of my class there was about 16 people and, even*

after two years, by the time I was about 13 or 14, that group of 16 became 11, and then moving on to the 5th and 6th years of that Leaving cycle,[3] *numbers just dropped off left, right, and centre. Knowing about health sciences was quite difficult. It was something you had to learn. When nobody around you is talking about this kind of stuff you have to try and find it out on your own and, even back then, as you know, the internet wasn't as big a thing. So, I don't know how I got it, but I managed to get this book from a guy who was a Guidance Counsellor in Tralee, of all places, and he gave me this book which was a very quick summary of all the courses available in college, and that's where I learned about science. So, I had to leave my school in 6th year and go to school in Tralee just to do sciences, so it was a bit challenging, but, anyway, in the end it worked out. Just, if you find yourself in kind of, em, remoter parts of the country – and that's true for anywhere, it's true for this part of the country and I'm sure it's true for anywhere – em, just accessing those kinds of opportunities are a little bit more challenging, like.... So, I definitely really enjoy and appreciate what I have so far... giving back to where I am from.* (P12,M,Irish)

These doctors also spoke about how they feel their background creates a unique empathy for patients from similar areas, helping them to understand their fears and anxieties, which can include going to the hospital when it is not a regular occurrence. They appreciated that this can be a daunting and unfamiliar experience as it takes people beyond the local community and the more familiar local medical environment:

I suppose I'm from, like, a very rural area and, you know, we'd – it'd be a lot of farmland and farmers and people would just be very private. So, for someone to go to the hospital they, yeah… we might know some of the nurses in the local hospital – but, you know, it

would be a scary, intimidating process, and you have to go and wait in the emergency department for how many hours and then, you know, you don't know what the process will be, and then family trying to find out what's happening. So, I'm just very conscious of that, and, you know, conscious of communicating with people and letting them know what the plan will be and how it's going to work out for them. Because I understand their anxieties. As the girl, before a doctor, from their local community, I always want to make sure they feel safe, secure, and comfortable visiting a doctor, or going through surgery. (P3,F,Irish)

Doctors suggested that this sentiment became noticeably more prevalent for them when the COVID-19 pandemic took place. Irish doctors expressed that they felt '*grateful to be here treating the locals*' (P2,M,Irish), '*at least I am glad what I was doing has some meaning to the locals, especially during this crisis.…it's something really unexpected you see*' (P15,F,Irish) as they perceive that the community greatly depended on and '*needed our [their] services during this crucial period*' (P2,M,Irish). These statements reflect a positive and committed attitude toward the people that they are helping through their medical expertise, especially in the face of a challenging global pandemic.

Theme 4: Engagement in sports, recreational activities, and social interactions

Many interviewees see their local communities as spaces where they can engage in various leisure pursuits which add interest to their lives and meet the need for things like fitness and social connection. Some indicated that they have very '*limited time available to participate in all non-work activities*' (P1,M,International) or even are '*extremely tired after reaching home after shifts*' (P8,F,International) due to their intense work schedules, but they emphasised that, when they have the opportunity, they try to attend and enjoy experiencing these non-work activities and the perks that come with them. As one participant explained, '*I don't do it often,*

but I do it when I get a chance, and I love it…. I go [to] yoga near my place…. It's really nice to switch off, get some workout done and make some friends' (P18,F,International). It is important to note that some interviewees highlighted the significance of engaging in simple activities with their family and friends, as well as the prospect of socialising with others, as a means of attaining respite and relaxation from their demanding daily routines. This respite, in turn, offers them some mental clarity and refreshes their minds.

> *Some Saturdays…of course when I am not on call, I will just for a coffee and cake with my mum. We normally chat for hours in the coffee shop and that's my therapy for sure (laughs).* (P4,F,Irish)

> *[I] go to the cinema... try and make plans….to meet some friends.* (P22,F,Irish)

> *I do things like go for cycles with friends… just to clear my mind.* (P6,F,International)

> *Now, since the exams finished, life started kind of filtering through again. So, for example with the kids now I'm doing my best to expand out their social lives and equally mine too… like having playdates during weekend and those opportunities at the school gates, those conversations, those connecting with other mothers 'oh you take my kids when I'm doing this, I'll take yours the week after.* (P21,F,Irish)

Participants also spoke about enjoying meeting their friends for coffee or dinner for casual conversations. Significantly, they noted that, during these engagements/meetups, they purposefully steer conversations away from medical topics, allowing themselves a reprieve from their professional attachments to give themselves a break from work: '*I meet my friends for coffee, for dinner, and try not to talk medical too much*' (P22,F,Irish) or '*[I] spend time with my wife, meet my friends in the park… and of course avoid medical topics…. Not sure if you know, we doctors when we meet outside of work, we tend to talk about work, even to my wife... I talk a lot about work…. She sometimes will stop me…. So, when I meet my friends who*

are a mix of medical and non-medical fellas, I try to talk about life, kids, school, something fun rather than getting bonked with work topics all the time' (P5,M,International).

In addition, interviewees recognise that these activities offer physical and recreational benefits – '*[It] builds a bit of relationship*' (P28,F,International), and can create '*some sort of friendship'* (P1,M,International) – which they deemed to be important: '*I have a few friends in yoga class and they are very nice to talk to too…. You don't believe me; I hardly get time to actually do any of these. It's only last year I took the effort to join the yoga class. I think it's very important to see to do something apart from work and make some friends*' (P18,F,International). These activities serve as a social platform for making connections and friends, whilst also fostering relationships and camaraderie. It is also pertinent to note that participants perceive these activities as a form of coping mechanism and recovery from their demanding work environment, which they note in phrases which mention that '*it's so important for us to bounce back*' (P4,F,Irish), '*feeling refreshed*' (P18,F,International) and the need to '*recharge'*(P8,F,International). Some doctors also mentioned that they had taken the initiative to commit to a fitness routine by joining a gym or participating in soccer games which they do in collaboration with their co-workers. Participating in physical activities with people from the same workplace was found to provide motivation, as there is a sense of peer support that encourages participants to engage in these activities, and this can make them more effective than solitary endeavours.

> *I joined a gym! I joined a gym recently, with one of my co-workers, to stay accountable. We don't get to go to gym together everyday, but sometimes we do, at least it is something we tried doing outside work to keep us going.* (P4,F,Irish)

> *I'm playing soccer. I play football with a few people from [my hospital] once a week – that is good because it's something I do outside of work, and these people, you see them*

every day, so they always check if I am attending the game… It's good, so the result is that I do some exercise then. (P31,M,Irish).

Essentially, engaging in activities, hobbies, social and community events with both work colleagues and individuals outside of doctors' workplaces helps cultivate doctors' overall relationships with people and expand their social circles and networks.

5.3.3 Sacrifice – community embeddedness

In discussions about community embeddedness, sacrifice refers to the perceived cost, or benefits that would be lost, when an employee chooses to leave their job (Mitchell *et al.*, 2001). Sacrifice relates to the ease or difficulty with which links and bonds can be broken, with such discussions encompassing the tangible and intangible costs of departing from one's community, including real, perceived, psychological, social, and material costs (Holtom and Inderrieden, 2006).

Theme 1: Leaving family and identity behind

Participants, specifically those of Irish origin, highlighted that, though they are aware that the '*work aspect is really hard*' (P3,F,Irish), with '*poor conditions'* (P15,F,Irish), there are some significant sacrifices that they would need to make if they moved to improve their work situations. This is accentuated because of the associated complexity of inter-job mobility between public and private hospitals (as discussed in Chapter 2), which is not possible or is not straightforward due to differing employment conditions and the current economic conditions. In other words, if doctors choose to leave their job to look for better working conditions, they usually must leave Ireland for another healthcare system. This would often involve difficult personal changes, such as moving away from their families for an extended time period and encountering physical separation from their loved ones. Many found this challenging given

their strong commitment to prioritising their families above all other considerations. As one interviewee said, '*family first, then everything else is second…not giving up this for now'* (P31,M,Irish).

One participant suggested that '*leaving family is the hardest… maybe that's the only thing stopping me'…..* '*living in a small town in (mentioned the county), my parents aren't exposed to a lot beyond our immediate surrounding. I am their go-to-person for almost everything and it's really hard to bring them with me, with their health condition, and my dad's love for farming runs deep, and it's the only way of life he's ever known. It's already difficult for them now as I am always at work and moving counties. Definitely can't be thinking about going beyond this'* (P3,F,Irish). Another shared that their '*parents are old and leaving them isn't going to be ideal'* (P4,F,Irish). Similarly, another interviewee mentioned that they consider family and surroundings as the most significant factors when making career decisions, due to the deep emotional connections and dependencies involved, particularly with regard to their parents: '*they are living with me… my dad suffers from some chronic illness too…. So leaving him and going is something I can't do for now'* (P31,M,Irish).

The COVID-19 pandemic was an additional factor that has influenced some Irish doctors' decisions to remain, as they became more concerned for their vulnerable elderly parents and were unwilling to leave them all alone in Ireland:

> *With Covid and its impact now, I am thinking twice. My parents are here, and I have no siblings, and I guess Covid really made me think if I really want to leave. Maybe not... my parents will not have any support if I leave.* (P24,F,Irish)

> *I think Covid, and then my dad died, and all my brothers and sisters are abroad, so my mom is still here. So, I think they are really the two reasons. It's a lot to decide to leave now when I think about what my family really needs.* (P20,M,Irish)

Typically, doctors are reluctant to sacrifice the opportunities to render support and fulfil their responsibilities and obligations as children, where their parents heavily rely on them. This sentiment appeared to become more profound owing to the COVID-19 pandemic, which was emotionally challenging due to the uncertainties it brought to the fore.

In the same vein, a mix of Irish and international participants who are married with family and children expressed that they occasionally have the desire to leave their current job for the sake of better working conditions, but ultimately, they decide to stay due to concerns over well-being and the preferences of their family members, such as the opportunity for their children to remain in the same schools:

> *If we leave, my son needs to change school…don't think it's the best decision and I don't want that ….It is important for him to get more chance to stay in the same school.* (P22,F,Irish)

> *My two girls are happy out in their school, I think if we leave to Australia now, they need to a lot of new adaptation which I think not necessary.* (P24,F,Irish)

> *I can go to[the] UK, I know I will get training quicker in UK, but when I was moving around, my son changed creche twice and it was having a negative impact on him because he has to make new friends, he has to interact with new teachers…. The first few weeks he was constantly crying before going to creche, and then slowly he understood, he adjusted there, and for now he is happy there. And there is a school beside the creche too which I am planning to send him[to] … as he already made some friends in creche who [are] going to the same school… and my work is sort of settled too [I don't need to move outside Dublin for now], so, again, taking him out and doing drastic change will be difficult for me and [even] more for him.* (P7,F,International)

Similarly, some participants mentioned the career stability of their spouse as an important factor in their decision-making which they aren't ready to sacrifice: '*you know, my husband is working here, but he can't change his job like that… I mean the same company. He can't transfer or change easily …. I am also not leaving him [and] the family alone here*' (P7,F,International).

One doctor explained his consideration of this factor in a way which made clear that, when decisions about family relocation are being made, doctors are often obliged to take on board their spouse's points of view: '*my wife will kill me if I want to leave– her job is very flexible and settled – and she definitely won't be following me if I am leaving… and I won't be leaving them here and going alone*' (P20,M,Irish). Another important factor which reduces the likelihood of moving arises when employees are reluctant to give up the familial support systems which reduce their financial burden, including childcare costs. One participant shared his appreciation for the fact that '*my brother's wife is looking after my children. I am so grateful as I am saving tons with the help she is giving. I know I draw a reasonable wage, but childcare for three kids below 4 is mental. It's only if you are close to family [that] you can get this sort of help around*' (P24,F,Irish).

Doctors stressed that '*family is the most important thing*' (P12,M,Irish) and that there is a need for multiple considerations, including deep thought, discussion, and compromise, before making a decision to change jobs, as it entails significant changes, not only for the individual but also for their immediate family. In other words, they were unwilling to compromise and go to a place that appeared to have better working conditions but required significant personal sacrifice: '*I know the [working] condition in Australia is better, but it's too much to think and change and do really if I want to leave*'*…not really ready to do that for now'* (P22,F,Irish).

Furthermore, participants, specifically those of Irish origin, reflected on their upbringings, through which they had established deep-rooted connections with, and appreciation of, their background, as well as significant values which they found extremely difficult to compromise: '*it's very hard to let go where I am from*'…*this is where I belong too, my family is here and I have some sense of identity'* (P23,F,Irish). This showed that they view their own upbringing positively, believing that it holds certain important values and qualities that are important to them and which they want to pass on to their children: *'I have been raised here and I want my children to be raised here too*' (P3,F,Irish), '*I am just doing the same for my children, it is just what we are use too…. I only can see that for my children here*' (P2,M,Irish). Thus, the sacrifice would be that their kids might not gain key values aligned with their own.

Similarly, some doctors expressed complex emotions about, and a sense of identity connected to, being Irish. They perceived leaving as letting go of this key identity: '*I really want to stay because I think Irish people just have an inherent like of being in Ireland, it just has an inherent draw to live and work here.. this seems to be more important*' (P26,M,Irish). One doctor explained that '*I know my work conditions suck, and I have a friend works in Australia now. She feels it's better there, but she said work is okay, but… for me, I think this is a big thing. I want to go, but giving up the upbringing that I had, and which my kids won't have if I leave, is something is really stopping me…like, you know, missing some part of Irish identity'* (P21,F,Irish). Some interviewees emphasised the importance of place by expressing that they are '*not a city guy, you know my story. I come from a very rural place, where we are close to our families. Family, friends, our little farm, and garden are all my life and I feel I am incomplete without them. So, staying here, despite knowing the fact the system is a failure like more of a disaster, that I accepted for myself*' (P12,M,Irish).

Besides, challenges such as finding a new job for a spouse, new schools for children, and adjusting to a different community, culture, and social norms are significant and can involve

substantial sacrifices when a junior doctor has family commitments '*because you can't do the things instantly if you have family, if your husband is working, if you have the kids that there is school going, like you know the further change all the environment that sometimes not effect positively*' (P21,F,Irish).

Theme 2: Feeling settled

Some participants expressed a firm commitment to settling in Ireland, and, where they had taken steps towards doing so, this gave them stability that they were reluctant to relinquish. For example, when participants mentioned that '*we just bought our house here*' (P7,F,International), '*we bought a house in Dublin and wouldn't want to make any drastic change for now*' (P2,M,Irish) or '*I have bought a house so definitely I would stay'* (P8,F,International), they typically associated feeling settled with their property purchase and a motivation to stay. As one doctor noted, the work already invested in putting down roots is a definite motive: '*we have also bought our house here and feel settled ….it was tough to even get a house*' (P10,F,International*).* When a participant or family member *'has a business here…more like a family business'* (P30,M,Irish), this can also motivate a doctor to stay. These sorts of commitments gave participants a sense of obligation, responsibility, and societal pressure which was difficult to sacrifice. In other words, according to doctors '*moving is a big decision…. It's not only packing the bag and go*' (P21,F,Irish), and this creates the need for careful consideration of and thoughtfulness about the '*many factors involved'* (P21,F,Irish) and potential consequences associated with such decisions. This complexity renders the act of making sacrifices all the more intricate. Individuals who are older and more senior often feel that their life circumstances have now changed to include more responsibilities and different priorities. This leads them to place greater value on stability over adventure or new experiences: '*maybe I would have considered if I was younger and more mobile. Now, life's priority is different*' (P13,M,International). Other participants with personal ties mentioned the possibility

of moving in purely theoretical terms which depended on them not having those ties in place: participants qualified their comment with phrases like, '*if only I was young and I don't have to think of anyone (laughs)* (P19,F,Irish), or said that '*I would have packed and left in my 20s'* (P21,F,Irish), noting that '*things which I would have just let go were different when I was single or the time I just finished my medicine, now having a family behind and kind off settled in life, certain decisions have quite changed*' (P14,M,International). These comments link doctors' practical realities with their personal aspirations and the commitments that they have at certain stages of life, and shape how opportunities to leave are perceived. As one doctor commented, '*now I am 39, 40 next year and my total to do list in life has changed. I have settled down in (county) and moving looks really big now'* (P2,M,Irish).

Beyond this specific attachment, some participants highlighted a deep sense of comfort and attachment to their current residence and location. These comforts included strong emotional, social, and physical ties. They emphasised that, although this sense of comfort did not necessarily extend to their professional lives/jobs, they felt it in their current living environment. Whilst their work environment is challenging, many participants pointed out that their life outside of work is fulfilling. For example an international doctor commented that '*we are so comfortable living here, though that comfort is not in work, there is comfort and settling feeling outside*' (P16,M,International), while an Irish doctor spoke about how '*we live in (an urban area) and my kids have adapted so well with the locals around….definitely we have a sense of community*' (P22,F,Irish). This comfort combats feelings of exhaustion and makes the prospect of relocating and settling in a new place if doctors change jobs more daunting. In other words, it creates a sense of reluctance to undertake the demanding process of relocation: '*[I'm] not sure if we have the energy to go and look and buy property in a new place… we are so done with all that*' (P8,F,International). To put it simply, many junior doctors perceive their lives in Ireland with satisfaction and feel '*somewhat settled*' (P1,M,International) through their

creation of multiple types of commitment which they perceive as being difficult to sacrifice if they decided to leave their jobs.

Theme 3: High-quality education and institutional resources

Most doctors, but specifically international doctors, emphasised high-quality education and the well-being of children as being important to them and something they don't want forgo. As one doctor noted, '*something I wouldn't sacrifice is the education…because schools are very good here*' (P13,M,International). International doctors perceive themselves to be '*lucky enough to come here*' and their '*children to get exposure over here*', which they '*don't want to let go of easily*' (P7,F,International). The free, high-quality education on offer is a significant retention factor: '*I love the fact that my children are getting a very high-quality education here and it's free*' and this advantage is weighed up in ways which mean they '*give priority to it more than work*' (P5,Irish,International). Moreover, they highlighted that other institutional resources, such as local libraries and childcare facilities, are important and superior to similar facilities elsewhere: '*It's different you know, we spend our weekends in the public library, my daughter is really getting exposed to a different style of living which I don't want her to lose just for me*' (P13,M,International), while another doctor worried about '*the need to give up other things like a good creche and even good options for after-school facilities* (P28,F,International). Comparing the resources and lifestyle benefits they gain from living in Ireland with their home countries, many participants stated their belief that Ireland offers better benefits in comparison to those countries:

> *They have childcare facilities you know. I mean good ones …. have you heard about childcare/creche in [developing country] Gosh, they are not that good you know*'. (P14,M,International)

> *Back in (developing country), only my mum looks after my son since the childcare services are not good and there are also not many in my town…but here it is not the case…. Sometimes its just not about work, its these things you see when you making decisions… of course for now, I don't want to lose this* (P16,M,International).

Irish doctors also had concern about the potential disruption to their children's lives if they move, and especially the loss of stability and social connections the children have developed at school and in their surroundings. They emphasised that their children are at the stage of being well-established in their school environments where they '*are grown*' (P21,F,Irish) and '*well settled in school*' (P22,F,Irish). This means, any discussions they might have about potential changes to their jobs might disturb the social bonds their children have formed. This indicates that choices are not just about school and education but also about the emotional and social connections which are important for children's well-being: '*they are happy out and they have friends in school now with whom they have built a healthy relationship…leaving Ireland means they have to sacrifice all this you know'* (P22,F,Irish). A few Irish participants also mentioned their children's activities in school. For example, one participant mentioned that '*my daughter plays camogie for school and she is looking forward to represent Cork next*' (P21,F,Irish), while another explained that '*my son is very involved in the church choir*' (P2,M,Irish). Children's sense of belonging in local institutions and the communities around them, as well as the continuity of children's lives are given priority over professional considerations and typically made participants very reluctant to leave.

5.4 Organisational embeddedness

Organisational embeddedness refers to the degree to which an individual is integrated into, and committed to, their organisation. It is characterised by a reluctance to leave, even when alternative job opportunities are available (Mitchell *et al.*, 2001). It is important to note that,

when an individual is deeply connected to their job (demonstrating job embeddedness), this does not necessarily mean they are also deeply connected to the organisation they work for. As discussed in Chapter 1, within the scope of this research, the assessment of organisational embeddedness among Irish public hospital system doctors pertains to the Health Service Executive (HSE), which is the predominant organisational entity for doctors in Ireland. In this context, switching between different public hospitals is infrequent among doctors in the public sector, though this is not always the case for doctors who aren't on training.

In this study, organisational embeddedness emerges as somewhat lesser or lighter in its impact on doctors' intention to stay in comparison to community embeddedness. Low levels of organisational embeddedness appear to be strongly related to the well-documented issues and challenges within the Irish public hospital system, particularly poor working conditions. While the research uncovered some organisational embeddedness factors that play a role in influencing the intention to stay, much of this can be apportioned to the postgraduate training programme, which provides doctors with meaningful benefits. This programme is run by an external professional body which operates as an integral part of the Health Service Executive (HSE), and its ability to function depends on collaboration with, and the use of various resources belonging to, hospitals and stakeholders, including consultants and clinical directors who play pivotal roles within the hospital setting by proving significant support and guidance.

The key dimensions of organisational embeddedness – fit, links, and sacrifice of organisational embeddedness – are explored below on a thematic basis. This study found that these dimensions are perceived quite differently by different doctors, reflecting a similar pattern to that discovered in their views on the distinct elements of community embeddedness.

5.4.1 Fit – organisational embeddedness

Fit, in this context, pertains to how well a person's skills and interests match the requirements of and benefits offered by an organisation. It encompasses the process through which an employee assesses how their values, knowledge, skills, and abilities align with the culture and demands of their job in the organisation (i.e., the HSE) (Mitchell *et al*., 2001).

Theme 1: Being a trainee doctor

Trainee doctors (enrolled in postgraduate specialty training) felt that the training and development that their role provides is an excellent fit for them. The training programme is understood to provide a clear set of '*expectations and objectives*' (P30,M,Irish) which ensure participants cover key aspects of the skills and knowledge needed for their medical work. It is also sufficiently rigorous to enable them to utilise their skills and capabilities effectively. Trainee doctors commonly expressed the view that they have '*a great training body*' (P3,F,Irish), which is '*very highly prestigious'* (P1,M,International), and '*specialised and academically driven'* (P21,F,Irish). The rigorous and esteemed nature of the training programme comes *'with a clear [structure, which makes] clear what needs to be done and what is next'* (P23,F,Irish), and this suggests that it has a strong scholarly focus which offers an important sense of direction and guidance in the early career phase of doctors. Many participants highlighted that, though the working conditions in the Irish healthcare system are considered inferior, the postgraduate training programmes that the training body provide are considered '*first class'* (P14), and the training body is often praised for being '*very proactive and innovative in trying to make situations better for trainees'* (P31).

Interviewees felt that trainees are assigned a designated trainer who acts as an additional support system, supervising them and ensuring they fulfil required tasks and targets. One participant noted that, '*since I am in training, I have my trainer who really supports me in my*

work and the training modules… at least I know there is someone I can go to' (P4,F,Irish), and another praised the programme before adding, '*not only that, we also have our trainers who are mainly in charge of training us' (*P15,F,Irish). One trainee doctor explained that '*If I do have a issue and don't fulfil the training checklist, I just go to my trainer and I say "trainer, I need to do this [clinical procedure]" and then he will assign someone to make sure they supervise me and I do my one c-section, you know? A simple thing. In [the place I was before training] maybe I did ten caesarean sections. Here, I'll be reaching thirty'* (P1,M,International). These trainers are generally held accountable for overseeing and supporting trainee doctors to make sure they *'tick the boxes'* (P10,F,International), and complete their assigned training tasks: *'my trainer will make sure I get it done and this is an advantage of being in the training programme'* (P20,M,Irish). This sort of mentorship and support structure is seen to be an essential advantage, not just of the programme but of being a junior doctor in Ireland in general.

Crucially, some interviewees mentioned that it is only through the training programme that they gain access to '*clear requirements and regular reviews'* (P2,M,Irish), with '*constant feedback'* (P4,F,Irish) and useful opportunities to '*be able [to] learn*' (P10,F,International). For example, one participant said, *'I think I learn and get the required skills only because I am doing a training'* (P21,F,Irish). They feel the benefits they gain from the training are significant and it is something they are very '*grateful for as the system [i.e., the hospital health system] don't really have any sort of feedback or review on their work*' (P31,M,Irish). The training programme stands in contrast with the general HSE system where the general attitude is '*no news is good news*' (P1,M,International),. When doctors are in the training programme, they '*experience a high standard of training and ideal way of work*' (P20,M,Irish), but doctors emphasised that the consistent and excellent experience gained from the training body is '*not available to doctors in their usual work setting*' (P19,F,Irish). One doctor, in particular, praised

the comprehensive level of support which makes the training programme a conducive environment for trainees: '*if you face any issue, your training body is there to look into you and your issues which normally the hospital doesn't*' (P24,F,Irish). As a result of this, the training body stands out as a reliable and high-performing entity that contributes positively meeting the needs of hospital doctors: '*I have nothing but good things to say about my scheme overall*' (P5,M,International).

Participants also feel that the training programme offers them '*quite a clear progression pathway*' (P5,M,International). For example, one junior doctor mentioned having '*a very clear path. I mean, [training body] has structured everything in that it's a very structured progression*' (P27,F,International). This progression includes career pathways: '*there is very clear structured career progression… as there are jobs at the end of it as consultants*' (P20,M,Irish). Many participants highlighted that this clear progression is only possible due to the training programme. One noted that '*without the training body, I can't seem to see how am I progressing or even how I get to measure my career progression*' (P3,F,Irish), while another commented, '*I think I have career progression, only because I have joined the training. Now it's very clear since I know what needs to be done and how I will progress. Otherwise, it's not that easy*' (P26,M,Irish). This is mainly because the training is structured in a way that provides exceptional clarity with regard to its objectives, with a detailed curriculum and clear learning outcomes. Participants emphasised that the programme's structured approach equips them with tangible metrics which enable them to assess their own progress, and they observed that, outside this structured framework, self-assessment becomes an uncertain and challenging process:

> *Within the BST, you have to do six months in neonates, six months in a specialty, six months of gen paeds. The other six months can be anything and then you interview, you do your exams, and you progress to the HST, and that's five years and it's very much*

laid out. The first two years are a year of neonates, a year of community hospital. Then, after that, in the next three years, you have to do at least one year of clinical and then you can choose whether you want to do a year of research or teaching or something. So… the progression is quite structured. (P4,F,Irish)

There is a clear progression as long as I have finished my clinical exam, training requirements and procedures and get through my annual review yearly… So, once you have that done, I think you are on the verge of becoming a consultant after next 3 to 4 years or so. (P12,M,Irish)

These statements regarding having a clear, structured programme and defined learning outcomes by trainees, were also backed by non-trainees who shared their perspectives. Most of them expressed their concerns over the significant *'lack of supervision and teaching'* they experienced, since they were '*not in the training scheme'* (P17,M,International). Some stated that [it is] '*like there is no one to tell you, [so how] do I improve these areas? I need to improve on this…since we aren't like the trainees, we don't have a portfolio which we need to fill in every 6 months…we don't fall into the 6-month review process. So, for us, if we don't hear any complaints, we just assume we are doing a fine job*' (P6,F,International), while another commented that, '*Since I am not in training I don't have feedback, or any check list. to complete on my procedures, [and] surgeries that I do'* (P13,M,International). Some even highlighted that they generally face challenges in '*monitoring [their] progress'* (P9,M,International) and '*having not a clear career path*', (P,28,F,International), highlighting that they have a vastly different 'learning experience' compared to the trainee doctors.

In this study, trainees at specialist registrar (SpR) level, who are typically in their final stages of training, emphasised the unique advantages derived from their programme. These benefits are generally not included in the standard experience of hospital doctors in Ireland. The SpR noted that they generally have '*protected research time – you have a day a week to do*

research' (P23,F,Irish), and this is typically a designated period where SpRs can engage in research activities without interruptions from their regular clinical responsibilities. They can also prioritise their research through designated time for *'some sort of special interest that's separate from the day job'* (P23,F,Irish). This enables these doctors to explore areas of particular interest to them. SpRs also benefit from a few opportunities for job flexibility, such as SpRs being allowed to do on-call duties from home, which they perceive as offering a major improvement in their professional lives: *'I am now SpR so I do on call at home – it's a game changer'* (P3,F,Irish)*, my on calls are more reasonable now as I am home and only contacted if needed through phone* (P14,M,International). This type of flexibility means for SpRs that their work-life balance has improved which means they can now commit to and enjoy structured activities that give them a sense that they have a better quality of life:

> *I have been able to do more structured activities since I have stopped doing on-site calls. That was quite disruptive, so it was hard to commit to anything, like guitar lessons, because you often would be unavailable. But, yes, I think it's really important to have that balance. I am having it more now to be fair.* (P21,F,Irish).

> *I am in the SpR post now, I have completed all exams.. I have a day off every week to work on my research, I am writing a paper collaborating with my consultant. This one day off in the middle of the week really benefiting me as in some sort of rejuvenation.. like getting energised. I also get to do my lunch hour walk once a week or even go to the gym, which I can't when I am on hospital runs, which normally I start at 7am and go up to 7pm… just like a marathon.* (P3,F,Irish)

Theme 2: Consultants as pillars of support

Most participants recognised that their consultants are a good fit for them in comments that indicated they highly appreciated the guidance and support received. They frequently highlighted that '*we have very supportive consultants*' (P14,M,International), '*I believe that in most of the hospitals where I've worked, the consultants are genuinely kind*' (P15,F,Irish). Others praised the quality of support, noting that their '*current consultant is excellent*' (P1,M,International) or '*the consultants are very sensible and helpful*' (P23,F,Irish), while others emphasised the value of their consultant being '*ambitious, proactive and a good teacher*' (P6,F,International). Many consultants were perceived as individuals who not only provide guidance and support but also impart knowledge and expertise. One trainee felt that their consultant '*fostered personal growth, learning, and a positive encouragement on those they worked with*' (P3,F,Irish), while another trainee doctor noted the motivating effect of her consultant's encouragement: '*I have been doing audits. I'm now writing an article… my consultants are trying to push me to do stuff to improve my CV… She always motivates me to do more than just the clinical stuff, which in a way I am grateful [for]'* (P26,M,Irish). Other participants echoed these types of praise, mentioning that *'my consultant encouraged me to complete my exams, and she was like one main reason I completed all papers on time*' (P23,F,Irish), or pointing that that his sort of support and encouragement makes doctors feel that there is '*somebody that believes in you and helps you*' (P1).

Some trainees suggested that their consultant was '*a good mentor'* (P1,M,International) and '*role model*' (P12,M,Irish), since they believed that '*their teaching, guidance, and sometimes their encouraging words make them [a] better doctor'* (P12,M,Irish). They saw their consultant as a person who is '*inspiring*' and who they '*always look up to*' (P2,M,Irish), as well as a '*a good clinician*' and '*a supervisor*' (P5,M,International). In fact, consultants of this type are

seen to exemplify qualities and characteristics which doctors find inspirational – '*I always tell myself, that when I am consultant myself, she is the person whom I want to become'* (P24,F,Irish). It is clear in comments praising consultants that a positive experience in the training phase encourages trainees to feel more invested in their careers, as they talk about becoming, in the future, the kind of inspiring person they admire, using their role model as guidance , and providing support in turn for their own trainees: '*[I] hope that when I am at his level, I can do the same for the juniors*' (P26,M,Irish).

Some non-trainee doctors, who face significant challenges due to the absence of structured learning opportunities, training, and supervision in their day-to-day work experiences, also expressed positive opinions about their consultants, suggesting that '*at least I have a consultant who really fulfils their duty as a consultant'* (P7,F,International) or noting that '*the consultants are generally very nice'* (P17,M,International). They suggested that consultants often take steps to advance their skills. For example, '*consultants at times make a big change in our work life since we are not in the training…. What I mean is like... let's say, if I need to do more procedures to get experience on [explained medical processes], normally a trainee doctor will be selected to do it since they need to meet their training requirements, but if the consultants want us to equally have those chances they will say "[mentioned name], why do you not do it and I will oversee it?" …. So, in a way, they try to foster equal opportunities for us…this is not always the case, but in some cases, consultant really try to help us*' (P13,M,International). Likewise, '*the support and guidance from consultants' has to be* considered *'very important'* for non-trainees, especially for them '*to be able to get some teaching, corrections of any wrong thoughts/medical decisions since otherwise these things don't exist'* (P28,F,International). Overall, one non-trainee doctor concluded that '*we know the system needs a lot of tinkering here and there, but one thing for sure they have consultants who are highly trained, qualified and really well suited to train the NCHD* (P30,F,International).

Some international non-trainee doctors suggested that their '*experience with Irish [native] consultants has been the best out of all the other consultants*' (P17,M,International). For example, one participant commented that '*I know I am not from Ireland, but the way the Irish consultants treat us is just very good. They are professional and they teach, guide and treat everyone as equal*' (P7,F,International). Another participant made an explicit comparison with Pakistani consultants: '*I will say my experience with Irish consultant has been great and even better than Pakistani consultants, like, from my experience, that because they are from my same country…. I know it's a big thing to say, but I would certainly say that… they are more academically driven and I feel the day-to-day work experiences are much more positive*' (P16,M,International). Importantly, it was noted that these consultants try not to '*differentiate trainees and non-trainees and treat everyone in an equal manner'* (P6,F,international) and this mode of professional conduct is preferred as it is perceived to be much more positive for and satisfactory to international doctors.

Participants also referred to the importance of consultants who are protective towards their teams. They considered this to be as crucial as other forms of support. For example, one doctor spoke about a consultant who '*will say, look, we've done what we've done. This is what the team has done, this is the steps we've taken, this is the review process, bam, bam, bam. She will not give in for what is deserved by her NCHD*' (P8,F,International). Respondents see this support as highly valuable, particularly since they feel that their jobs sometimes as a junior doctors '*have no boundaries*' (P3,F,Irish), which can mean they often feel compelled to complete additional work beyond what is strictly required. In these circumstances, it is very useful to have a protective consultant who '*is very good at protecting her NCHD and making sure they do what they are supposed to while at the same time not doing a whole lot of work which isn't necessary*' (P9,M,International). Some doctors also mentioned that their consultants '*make the decisions for us sometimes just to make sure we are not bullied by others*'

(P13,M,International), and this too meets a real need: 'Y*ou won't believe me, we can easily get bullied by others sometimes. The nurse or social worker will demand for so many things from us which is not actually our work. As a SHO, my say isn't that strong, so, if the consultant don't stand up for us, we end up doing all the work*' (P23,F,Irish). Participants believe that this support ensures that junior doctors are safeguarded and that they are not subjected to any pressure or mistreatment from others. One participant described this aspect of a consultant's role as being to '*keep an eye on you to make sure you're safe*' (P20,M,Irish).

Generally, participants emphasised that consultants with the above-mentioned qualities are particularly important to junior hospital doctors, given their lack of experience or the fact that they are still in the junior stage of their career: '*the support and guidance from consultants are very important, especially because we are still NCHD*' (P7,F,International). This reflects junior doctors' understanding that they are '*less experienced*' (P1,M,International) and may need more supervision and guidance than other hospital doctors. For example, one participant noted that junior doctors often '*need final say from our consultants before any decisions*' as they are '*still on junior level*' (P4,F,Irish). This situation results in them perceiving their consultant as their '*main support*' (P28,F,Irish) or even as *'my number one level of support*' (P17,M,International). Some of the participants provided specific examples of the type of support they have received from their consultants:

> *I was walking around with a panicked face and my consultant...was like, '[name redacted], what's wrong? Tell me, come here, you look so nervous. And I was, like, 'No, I'm stuck with [brief on the case]'. 'Don't worry, I'm here. I will make the call'... and he told me, do this, this, this. Like, he literally helped me though he had his own patients and things to deal with that day.... I really think there is good support and good quality checks from the consultants in our unit.* (P1,M,International)

Another doctor shared a similar memory of an incident that had occurred early in their time as a registrar:

> *I remember my very first week of nights as a registrar – I was petrified, like, I just felt like I wasn't ready. I am the youngest registrar in my hospital…. So, I called my consultants on call if I wasn't sure about something, I'd pick up the phone and I'd apologise that I'm calling so late but I'm a new registrar and I just want a second opinion, and she was more than happy to take a phone call. And before hanging up she sort of gave me some encouragement, saying you are doing great and you will be good… it's okay to feel nervous. You will get there.... That just lifted me up. Because I feel as junior doctor... I almost need consultant guidance most of the tim*e. (P27,F,International)

Meanwhile, another participant praised his consultant for their long-term proactive approach to providing support:

> *He actually noticed at the beginning of the year that that I was behaving a little bit differently and he took me aside and [said] 'How are you getting on?', and it was really hard at first to tell him 'I feel like a fake doctor stepping up to registrar so quickly', and he was the only one to sit down and say 'OK, where can I help, what can I do?[clinical discussion]'….*
>
> *So, he basically took the time and effort, even though he had lots of things keeping him busy – but he still took out the time to stay back on Thursdays and, you know, go over the patients with me that I wanted to bring up and that I wanted to discuss. And he knew himself that he was only developing my confidence, that all I needed was just a little bit of confidence, em, and for me that's all it was.* (P10,F,International)

These accounts reflect the vulnerability of junior doctors who are still mastering medical terms and procedures, and they also highlight the significance of guidance and support in a

professional setting. This sort of encouragement and fostering of a supportive environment that promotes growth, understanding, and allows them to seek help when in doubt provides a platform for mutual learning and feedback. This assurance is very important since junior doctors are relatively new to the practical aspects of medical care.

It is also important to note that, even though many participants perceive their relationship and support from consultants as excellent, the most challenging aspect of the experience is the limited availability of time from the consultant. While the consultants are willing to help, the time they get with junior doctors is very limited. This is because they are often occupied with medical procedures, other administrative related requirements and attachments to private hospitals. As a result, they have extremely limited time which can be spent on junior doctors.

> *consultants are usually very helpful, its just that getting time with them is hard…they normally be there for ward rounds for me then they will at some procedures to attend to which we will split and some will have private practice which they need to go to, so they are busy as well* (P13, M,International).

However, these challenges had noticeable improvements during COVID-19. Junior doctor especially noted the increase availability of consultants and the time spent with them. This situation was possible due to the redeployment of hospital staff members. Doctors mentioned that: '*consultants barely having time*' but the *pandemic brought about a different experience* (P8,F,International) which mainly due to '*restructuring of work arrangements* and *reconfiguration of hospital settings*' (P3,F,Irish) which led to many doctors being redeployed to hospital and ward-based care. Consequently, more '*consultants became available*' (P3,F,Irish) on the hospital floor, greatly enhancing doctors' work experiences. Doctors typically observed that '*the consultants were seen more than usual*' (P4,F,Irish) which resulted in better support, better clinical supervision, improved workplace relationships, and boosted

workplace morale. Participants spoke about appreciating the assistance they received through improved oversight of their clinical work, and they also mentioned other personal career development opportunities which emerged because of the increased availability of consultants:

> *I really think the effectiveness of the consultants was pretty good during the COVID stages. The consultants were more available during this time as their consultations and most treatments were cancelled. So they were more approachable and most important they were available in the hospital. Because normally this wouldn't be the case. It's a rocket science if you can find consultants just like that…. Yes, even [though] we know they will help us when we are stuck and give support, getting time with them has been hard, until the COVID changes took place.* (P15,F,Irish)

> *I did lots more dialysis under her supervision since she was available… and also currently I am working on an audit and only when COVID [came did] she have some time to review my audit* (P19,F,Irish)

> *I do think that consultants have become more engaged and, as a result, are probably taking on more leadership and management roles, which is good as well…. It has just reminded people that what we do on a day-to-day basis is kind of firefighting and we suddenly were able to work so much better and deliver much better outcomes for people.* (P20,M,Irish)

> *Of course, she has been always like that, but it was just during COVID we had spent more time together. She saw my interest in her job and in the community paediatrics, so she told me I did this diploma, you should do this diploma and I could be your mentor. And when I start this diploma, It was beginning of COVID so since the elective got*

postponed she had the time to correct my assessment, and helped in lots of extra work… All this she did without being paid just to help me so that's really something…. She even put forward my name for getting funding for one of the courses and I am just grateful she is so kind. After her guidance only, I finally found a space in the system. She is the person I look up to. She is the best mentor (P30,F,International).

While most of the participants spoke about senior consultants who have been working for a considerable amount of time, some also highlighted the supportive and approachable nature of '*new consultants'* who have just completed their postgraduate training programmes and moved up from junior status to consultant level. These newly appointed consultants are considered to be an even better fit for the system as participants felt that the '*new consultants, like the one coming after being an SPR for a few years these days, are really nice in [the] sense that they are approachable, friendly and they think like us*' (P27,F,International).

Another stressed that '*the new consultants, I have to say are brilliant too*' (P18,F,International). Notably, respondents indicated that these new consultants' recent experience as junior doctors had equipped them with the ability to empathise with current junior doctors: '*because they just went through the whole NCHD journey recently and could resonate to the whole mess we have to go through*' (P1,M,International). These new consultants are often found to be even more considerate as '*they have been through the same challenges*' (P31,M,Irish). In other words, '*they kind of know the pain and hardships*' (P7,F,International). In the same vein, some participants expressed optimism about the future quality of consultants based on the fact that they will have relevant experience of healthcare difficulties: '*I have confidence that in [the] future the consultants will be even more supportive'* (P27,F,International).

Theme 3: Transformation of the health system and working conditions during the COVID-19

As discussed in Chapter 2 (The Health System Response to COVID-19 Pandemic), doctors reported notable improvements in their work experience and conditions, especially during the first phase of the pandemic. These changes seemed to match doctors' expectations, abilities and interest in the HSE and highlighted what it could offer to make it a good fit for them, even though it was just a phase. These improvements stemmed from the significant '*reconfiguration and reshuffling of the hospital*' (P18,F,Interntional) and '*new working arrangements'* (P2,M,Irish) which were introduced in response to COVID-19. Doctors mentioned that '*there was a variety of change in the hospital environment*' and the '*whole system was sort of panicked and the NCHD got extremely busy*' (P27,F,International), but the prompt solutions and changes which were perceived to be '*organised and needed*' (P18,F,International) brought some positive changes. In fact, changes which doctors once considered impossible or difficult to implement became feasible during this crisis:

> *Covid did create some positive things for us. (P6,F,International)*
>
> *We experienced different approaches when Covid-19 exploded. Which was positive to some extent, like, the work experiences were better. (P4,F,Irish)*
>
> *We saw some changes and improvements during Covid. That gave me some confidence, that things we thought were impossible previously were brought to our attention that it is possible. (P28,F,International)*

Some doctors acknowledge that the transformation and considerable effort invested resulted in doctors witnessing the system's adaptability and its ability to implement adjustments, though they were highly sceptical about the sustainability of these changes post-Covid:

The system is bizarre, but... we did see some changes during Covid, some positive I would say but I swear... I don't know if things will be the same or even be worst than before after Covid, but at least [we were] seeing that things can be done differently…. (P15,F,Irish)

I saw the system did a lot of changes, took some important effort, but if you ask me will this [endure]. I am not sure, since I was not working here long pre-pandemic. But if you ask me, can the system do it. I would say yes. I saw it. But not sure how long it will last. we just wait and see what happens in future (P27,F,International)

Among the changes experienced by doctors were '*better staffing. [For example,] we were on about a 1 in 6 rota, which is one of the best I've ever been on'* (P3,F,Irish). Doctors' work rotas were much better as '*it was prepared much more better and organised'* (P1,M,International). Typically, doctors stated that '*I won't say that this staffing actually solved all problems ...but... it was better in the sense that everyone had their own bubble which means the team they have to work with and it was clear [when] will be your day off, who is your replacement and yeah. Maybe it was just a push for the management to do things differently.* (P22,F,Irish). Doctors also frequently highlighted that this change in the work system resulted in many doctors being redeployed to hospital and ward-based care. This led to more doctors being available, and this was seen as greatly improving their experience at work, due in no small part to doctors' perceiving their duty rotations as being more manageable. In essence, several doctors felt that extreme working practices, which had become normalised before the pandemic, had been improved to create a much more appropriate scenario. For example, there were more doctors available and there was '*better teamwork'*, (P15,F,Irish) '*a lot of camaraderie and a lot of pulling together'* (P14,M,International*)* as well as '*more consultants were available in hospital*' (P20, M,Irish) which provided junior doctors with better support, clinical supervision, improved workplace relationships, and workplace morale. Doctors particularly appreciated the

increased availability of consultants, as they observed that this marked a substantial change from the situation in pre-pandemic times. This change not only enabled them to receive valuable *'guidance, help and support from the consultants'* (P10,F, International) but also allowed them to dedicate more attention to their personal career development, through working on their audits or research papers. They reported that they had previously lacked this kind of support and had to work alone, and they also discussed how challenging this was for doctors, especially, junior doctors, who were still building expertise and experience.

> *During Covid, actually there were more doctors around. This was unfamiliar before Covid. It was great to have more people.… So, normally, we have two SHOs [senior house officer], one Reg [registrar], and one intern [internship student]. But with Covid allocation, we had three SHOs, two Regs, and two interns. That's really good.… Also, that time, the consultants were seen more than usual. (P.4,F,Irish)*

Additionally, the COVID-19 pandemic prompted a positive shift in overall work culture, especially around expectations and acceptance of illness and taking sick leave among doctors. Doctors mentioned that, in the past, there were '*kind of historical things like people would go to work regardless. The leg could be hanging off you and you'd still go to work'*. This was mainly due to poor staffing and the normalisation of overworking within the system. However, due to the pandemic, health and safety concerns became more prominent, leading management to realise the importance of '*acknowledging illness*', and so there was much *'more acceptance and understanding if someone is sick'*. Specifically, doctors observed there was a greater acceptance and understanding when they were unwell, and it became much more '*normal to take sick leave*' and to prioritise health over work commitments. Some even described this as '*kind of for the first time that I've seen in in more than a decade people are willing to say I am sick. I need to go on sick leave. Before that they will just come in* (P20,F,Irish).

Doctors working in urban hospitals (tertiary hospitals) specifically highlighted the positive impact of non-clinical managers who were involved in COVID-19 pandemic management and who were found to be effective:

We had non-clinical managers who got involved and they did a pretty reasonable plan and it seemed to work out well. Generally, I think non-clinical managers are really positive because they don't accept the status quo. So, they come in and they look at the situation and they won't come with all the preconceptions that the rest of us have. Where we think things should be or can only be done in a particular way and they will also apply a bit of pressure and say that that's not acceptable. I think having properly trained managers who have power and who are accountable is really important as well. So, you know there's a difference between sort of being a functionary and being an actual manager and a leader. So, if you are coming in just to deliver something that has already been decided and that you have no control over , you can be sort of a project manager, but even in that you often have very little influence or control. You're just kind of ticking boxes and making sure that things are done but if there's a problem you can't really go back and change it, but I think having actual trained project managers, people who understand that you need to be agile in health care as well, who then have the confidence and the remit to go back to consultants and to CEOs and say, look, this isn't working? That's really helpful (P21,F,Irish)

Involvement from managers, like in hospital management who are not specifically your team or consultants, was good and prompt. They managed well and this arrangement to work on pods, team-based, was a good and safe approach (P3,F,Irish)

When Covid came first, I was in [name of urban hospital] and it was actually managed very, very well in [urban hospital]. The CEO would send out daily emails and they would

have a daily meeting that you could attend. We knew what was going on, we knew what the lay of the land was, the staffing was organised, there was a proper kind of level of – of management. So, the CEO is non-clinical so they'd come from a managerial background – but in [the urban hospital] they worked well with the clinical staff to make decisions (P4,F,Irish).

Communication and assistance '*in terms of updating and updating of protocols'* were also seen to be '*up to date'*, which kept the junior doctors and hospital teams '*informed on the protocols and the Covid pathways'* (P6,F,International). In other words, there was '*continuous communication as to what is next, what are we doing next, what is the next challenge in terms of this'* (P2,F,Irish) which doctors generally found *'amazing'*. One participant summarised her overall positive experience, commenting that *'I would say yes, [we] got very good management from up above, I mean very good managerial support... they were quick and quite efficient'* (P6,F,International).

Importantly, doctors stressed that this approach was new. They spoke about how, previously (i.e., pre-pandemic), they had never had 'managers' to assist with doctors' non-clinical tasks and requirements. The efforts and interventions of these managers were considered helpful, as they allowed doctors to focus on their clinical responsibilities and roles, while management aspects were overseen by those individuals who used relevant expertise, appropriately deployed.

Doctors also shared their opinions that the pandemic made management '*think out of the box'* (P31,M,Irish) and generally improve on '*flexibility*', incorporating some new initiatives such as *'phone consultations, tele medicine' - phone call to patients who can be treated over the phone or a phone call for patients on repeat prescriptions*' (P22,F,Irish) which *'was a big change to us [doctors] and made consultations move quickly'* and have '*Zoom meetings, Zoom*

training online' which ought to '*save a lot of time*' and also provides options for doctors to review material later, when they need to, at a later time (P5,M,International).:

> *It forced services to think about more efficient ways of doing things… We can have all our meetings on Zoom now and it's kind of mad we didn't think of doing that before it means you can be more engaged with stuff because you don't have to physically go there.* (P3,F,Irish)

> *I think they acted fast and when I said thinking outside the box, I meant the management. They were actually efficient in most of the work arrangement when Covid hit. They moved from the traditional way of how medicine is done to a more contemporary way which was good…..and only during Covid I saw some managers or higher team getting into the picture. But overall, it was way [more] efficient than before*. (P23,F, Irish)

> *the adoption of new ways of doing things, new systems, new technology, that's all been really good….telephone calls and telemedicine. I think that people are willing to change and try new things which were never done before like the way clinics run either timewise or you know physically and that's good for both patients and staff* (P8,F,International).

There were also mentions of the management's thoughtful gestures during COVID-19, where they acknowledged and valued the contributions shown by junior doctors in the face of unprecedented challenges. According to the doctors who participated in this study, this was unexpected as it had never occurred before; however, they highly appreciated it as they believed that a small gesture of appreciation carried a long way and motivated them to work even harder: '*the clinical director actually gave us a little medallion gift ..for all of us … and it says 'Covid-19 pandemic 2020-2021' there also and behind it says 'Dedication, Compassion, and Resilience', you know? This is what – so this small thing, right, like we never expected the clinical director to give us this, you know, this to each one of us.* (P1,M,International).

Overall, doctors stressed that this change which was '*new*' to them during the initial stage of pandemic gave them an '*indication'* and '*hope'* that change was possible and, most importantly, that '*the system is capable to implement changes'* (P20,M,Irish) which could result in '*more comfortable working environment for us [doctors]'*. For example, they mentioned: '*at least seeing that things can be done differently – there is a way, we have a hope maybe things will change for better in future'* (P15,F,Irish.). Even though, the pandemic improvements did not solve all the issues in the system, notable changes were observed that instantly made doctors experience quite positive. However, some doctors did note that, as the pandemic progressed, these positive experiences became more fleeting rather than becoming enriched, and the more positive work atmosphere they had experienced deteriorated progressively: *'it wasn't long as more people fall sick and we have less staffs again' (P5, M, International).* Meaning to say, further pandemic challenges which resulted in more doctors becoming infected, and prolonged working in bubble/pod/clusters resulting in increased feelings of isolation. Nevertheless, they were still glad that '*they did see some changes, though it was a short period…so leaving us knowing the system is capable [of change]'* (P18,M,International) or '*It took a pandemic to see some changes, but [now] we at least we know changes can be done, of course, these things are not easy, but at least we saw it'* (P2,M,Irish).

5.4.2. Links - organisational embeddedness

In this context of retention, 'links' refer to the extent of the connections and/or friendship ties that individuals have with other people and activities within their workplace. Links can also be generated through task interdependence and any sort of relationship with other people and activities in and directly connected to the workplace. For doctors in this study, these could include formal and informal connections created within and through their organisations, the Health Service Executive (HSE) in general, hospitals, and also training bodies.

Theme 1: Supportive teamwork and a collegial relationship with peers

Doctors generally expressed positive views about their relationships with their colleagues, mentioning that '*most of the people we work with are nice*' (P13,M,International), '*people I work with in hospital are very kind, they are nice*' (P6,F,International), or that '*I am happy in the hospital, the team is good*' (P18,F,International). Firstly, they expressed their satisfaction with the positive workplace relationships generated with their co-workers (i.e., other junior doctors) and they placed particular emphasis on factors including teamwork and support: '*the teamwork is good*' (P2,M,Irish) and there is a '*pretty high level of support from each other*' (P25,F,Irish).

This sense of collegiality or camaraderie with colleagues was found to extend beyond casual acts of kindness and support to encompass a proactive approach whereby people looked out for each other, worked collaboratively, and generally cared for each other's well-being:

> *When I need it, so, if there was an emergency and there was a big case or something important, if I wanted the help, yeah, I know I can count on my colleagues.* (P1,M,International)

> *There's a lot of collegiality within my hospital – we look out for each other, the Regs and the SHOs, the SHOs look after the interns and vice versa.* (P14,M,International)

> *I feel like we really look out for each when we see things that shouldn't be happening, so, when we see one person carrying the weight of 5 people on the team, we escalate that and we tell the people that are involved that you know something here needs to change, so I really think that people in my current hospital look out for each other.* (P31,M,Irish).

Some interviewees specified that they can '*rely more on other NCHDs rather than the management*' (P6,F,International), giving the example of a situation where, '*if we are stuck, I think our WhatsApp chat among my team is more efficient to solve the problem rather than contacting the HR or the management*' (P15,F,Irish). They elaborated that, during each team *'rotation, we have our own WhatsApp group*' which they consider as an active platform for discussing work-related matters, sick leave, and on-call schedules. Doctors perceived this group to be highly functional, as it helps to '*answer a lot of questions'* (P15,F,Irish). For instance, when a doctor needs to take sick leave and request someone to cover their shift, they simply need to post an '*I'm off sick, can someone take my shift?*' (P2,M,Irish) message and there will be some response and support rendered by their co-workers which is usually '*quicker and more efficient'* (P2,M,Irish) than responses produced through formal channels. This indicates that the junior doctors' team, and the mutual support they offer to each other, can represent the most effective and efficient ways of addressing workplace issues they encounter.

Secondly, doctors spoke warmly about positive relationships with their consultants, describing them as '*very engaged'*, '*friendly'* and '*approachabl*e'. In particular, they emphasised how important it is to '*really have a good relationship with my [their] consultant* (P11,F,International) to the extent that they are comfortable with '*discuss[ing] work and sometimes personal matters'* (P25,F,Irish) with their consultants. Although they acknowledge *'the level of interaction varies from hospital to hospital or consultant to consultant, there are times when they [are] definitely more busy and you really can't interact much, but it's just something you know in general that you can always ask for advice and help. They are generally happy enough to let you do your own thing if you feel comfortable with making those decisions, but they are quite available for support if you need it'* (P31,M,Irish). In other words, consultants were described as '*very available*' (P14,M,International) when doctors really needed them. Examples that illustrated these positive relationships include:

I have a great relationship with my consultant, I text her, she will text me too, we get along very well, I think one of the best consultants I have ever worked [with]. Really nice, really approachable, em, nice supervision…. She was great, very approachable, even when I was sick she texted me 'Are you ok? Do you need me for anything to talk to'… (P25,F,Irish)

For my training I have weekly supervision on a Tuesday every week. We meet for an hour and discuss what's happening. And it might include even little bit of chat around our personal lives and to ventilate our feelings how are things, not just at work but at home matters too. (P22,F,Irish)

Some non-trainee doctors described experiences which demonstrated that they valued the open communication and positive relationship they had with their consultants. They perceive that this relationship not only provides opportunities for skills development but also serves as a crucial source of guidance and assurance on their performance, when [they] do not have any other opportunities for an official review:

About two weeks ago my consultant let me do a thermal ablation which I have never done in my life, but throughout the process he was encouraging me and telling me that I can do it, and kept the momentum going… After the procedure we sat and discussed over the whole thing.... It's just nice to have someone whom trust and have good relationship with you…. and for me it's so important as I don't have evaluation like trainees so only through consultant informal feedback, discussion do we actually know we are doing a good job or not and are we even able to some procedures … (P13,M,International)

I make sure I speak to my consultant weekly…. She hardly has the time but normally Friday is a good day to knock on her door and have a short discussion. I do this every rotation…. I think, me being a non-trainee, I just have to put extra effort into maintaining

the relationship, get some feedback, you see, because otherwise I will never know how I am doing… unless something bad happens to the children then I will be called… So early precaution is better (P17,M,International)

Doctors also pointed out that despite their job rotations mandate frequent changes of consultants, often preventing them from working with one for an extended period of time, they still '*cherish each and every rotation as we somehow still try to keep in touch even [when] I am not working with her anymore*' (P3,F,Irish). A facilitating factor here is that '*Ireland is small. When you work for one consultant, that doesn't mean you won't meet again, or work again with them in another rotation in coming years…so having a good relationship with them is very important actually*.' (P15,F,Irish). To put it simply, establishing and maintaining a positive relationship and link with consultants is imperative because these connections can continue in future rotations.

In a similar manner, doctors also reported good interactions with other hospital personnel with whom they frequently collaborate for work, such as nurses, secretaries, and social workers. They emphasised that they generally receive a substantial amount of support from these teams, particularly during times of urgency or significant cases:

I get a pretty high level of support from the team, the nurse, caretakers… of course like when I need it, so if there was an emergency and there was a big case or something important, the nurse team will absolutely get involved, there is no doubt in that. (P31,M,Irish)

The department's secretary she looks after all, she is brilliant… she mingles and gets along with the doctors well…we send her the rota and for every trainee, she looks at the hours that they have done [them] and she submits our overtime for us, which is amazing to be honest it was great, and she never made a mistake… because 80% [of the time] we

doctors we do our own rota since there is usually no one to help us… but when someone like her does it…we worry less on all this stuffs and just focus on our clinical work. (P3,F,Irish)

I believe, to be fair the team is usually good, the nurse, social workers…we get a lot along well. Sometimes if we really get a chance we go for lunch together. (P23,F,Irish)

In psychiatry …we have very good proactive teams involving social workers, psychologist, speech and language therapist…and sometimes we underestimate the relationship with these people but they are very important to the team if we want our clinical work to move smoothly… so I am grateful for this team I have now. (P5,M,International)

Participants highlighted that, as the nature of the work is generally demanding, intense, and challenging, it significantly improves the situation when they have colleagues who are pleasant and supportive: one participant noted that *'[As] work is mental, when the people we work with are nice, it really makes the situation more survivable'* (P8,F,International), while another commented that '*even though it's an extremely busy place... patient load is too high, we are only a small team... I think people there do their best and there's a real culture of an overall kind of friendliness…. It's actually a very nice vibe there, so it makes it a little different to our work*' (P6,F,International). *Another respondent reported similarly that reaching out to their 'colleagues after challenging cases at work, or even venting or discussing work-related issues, has a very positive impact on their well-being' as they can 'give out [i.e., complain] about work' or 'just talk about really crap, something really terrible happened or what happened, blah blah' (P14,M,International). This indicates the importance of having co-workers who are understanding and nice enough to allow junior doctors to vent and share their daily work experience, which ultimately makes their work environment more manageable and supportive.*

5.4.3 Sacrifice - organisational embeddedness

Sacrifice, in organisational embeddedness terms, primarily centres around the actual or perceived psychological, social, or financial costs associated with leaving one's current job or organisation. This component can be used to explain how easily the links and fit discussed above can be broken. To estimate the cost of leaving, we need to ask what sacrifices employees would have to make in relation to their organisation if they chose to leave.

Theme 1: Predetermined progression for trainee doctors

Trainee doctors typically view the training programme as a great fit for their career progression as it advances their career pathways to become a consultant. They frequently find it challenging to sacrifice the training programme because of the benefits it has to offer. For example, one participant shared that: '*what keeps me here is the BST programme, I want to be a trainee in obstetrics and gynaecology trained in Ireland… and now, being in the training, I can see I am getting the high standard training that is needed. It is really good and high standard….which of course is something you can't let go easily*' (P1,M,International). Some emphasised that it is exceptionally '*difficult to get into the training programme*', given the rigorous selection process and the '*high standards of training*' (P4,F,Irish) it upholds. As a result, doctors have invested considerable effort in securing their spots in the programme, and many expressed reluctance to relinquish these opportunities or expressed the view that they could not be dismissed easily: '*so yes, training is the only thing from the work aspect hard to let go* (P4,F,Irish). One participant mentioned that, '*the programme is highly competitive due to its exclusive nature and the high standards maintained which makes it so difficult to even get in, and due to these reasons it's not easy to leave the training programme just like that*' (P2,M,Irish). Likewise another stated that, '*I struggled so hard to get into the programme and, if you ask me will I leave... of course no…… but this is not because I want to be in this system*

but it's because of I want to get the training done…three years from now I will be graduating from Royal College of Surgeons, em, which is international recognised with high reputation and prestigious too' (P26,M,Irish). It is the view of the doctors interviewed for this study that the training they are undergoing is of utmost importance across all levels. They possess a positive outlook towards the specialty training they receive, and its quality may not necessarily be replicated in other places. Consequently, forsaking this training and its benefits is not a desirable option for them no matter the wider difficult working conditions.

Additionally, doctors highlighted that if they discontinue or give up their training programme midway and leave, for instance, to join a different healthcare system, such as Australia's and gain 1-2 years of training in Australia, it may not be easily incorporated within their overall training years in Ireland: their time spent working as a junior doctor or trainee in Australia might not be recognised/counted if they wish to return to Ireland during their junior doctor career phase and so they would be required to commence their training all over again:

> *If I leave halfway and spent 1 year in Australia and then come back, it wouldn't be counted… there is no such flexibility in the training programme.* (P4,F,Irish)

> *I never really thought about leaving since I am in training and of course… you have to know, international experiences are not really recognised in our training unless you complete the whole training and go out for a fellowship [this is when they have completed the training].* (P,26,M,Irish)

Generally, doctors states that '*once you are a trainee, it really needs to be a big offer from elsewhere for you to leave since giving up the training programme is a huge deal… and once you complete your BST and you think of leaving, there comes tendency not to give up an HST opportunity and HST is a great deal to give up…so the cycle of training continues until one point where you feel no point to of leave as the consultant post is coming (laughing). For me,*

I would have left after the internship if I didn't get a training post that time, but since God had another plan for me, I am here now (P31,M.Irish). Doctors typically expressed their faith and considerable confidence in their training programme and the advantages to be gained from it, arguing that it allows them to make the best '*progression in their career*' (P8,F,International). In other words, they feel they '*can't say [positive things] about HSE, but, within my specialty being in training, I am trained well, and of course I am progressing each year due to this training and I am certainly not giving up on that*' (P2,M,Irish). Another participant who had previously worked in another healthcare setting expressed a positive opinion regarding the training programme in Ireland in comparison with that alternative and made clear that they had no intention of relinquishing its benefits: '*I would say training opportunities are better here, which suited me here, from what I have experienced from (another European country)…. It's higher in standard here, the objectives and what needs to be done is very clear, there is also ample of support given for trainees, so this is something really important for me*' (P30,F,International).

Another significant factor for those trainees who are almost approaching the end of their training (SpR), is that it is not easy to sacrifice the job as they have the '*reassurance*' of a clear path towards attaining a consultant position. According to one interviewee *'this reassurance is actually making me go through 7 years because I know how the end shapes'* (P23,F,Irish) and one doctor even visualised the end point of this process when discussing their sacrifices: *'I have reached here, I will be a consultant and all this hard work will be paid off'* (P21,F,Irish). In the main, the participants believe that the prospect of future affirmation helps them to envision a better future or result at the end of their training programme. One participant explained that they *'put up with a lot because at a subconscious level we think, "oh eventually we'll be consultants and all of this will be worth it". We know everything we go through now, the hard time, the struggles, the hours, are all temporary. It will be okay when we have climbed*

the ladder to be a consultant and when I am already at this stage, why would I just give up (P20,M,Irish). It is equally important to note that some doctors have prioritised their careers over their personal lives, and when they are reasonably confident that they will get a job as a consultant in Ireland which they have aimed for, they want to stick to their path: '*I didn't want to get pregnant until I was secure on the training scheme, you know. So, it took so long, so many different routes to try to get onto the training scheme …While the journey was fraught with many challenges, at least I knew I had an opportunity to get onto it. I am reasonably confident that I will get a job as a consultant in Ireland now. I think that's the only aim in my career for now'* (P3,F,Irish).

Most of the doctors who are about to complete their training programme, or who know it is only a few more years away, strongly believe that stability will be secured when they have completed it. They know their pathway and have relative certainty that they will be able to secure a consultant position afterwards:

> *You actually only kind of settle when you are a consultant in a permanent post in the job you want.* (P24,F,Irish)

> *[I] do not deny that the road to the final stage of being a consultant after this scheme is not going to be easy, there's a long waiting list but, when you have come this far, you typically know the route well… Sometimes we can do locum jobs while waiting.* (P23,F,Irish)

> *They managed to create loads of new jobs, so it actually wasn't too bad in the end. We know we will get a job when training is over.* (P5,F,International)

Some highlighted their future career aspirations and the strategies they intend to consider upon completing their training programme which will enable them to venture into the field of

research or teaching while seeking a consultant position. These aspirations are considered hard to forgo, which makes junior doctors remain in their job at this juncture:

> *The consultant job at the end is getting way better now for my specialty, I know the media speaks differently but it all depends….* W*hen you are an SPR you kinda know what to do, how to do it, I plan to focus a little more on my research, I also will be teaching in [mentioned an university] for next semester… then do some locum consultant post while wait for my permanent position* ….(P3,F,Irish)

> *Coming this far I certainly think twice to give up and I can keep my options slightly wider when I am an SPR and when I am near completion of HST... I am doing on a diploma programme now which will then aid me into teaching in [mentioned institution] when I complete my training, which I then plan to teach during my research days or so…and then the rest have clinical days…* (P2,M,Irish)

Although some doctors reported that they had contemplated leaving the Irish healthcare system upon completion of their training because of the poor working conditions, some intimated that these sentiments subsided as they neared the conclusion of their training, in part, owing to the assurances they received at the end:

> *Every year I contemplated whether I should leave, but those thoughts faded off when I became an SPR, as I know the road is getting to a very end. Next, I am more focused on progressing well in HST and see what roles open there for me.* (P26,M,Irish)

> *When I was a SHO, I really wanted to get out of the system, completely out. But, I didn't want to give up the training… then. Now I will think twice since I will be entering HST after this BST. My career will be at its peak and I will be looking forward to attaining a consultant position, not sure that time leaving will be best. It's hard to give up something*

you have worked so hard for and starting back new at some other place is a lot to envisage. (P8,F,International)

I'll still be working for the HSE but, at first, it was because of the training – I was tied up to it –now, because I know how the end will look like. (P15,F,Irish)

Similarly, another participant explained how being near the end of their training shaped their views about leaving or staying*:*

If you give me a chance, I will leave tomorrow, but if you do HST now, you will have a different point of view, where the aim of achieving better work conditions dissolves, or maybe you just give up on that. And the aim of focusing on yourself starts with the fact that the only thing I want now is to complete the HST and look forward in applying for the permanent consultant role. I don't even mind getting into another county or [mentioned a county name]. Commuting isn't a big deal since, as a consultant, I actually have a lot of flexibility and work less than 40 hours per week. (P11,F,International)

Theme 2: Reluctance to embrace change due to fear and familiarity

For some doctors, there is a certain level of personal sentiment towards either their job or the Irish health system despite the dissatisfaction or frustration they may experience, and this can be difficult to forgo: even '*though the system sucks*' (P26,M,Irish) they still welcome '*the familiarity with the job*' (P21,F,Irish) or express the view that '*change is scary*' (P8,F,International). This suggests that, despite their dissatisfaction, interviewees often recognise the comfort that comes from being accustomed to their jobs. Some also acknowledged their own apprehension about change as an inhibiting factor – '*change is daunting, even if I want it so much*' (P18). Typically, the routine or the familiarity that they have with people in the workplace, and with their work environment, its processes, and the system, provides a level of comfort that makes the idea of leaving complex, even though they

recognise many flaws: '*[It is] something I am used to, of course. If you ask me, everything is awful and I want to leave tomorrow, but behind the scenes it has something which you are comfortable and used to the people, environment, the way of doing this and whole system*' (P2).

One participant explained their dilemma about staying or leaving succinctly in these terms: '*You see when you work in a system and you know what has to be done and how things get done here, it's not easy for you to leave.... When you have been working and doing it for years, you get used to it. I have to make so many decisions if I want to leave…. That's because change is hard. Even if we know sometimes change eases things*' (P24).

Given the limited opportunities for inter-hospital mobility for doctors within Ireland, some doctors expressed concern about the process of leaving due to it involving relocating to another country which involves significant preparation and effort. Also, given their current workload and level of commitments, doctors mentioned that they are unable to dedicate the necessary time and resources to such an extensive, self-initiated endeavour:

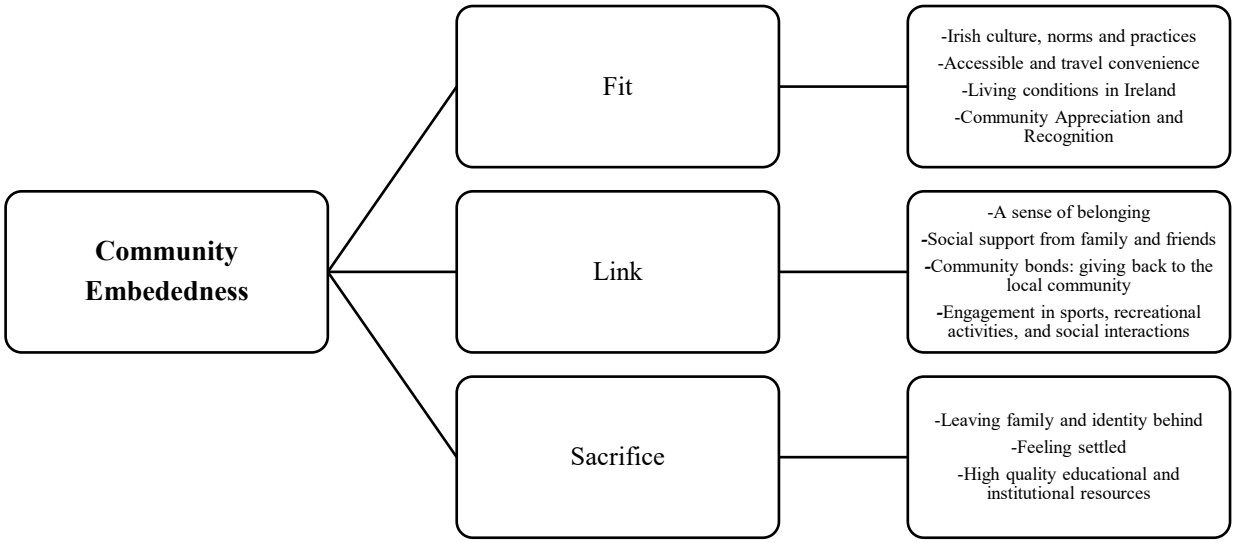
> *Sometimes moving out of a country needs a lot of work done but I am nowhere having time to do this work and searches.* (P27,F,International)

> *You don't like CUH, you can move to Mercy, but this is not that. If I want to leave, I have to leave Ireland itself. This needs a lot to think of now… Being a trainee you just have no time and in this situation moving is just hard* (P21,F,Irish).

> *I'm just familiar with it. I think, as a doctor, there is a huge fear of going into the unknown because you are more prone to making mistakes, you are more prone to getting into trouble in a system that you don't know, especially in the specialty that I work in, where there's a huge amount of autonomy, once you become a GP or a family physician. So, I know the Irish healthcare system, I know what the guidelines are, and I'm comfortable in it. So, I think that's probably the biggest thing. My biggest worry with moving as a*

doctor would be trying to learn a whole different system and being worried about making mistakes as you go along, mistakes that will cost you quite dearly. (P12,M,Irish)

Undoubtedly, having a deep understanding of a healthcare system provides a foundation of security and self-assurance. Consequently, the decision to relocate and adapt to a new healthcare system can be seen as a deterrent by many doctors, even though they know the working conditions here are not the best fit for them.



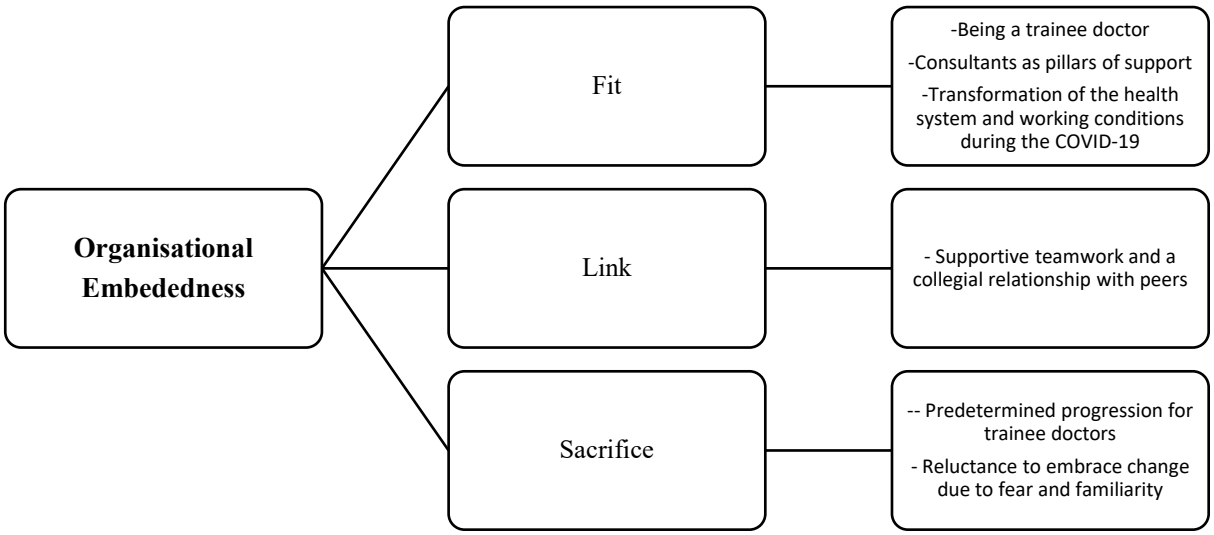


Table 7: 2x3 matrix of community & organisational embeddedness – fit, links, sacrifice

CHAPTER 6

Discussion

6.1 Introduction

In this chapter, the main findings and the key contribution of this thesis are discussed. The focus returns to the initial research question, which was centred on understanding why junior hospital doctors intend to stay within the Irish public healthcare system given the longstanding and frequently reported and documented poor working conditions. The study examined this phenomenon through the lens of job embeddedness theory, specifically utilising the concepts of organisational and community embeddedness and the dimensions of fit, links, and sacrifice. Initially, this chapter will revisit this study's research aims and objectives. It will then provide an overall summary of its key findings before discussing its theoretical and practical contributions and implications. Finally, the chapter will outline the limitations of this research and suggest areas for future research exploration.

6.2 Revisiting the research aim and objectives

This thesis began with by stating the aim of examining a less researched issue – the intention to stay amongst junior hospital doctors within Ireland's public healthcare system – with a specific focus on the role of organisational (on-the-job) and community (off-the-job) embeddedness. Specifically, the study sought to satisfy two research objectives:

i. To explore the factors that contribute to the intention to stay within the Irish public healthcare system of junior hospital doctors in the Irish public sector.

ii. To provide insights into less explored aspects of healthcare management by identifying and analysing the factors that influence doctors' intentions to stay in the Irish public healthcare system. This can ultimately contribute to the development of strategies and policies aimed at addressing the longstanding problem of high doctor turnover.

6.3 Overall summary of the key findings

This thesis responds to the call for a more grounded approach to understanding the issue of hospital doctors' retention and the need for more research into diversified retention strategies for Irish hospital doctors (Brugha *et al.*, 2021). This study contributes to the healthcare management literature by addressing the following questions:

i) Firstly, why do some junior hospital doctors intend to stay in their roles despite the prevalent challenges and sometimes poor conditions which cause others to leave?

ii) Secondly, did the COVID-19 pandemic impact the working lives/experiences of doctors and their intention to stay, and, if so, how?

The second question arose naturally from the fact that research was conducted during the current COVID-19 pandemic. Despite a decade of extensive discussions surrounding the turnover of hospital doctors from the Irish public healthcare system due to the poor conditions they experience (Bidwell *et al.*, 2013; Humphries *et al.*, 2013, 2014, 2017, 2019, 2024; McGowan *et al.*, 2013; Humphries *et al.*, 2014; O'Connor *et al.*, 2017; Humphries *et al.,* 2018 Brugha *et al.*, 2020, 2021), we still know very little about what makes some doctors stay, and particularly why they intend to stay despite facing challenges that cause so many to leave. By examining the reasons why doctors intend to stay, this study offers fresh insights on the other side of the story, the under-explored aspect of retention. This study expands on previous research (Ng and Feldman, 2007, 2014; Valle *et al*., 2016) by examining how job embeddedness theory, encompassing both organisational (on-the-job) and community (off-the-job) aspects, can be used to understand influences on doctors' intentions to stay.

Examining this situation from the job embeddedness theory perspective enabled the study to gather useful insights into the interplay between doctors' work-related experiences and their life outside of work, helping to evaluate how these factors and their interplay shape junior doctors' decision-making. This approach adds depth to the existing body of knowledge, as

many researchers within this area of healthcare management have been heavily focused on empirical testing and quantitative research on turnover, often neglecting the more qualitative, lived experiences of doctors while also making limited used of broader theoretical frameworks (Sharma et al., 2012; Seathu Raman et al., 2024, Ali Jadoo *et al.*, 2015; Lambert et al., 2018; Humphries *et al.*, 2018, 2019; Oh and Kim, 2019; Zhang *et al.*, 2019; Brugha *et al.*, 2021). By addressing such gaps, the study contributes to a more comprehensive understanding of the factors that influence junior hospital doctors' intention to stay in their roles, which, in turn, can help guide managerial interventions aimed at reducing turnover.

6.3.1 The distinction between participants' staying within their job and in Ireland

As discussed in Chapter 4, the participants in this study were public sector hospital doctors employed by the Health Service Executive (HSE). This means all participants shared the common experience of working within the HSE, an organisation encompassing multiple public hospitals under a single administrative structure. The key findings of this thesis focus specifically on the concept of 'staying' – that is, remaining in their current job within the HSE. Participants were made aware of the distinction between staying in their job and staying in Ireland, with the study being primarily concerned with their commitment to their intention to stay in their job. However, due to the nature of working in the Irish public health system, doctors who choose to leave their jobs often need to relocate to another healthcare system or country. This is because public sector doctors in Ireland work under a single institution, the HSE, and changing jobs between different public hospitals is not a straightforward process. This is because trainee doctors are bound by fixed job rotations that are determined by the training body throughout their training programme, so their ability to select their preferred hospital in which to work is limited for them. Additionally, they are not permitted to apply or work in private hospitals as their training programme does not allow for such opportunities. Although those who are non-trainee doctors are technically able to move/change their jobs

between hospitals, it isn't something they commonly do, as all uniform practices, conditions, and regulations are governed by the HSE. Therefore, participants were clearly informed that this thesis was looking specifically at them staying in their job, even though they often equate that with staying in Ireland due to the intertwined nature of their work and residency. In other words, the primary focus was on the intention to stay at their job itself rather than the opportunity to stay in Ireland. While some doctors expressed a preference for staying in their job primarily because they wish to remain in Ireland, the study made a clear distinction between the desire to stay in the job itself and the desire to stay in the country, and ensured that participants understood this distinction in the context of the research.

6.4 Community embeddedness

Turning to the first research question, this study indicates that community embeddedness, also talked about in terms of the off-the-job dimensions of a doctor's life outside of their work, are critically important in explaining why many of the doctors interviewed were intent on staying within the Irish public healthcare system (Ng & Feldman, 2014). Specifically, community embeddedness, whereby doctors prioritise their lives outside of their work, appears to make them stay within the Irish public health system. This is despite the poor working conditions that lead to significant challenges and difficulties. This intimates that doctors' connections to community and their personal lives outside of work should be considered crucial factors in their retention decisions and is worthy of consideration by hospital management in terms of how to support this further. Indeed, doctors are more likely to stay when they feel that key off-the-job factors *fit* their personal aspirations and interests, creating congruence with their community environment. They are also more likely to stay when they have strong *links*, whereby they benefit from a substantial network of connections with various people and activities within the community, or where there are significant and unwelcome *sacrifices* that

would need to be made, in terms of the loss of community-related factors if a move was undertaken (Mitchell *et al.*, 2001; Feldman, Ng and Vogel, 2012).

Turning to the community embeddedness dimension, this study's core findings highlight the relevance of hospital doctors' prior lived experience. Specifically, the interview data suggest that hospital doctors who are native to Ireland, and international doctors, many of whom are recent migrants, place considerable importance on their community embeddedness which they often assess in relation to earlier experiences in their lives. This is to say that, irrespective of their origins, junior doctors within the Irish healthcare system view their off-the-job context and life outside of work as a pivotal element that informs and influences their intentions to stay.

Notably, for some international doctors, community embeddedness is the primary, or even the sole, reason for their continued employment within the Irish public health system and their intention to remain. This is because (as highlighted in Chapter 2), some international doctors are not enrolled in training programmes and fill non-training junior doctor posts within the Irish healthcare system. Their roles are typically based on fixed-term contracts which often present numerous challenges that can include little or no access to training, slow or stalled career progression, lack of job security due to fixed-term contract employment, and lack of structured guidance and support (Tyrrell *et al.*, 2016; Roditis, 2023). In other words, these doctors gain limited benefits from their positions from an organisational standpoint, and they may be better off going elsewhere in career progression terms. Therefore, it is off-the-job factors/or life and experience outside of work that they consider especially strongly when they are weighing up whether or not they intend to stay in Ireland's public health system.

6.4.1 Community embeddedness – distinctions between Irish and international doctors

Firstly, the interview findings indicate that, even though both groups of doctors (Irish and international) appear to be highly embedded in the community, distinctions become apparent within the dimensions of community embeddedness (fit, links, and sacrifice) when they are examined more closely. Specifically, Irish and international doctors are found to have somewhat different perspectives and have varying degrees of attachment to facets within the three dimensions of fit, links, and sacrifice.

International doctors – finding a good fit with the living conditions in Ireland

In the instance of the fit dimension, many international doctors feel that their experience and life in Ireland aligns closely with their interests, expectations, and needs (Mitchell *et al.*, 2001). This alignment creates a sense of non-work fit, with several community-related factors matching their preferences as either individuals or as families (Feldman *et al.,* 2012; Ng and Feldman, 2014), and this typically leads to a high level of satisfaction with their quality of life. The view that Ireland is a good fit is particularly significant for those doctors who originate from developing or middle-income countries in the Global South, such as Pakistan, Bangladesh, Sudan, India, and South Africa, where living conditions can be affected by issues such as poor socio-economic outlook, weak infrastructure, low incomes, and high levels of poverty and corruption, as well as high population density which can lead to limited institutional resources (Thomas-Slayter, 2003; Loayza and Wada, 2012; Moncada, 2013; Tikly and Barrett, 2013; Agrawal, 2015; Beegle *et al.*, 2016; Nazir, Nadeem and Véronneau, 2016; Mahmud *et al.*, 2018; Nadeem *et al.*, 2020). For example, widespread corruption in Bangladesh is so pervasive, permeating both micro and macro levels, that it threatens to become a way of life, compromising the government's ability to safeguard the well-being of its population

(Kabir *et al.*, 2021). Similarly, Pakistan struggles with a high rate of road traffic deaths, ranging from 26,751–33,510 annually, due to the country's problematic transportation infrastructure (Imran and Niazi, 2011; Nazir, Nadeem and Véronneau, 2016). This can result in significant inconvenience, risk, and poor life quality. Hence, international doctors from these countries derive significant personal gain from their life outside of work in Ireland (community aspects), which they find far better than the experiences or conditions that were available to them when they were growing up and which may still prevail in their countries of origin.

Among the key aspects of life in Ireland that international doctors appreciate are accessible and convenient travel and the country's general geographical advantages. Ireland's convenient geography and accessibility forms a positive contrast for many to their home countries, and when doctors make comparisons, these disparities result in an appreciation of the superior infrastructure and ease of travel they now experience in Ireland. In a similar vein, for international doctors who have a passion for local travel and leisure, Ireland can be an attractive and highly appealing location on the basis of its attractive landform, flora, and fauna (Foster, 1998). Its proximity to other European countries like the UK, France, and Poland also enhances Ireland's attractiveness. Likewise, the ease of domestic travel allows international doctors to explore Ireland's natural beauty and attractions, often offering them a therapeutic escape from work-related stresses, via opportunities for leisurely weekend getaways. This ease of travel within Ireland and to neighbouring countries enables them to balance their professional commitments with their personal hobbies (i.e., travelling, hiking, sightseeing) and mental health needs, making Ireland a suitable place for them to fulfil their needs outside work.

International doctors, or at least those within the sample here, generally also tend to appreciate and find a good fit with the social, educational, and political aspects of Irish life. Their personal values and desire for a peaceful, stable, and safe environment match well with aspects of their lives outside of work in Ireland, despite the professional challenges they face in their day-to-

day employment. Since a significant number of international doctors are non-trainees, and encounter obstacles in terms of career advancement (e.g., lack of training and development, limited career progression), many of them prioritise their lifestyle, quality of life, and family well-being when deciding whether to stay in their current positions within the Ireland public healthcare system. While they also recognise their problematic working conditions, which often include high workloads, and long hours. It appears that some of these doctors find that the benefits gained from the community aspects compensate for the challenges they face professionally/at work. Importantly, they feel that their life outside of work enables them, to some degree, to bounce back or recharge after work, as their leisure activities rejuvenate them and give them time to unwind. This is in spite of less than ideal and expected time off. In interviews, this sentiment was often expressed in terms of complex preferences which spoke volumes about the quality of life and well-being experienced by international doctors in Ireland. For example, simple leisure activities and life experiences such as cycling with their children, going for a walk, doing sports with others and enjoying a peaceful life; all of which may seem normal for people from Ireland, take on a poignant significance for these doctors who value the environment and safety Ireland provides. Many international doctors appear to truly appreciate how these simple activities transform into cherished moments, and reflecting on them provides crucial respite when their days at the hospital are hectic and demanding. Lazarus (2006) argues, leisure activities can be viewed as a form of emotion-focused strategy and used as a coping mechanism to escape from the stresses arising from work. According to Cohen (1995) and Halvorsen *et al*. (2015), these off-the-job/social activities outside of work are also important as they help to build community links which have been shown to increase retention. Typically, doctors in this group believe that their life outside of work aligns well with their needs and interests (or maybe offers some benefits they wanted to experience when they were back in their home countries). This appears to assist them in managing the demands

of their profession. This alignment is further enhanced by various benefits that they perceive in their current environment over the lifestyle they were accustomed to in their home countries, which they often considered to be somewhat substandard. In other words, it can be argued that positive living conditions in Ireland created by community and surroundings play a significant role in the resilience and overall satisfaction of international doctors, influencing their intentions to stay in their jobs. This type of decision-making suggests a holistic approach to life choices, where personal well-being and satisfaction can outweigh career advancement and an intense work environment.

The community aspect of job embeddedness seems to enable some doctors to find solace in activities that allow them to achieve mental and physical relief. Overall, these findings suggest that international doctors in Ireland experience a good community fit, even though it is in an entirely new/different country/community. This finding contrasts with some existing research, which intimates that individuals experience a better fit if they share similar backgrounds (Sessa and Bowling, 2020). Overall, this study suggests that, while international doctors differ from the general community in Ireland in many respects, such as culture, ethnicity, race, and upbringing, they manage to establish a life in Ireland within their new community that suits their expectations, interests, needs, and wants.

In this context, *gender safety* appeared to be another topic relevant to international participants. Several doctors highlighted the importance of gender in relation to safety in urban life and social interactions. Female doctors from developing countries with poor infrastructure and with safety issues reported being quite concerned over the physical, sexual, and psychological harm arising from violence or 'fear on streets', which left them with a fear of travelling or of engaging in any sort of social or public realm activities back in their home countries (Badiora and Ntamark, 2016, p. 111). According to Anand and Tiwari (2006), inadequate pedestrian infrastructure, non-existent or poorly designed roads, lack of pedestrian crossings, poorly

located shelters, and high steps on buses can all contribute to an environment that is hostile for women in developing countries. In these countries, women also frequently report inappropriate touching, groping, and being followed by strangers, which made them feel unsafe when engaging in hobbies or leisure activities. Some doctors in this study also stated that they did not engage in extra-curricular activities back home due to conditions which made these activities unappealing for females. Female doctors in Ireland spoke about how they feel much safer in participating in public life and recreational activities that reflect their preferences and how these provide them with positive experiences. This has encouraged some to pursue their hobbies further, for example, through cycling, and joining groups like Women Cycling Ireland, which keep them active outside of work. They are particularly grateful that, despite the busy environment they encounter at work, they can still find peace and enjoyment in their life outside those responsibilities, which they, in part, attribute to Ireland's natural surroundings.

Furthermore, several participants praised and appreciated the quality of education that their children receive in Ireland, recognising its holistic approach and nurturing pedagogy, which focuses not just on academic excellence but also on the overall development of children and the interactive nature of the learning process (Hayes and O'Flaherty, 1997; Hayes, 2008; Hynes, 2018). This type of progressive education is highly valued, since the countries from which many international doctors originate may have more rigid or exam-focused systems. For example, in India, the public education system is often based on examinations, where student performance over a full academic session is disregarded, with the sole focus being on scoring high marks in exams (Sharma, 2014). Research has also shown that, in Pakistan, the primary objective of the education system has shifted from acquiring knowledge and focusing on learning to merely passing exams, creating a detrimental impact for the entire educational system (Khattak, 2012). Strategies such as memorisation, regurgitation, reliance on sample papers and guidebooks, and even cheating are used to ensure 'passing or clearing exams with

good marks' (Khan and Ashraf, 2023, p. 94). Such an approach can lead to significant neglect of more comprehensive approaches to education, where critical thinking, comprehension, skills development, and creativity are valued (Petzer, 2010).

The matter of schooling costs also emerged as a factor in some interviews, where the accessibility and affordability of high-quality education in Ireland was mentioned. This was again considered in terms of comparison to the high costs of education in some doctors' home countries. For instance, in India, a considerable disparity exists between the quality of education provided in government and private schools. This gap is mainly attributed to the lack of basic resources in many government schools in India as they often lack adequate classrooms, libraries, laboratories, and trained teachers, and this leads many people to send their children to private schools. This choice, however, comes with a significant financial burden, even for early education levels like pre-school, where parents are required to invest a considerable sum monthly (Kothari, 1966; Gouda *et al.*, 2013). Though it is undeniable that doctors hold highly skilled, high status, and well-paid occupations (Humphries *et al.*, 2019) which would enable them to afford private schooling for their children, the decision to educate a child in India becomes questionable when one can access a better quality of education through an inclusive, free education system elsewhere. The inclusiveness of Irish education is therefore an important factor in doctors' appreciation of what they gain by staying here in Ireland.

Irish doctors finding a good fit with their own culture

Moving on to consider native Irish doctors, this study's findings suggest that they tend to resonate with the dimensions of community embeddedness on a different basis to their international peers. Firstly, Irish doctor interviewees placed emphasis on the cultural fit that they experience in Ireland; the country in which they were born. They highlighted that they

tend to have a deep-seated affection for, and pride in, the country as well as an affinity for their own Irish cultural heritage (Negra, 2006). Many are deeply connected to the core concepts of Irish culture, which they associate with modesty, humour, ingenuity, creativity, patriotism, and warmth, and they often seek to adopt these traits in their own lives (Scroope, 2017). Findings based on this study's native Irish sub-group highlight the importance of this affinity in relation to the dimension of fit, suggesting that Irish doctors have a strong sense of cultural identity and an attachment to being Irish that either inclines them to continue residing in Ireland, or makes it difficult for them to leave. Specifically, these cultural norms, values, and practices impact Irish doctors' adaptability and openness towards other cultures, as they face challenges when it comes to adapting and adjusting to different cultures. For example, some Irish doctors involved in this study felt that, although they had worked in other countries such as America or New Zealand or had even spent a couple of years in the UK, they found the culture, norms, and practices elsewhere to be different to what they were used to in Ireland, and they found those norms hard to adapt to and get along with.

Irish doctors seem to still 'do things the Irish way' and spend time with people who are Irish, and this was reflected even when they spoke about time spent working in foreign countries. To put it simply, many Irish native doctors thought it was difficult to get comfortable with community aspects of life in a different country as they often felt that they were not well connected to the broader community there (Ng and Feldman, 2014). In these cases, this made it challenging for them to create links, such as formal and informal connections and relationships with people outside of work (Mitchell *et al.*, 2001; Ng and Feldman, 2014). These perceptions strongly shaped their intention to stay in Ireland, even though the work aspects of life were not especially appealing. Specifically, they stated that the culture and level of comfort which they feel in Ireland and within the community here are far more important than the professional aspects of their lives.

At this juncture, the study suggests that national culture may have a substantial influence on improving community embeddedness. Building on previous research by (Mallol *et al*., 2007; Ramesh and Gelfand, 2010; Chen and Ayoun, 2022) which highlights the importance of culture in job embeddedness i.e. individualistic and collectivistic, Hispanic culture context, and influence of national culture. For example, Chen and Ayoun, (2022) found the national culture to moderate the relations between affiliative humor and perceived workplace aggression, aggressive humor and perceived workplace fun, as well as the relationship between workplace fun and on the job embeddedness. This study adds towards those findings, specifically highlighting the influence of Ireland's national culture towards off-the-job factors. National culture encompasses collective values, beliefs, customs, norms and traditions which shape the identity of the society and influence everything from social practices to bringing a significant meaning towards community embeddedness (Morden, 1999; Mallol et al., 2007). The research extends prior research by intimating the national cultural context may have key relevance to the components of job embeddedness. Although not a specific focus of the research, the findings indicated that the Irish national culture may be providing doctors with collective reasons to remain in their roles owing to how they perceive their embeddedness within the community. Interestingly, the study also notes that Irish and international doctors perceive Ireland's national culture differently, for Irish doctors, it is rooted in their native identity and belongings, while for international doctors, it is more about finding the Ireland national culture being a good fit for them.

Irish doctors finding good links with their surrounding community, family, and social ties

In addition to their strong cultural adherence to traditional Irish norms, practices and values, Irish doctors also exhibited a profound sense of connection, belonging, and attachment to the localities where they were born and raised. This attachment took the form of socio-cultural identity and national identity, as well as emotional and place-based attachment. The

attachments many Irish-born doctors expressed were not just about physical location but also included shared experiences, traditions, and family and social connections that were associated with it. Even when the work aspects of these doctors' lives were challenging (i.e., poor conditions, long hours, and frequent rotations), the notion of Ireland being 'home' seemed to prevail. Accordingly, this study found that Irish doctors demonstrated a profound sense of rootedness and belonging, regardless of other life circumstances. Irish doctors emphasised the importance of links including local connections, long-standing relationships, and familiarity with local establishments such as cafés, gyms, or restaurants which contributed significantly to their sense of belonging. They further highlighted the importance of being part of a close-knit community that commonly extends beyond geographic proximity to involve emotional, social, and cultural bonds and identity. These associations appeared very important for this group.

There is a large body of cross-cultural research, though not directly related to turnover, suggesting the inclusion of family and its values being an addition to job embeddedness (Bordia and Blau, 2003; Ramesh, 2007; Treuren, 2019). Some findings indicate that when individuals are more embedded in their community, particularly through strong family connections, experience less conflict between their work and family roles. This is because close family ties provide essential support and help balance work and family responsibilities. (Li *et al.*, 2019). In other words, an employee with strong family bonds is less likely to want to leave their jobs, as these connections help mitigate conflicts between work and family life. Adding to this knowledge, this study further highlights the community embeddedness, particularly emphasising how family ties and responsibilities play a crucial role in the decision making process of doctors. For many Irish doctors, the well-being and proximity of their families, extended families, and friends appeared to be more important than professional considerations; something that Covid appeared to have strengthened. They commonly prioritised their families over work, often emphasising the profound responsibilities they have towards their family i.e.

caring for ageing parents, emotional comfort, stability, and practical assistance that they gain from these networks. Staying close to family, extended family, and friends is a main priority for them due to the obligation of fulfilling their responsibilities, and finding emotional comfort and physical support. This sense of family connection and social support not only gives doctors strength but can also ensure that they have assistance with daily domestic tasks such as childcare, helping them to manage the stress associated with their work and their high workload and long hours. According to Treuren and Fein (2021), social support received by employees outside of work can have a positive effect on their life at work as it reduces the conflict between work and life. In other words, employees who get better access to social and psychological resources outside of work are generally able to cope better with difficult situations at work. Likewise, research on community links suggests that when an individual gets more additional tangible and intangible support (i.e., childcare and intangible support such as emotional support from family and friends in a family emergency) s/he will be not only highly embedded in their community but will also have more energy for attending to work-related matters as this may indirectly increase their ability to work and make them more productive in the workplace (Martins *et al.,* 2002; Herrero and Gracia, 2007; Lin *et al.,* 2009). This finding appears evident in the context of many Irish hospital doctors. The balance and support associated with community embeddedness links are particularly crucial for those with multiple children because this embeddedness can help to offset the costs of childcare in current economic conditions (Russell *et al.*, 2018; Doorley *et al.*, 2021). Childcare costs in Ireland are among the highest in the OECD. If doctors leave Ireland for other places, they will lose these essential family supports which can help to offset childcare challenges. Doctors' family members currently support their resilience, as well as providing tangible everyday assistance, helping doctors to navigate the demands involved in their jobs and parenting responsibilities. Overall, the collective efforts of doctors' extended families facilitate their hectic lifestyles and help to

illustrate the importance of broader community involvement for managing daily life and maintaining a reasonable work-life balance (Shi *et al.*, 2021). Typically, Irish doctors have a long-term established connection with their community surroundings, as well as tangible supports, which they receive from their family and loved ones, and these factors are shown to embed them within their communities (Mitchell *et al.*, 2001).

A sense of obligation to give back – particularly for hospital doctors from rural communities

Strong community links and connections often resulted in Irish doctors' commitment to serving their local communities, whereby they expressed a deep sense of duty and a desire to give back to the people with whom they grew up. Specifically, they felt a great sense of honour and satisfaction from providing care for those from within their own communities, compared to treating patients in foreign countries where they lacked personal connections. Irish doctors tended to argue that patients, for them, represent more than a collection of illnesses. Instead, they are understood as individuals, filled with worry and anxiety, who hope to receive comfort and assistance from someone they can trust. While research has previously indicated that there is a sense of duty among doctors (Valle *et al.,* 2016), this finding in the present study may have been magnified due to the timing of the interviews, i.e., amid a global health pandemic.

This sentiment (the desire to give back) was especially strong among doctors who were born and raised in rural or less privileged areas in Ireland. Rural areas of Ireland can be characterised by features such as a lack of economic growth, low rates of population density and great physical distance from economic hubs (Tregear and Cooper, 2016). As a result of the awareness of these problems, rural-born and raised Irish doctors in this sample appeared to be more strongly embedded in their communities than other participants. This deep-rootedness and the emphasis on strong links and ties developed in their local communities made them feel positive about staying in Ireland and contributing their medical services to the people there, especially

where this benefitted the vulnerable communities they had encountered in their earlier lives. It is important to note that junior doctors, like those involved in this study, may not yet be in a position to support their own rural communities at this stage in their careers, when training programmes tend to embed them in hospitals in larger towns and cities. However, their strong desire to continue working in Ireland is often motivated by their growing certainty that they will be able to support these communities when they become consultants. These findings are similar to those identified by Reitz (2009), who observed that rural nurses exhibit a greater degree of embeddedness towards their local communities than nurses from urban backgrounds.

In this sample, doctors' strong connection with rural communities arose mainly because the patients' challenges resonated strongly with the difficulties these doctors had faced while growing up, including issues with accessing opportunities for education and other supports. For example, some of these doctors were the first in their families to be properly exposed to science and to get a chance to attend college. This situation apparently instilled in them a strong belief in giving back to society. To put it simply, they tended to appreciate what they have now and believed that it was essential to give back to their local communities as a way of demonstrating that appreciation. Additionally, these doctors mentioned their unique understanding of, and empathy for, patients who are from similar backgrounds (i.e., rural/farming backgrounds). This appeared to help them to understand these patients or their fears and anxieties about healthcare dynamics, hospital visits, and interacting with doctors, which are often outside their regular daily experiences. This empathy appeared to arise from their own experiences growing up in rural areas and facing similar challenges. As a result, they strongly promoted making the approach to healthcare more welcoming; the timing of the interviews, however, may have further strengthened such perspectives given that restrictions were in place which may have isolated Irish people from their homeplaces.

The role of gender dynamics in healthcare, specifically in male-dominated specialities like surgery was also discussed by these doctors. Among them, a female surgeon raised in rural Ireland highlighted the critical importance of serving her community's medical needs. She placed a special emphasis on developing strategies to ensure rural patients' comfort, as they often experience significant anxiety, especially in vulnerable situations like surgery. Understanding the fear of surgical procedures in her community, and as a surgeon and a female doctor, she strives to create a familiar and comfortable environment for surgical procedures. The notion of being a 'girl next door' before being a surgeon underscores the importance of empathetic and compassionate care. Her approach highlights the unique impact that female surgeons can have in alleviating patients' fears and anxieties, thereby enhancing the overall quality of the psychological and emotional aspects of patient care. This finding illustrates that an individual's life experience or upbringing can play a significant role in the depth of their community embeddedness.

The sacrifice dimension for both Irish and international doctors

This study highlighted that the dimensions of fit and links can directly or indirectly influence the sacrifice dimension. For international doctors, the strong community fit which they find suits their needs and interests is found to translate into something they do not want to sacrifice. This typically involves the living conditions in Ireland which include safety, good infrastructure, high quality education, childcare, good public facilities, and the political openness they currently enjoy. Accordingly, they highly value the quality of life they are currently experiencing, seeing it as a key reason for their intention to stay, as it is for them a non-negotiable element on which they are unwilling to compromise. The resources which are currently available to them contribute to an improved lifestyle for their families, and sacrificing this lifestyle is not considered to be worthwhile.

On the other hand, for the Irish doctors in this study, the community fit and links dimensions which they perceive to be important relate to strong cultural norms, values and practices. Meanwhile, the links dimension, which encompasses social support from family and friends, is found to be instrumental in shaping some of the sacrifice dimensions of community embeddedness. In simple terms, doctors perceive that they have a strong cultural identity connecting them to Ireland and their homeplace, and this makes the idea of leaving Ireland challenging, as it also means sacrificing a part of their identity and the values they wish to live by, uphold, and pass on to their children.

For many, their bond with their Irish roots, community, and way of life is irreplaceable and serves as a pivotal factor in their decision to stay in Ireland. The emotional and psychological costs associated with leaving familiar cultural environments are thus a significant deterrent from leaving. Similarly, the links obtained via social support from their extended family and friends can result in significant sacrifices if they leave, with Irish doctors often facing difficulty, as they are unable to forgo their strong family ties and reliance on familial support systems. Moving away would often mean losing vital support networks and ties (i.e., childcare, emotional support) and taking on emotional stress in relation to their sense of duty and attachment (e.g., not being able to directly support aging parents or other friends with health issues). This situation shows the significant role that family plays in the lives of Irish doctors and the high level of sacrifice that they would have to make in leaving. The emotional and practical challenges involved in relocating can make it a difficult decision, where the loss of support networks and ties are significant factors to consider. The strong links that doctors who come from rural communities have with their homeplaces, discussed above, also have implications in terms of the sacrifice dimension.

Many doctors expressed the view that the most challenging aspect of relocation is leaving their families behind, especially if their families live in small towns or rural areas where they heavily rely on these doctors for their various daily needs. Indeed, some of these doctors expressed the view that they already feel the strain of being away from their families due to the current job rotation system. Significantly, both Irish and international doctors, particularly doctors who have kinship responsibilities, emphasised the challenges arising from family commitments, such as having a working spouse and school-going children, which add complexity to their decisions. Although they may have the desire to leave their current jobs in search of better working conditions, they often don't pursue it, as they don't want their family members to undergo drastic changes. For example, the challenges associated with transferring jobs or the impossibility of their spouse changing job or securing a suitable position elsewhere were shared as significant factors in decision-making.

Furthermore, doctors, both Irish and international, also expressed a strong desire for stability and a sense of being settled in Ireland which makes them reluctant to move. For example, they are unwilling to sacrifice homes they have purchased or stable family businesses in which they have made considerable financial investment. The investments made not only create a sense of stability but also bring feelings of obligation, responsibility, and societal pressure which make the idea of relocating seem daunting and complex. The idea of starting afresh, with all of the accompanying uncertainties, effectively acts as a deterrent. This aligns with Mitchell *et al.*'s (2001) notion of sacrifice, as it involves giving up a sense of security and involves tangible costs which can include the financial and logistical challenges of moving, selling property, or disrupting established routines.

It is important to note that an element of collective decision-making is usually involved when it comes to the dimension of fit and sacrifice in the context of community embeddedness,

because doctors' families, as well as doctors themselves, are involved in deciding whether or not to leave or stay. In other words, decisions do not simply take into account fit/sacrifice for doctors alone but also for the people with whom they have relationships. For example, consideration of sacrifices that would need to be made by a doctor's parents, spouse/partner, and children clearly play a role in doctors' decisions to stay. Based on these findings, the study strongly indicates that both international and Irish doctors are very much embedded in their communities, and this plays as a major role in their retention decisions (Mitchell *et al.*, 2001).

Building on the above, it is evident that while the age of doctors does not significantly impact their decisions to stay, other life factors due to their age such as marital, and family responsibilities, along with the feeling of being settled at their current age – play an important role. Doctors, both Irish and international, who are married or have family responsibilities tend to be more embedded in their communities, driven by obligations to their children, spouse and extended family. These responsibilities that come along with being old result in doctors prioritising stability over the adventurous and mobility they might have considered in their younger age. Consequently, these commitments strengthen their ties to the community and are more likely to increase their intention to stay.

6.5 Organisational embeddedness

It is notable that organisational embeddedness did not play anywhere near as substantial a role in this study as community embeddedness; only contributing in a small way to doctors' intentions to stay. The limited resonance of organisational embeddedness would stand in contrast to much of the retention literature from other organisational and role contexts. According to Lee *et al.* (2004), an employee's attitude develops over time and arises from organisational fit, links, and sacrifice which are shaped by many factors. For these doctors, the lesser influence of organisational embeddedness can be attributed to the widely reported

problematic issues surrounding the Irish public hospital system, such as poor working conditions, that negatively impact their work experiences. Indeed, these issues seem to be the primary reasons why doctors voluntarily leave the Irish public healthcare system (McGowan *et al.*, 2013; Degen *et al.*, 2014; Humphries, Crowe, and Brugha, 2018b; Humphries *et al.*, 2019, 2020; O'Neill, 2022; Chalikonda, 2023). To put it simply, analysis of the organisational embeddedness of hospital doctors indicates a low level of fit. In basic terms, doctor's abilities and expectations do not fully align with organisational conditions and rewards. Although doctors develop some links with colleagues at work, and there are a number of related sacrifices that they are not willing to make, the significance attributed to these elements is deemed less than that given to the community-related aspects of links and sacrifice.

6.5.1 Organisational embeddedness – distinctions between trainees and non-trainee

Trainee doctors are embedded in the organisation due to the benefits they gain as trainees

This study did identify some distinctions that reflected doctors' differing job statuses, distinguishing between those who are in training and those who are not (trainees and non-trainees). The findings indicated that doctors undergoing postgraduate training programmes are slightly more embedded in their organisations due to the advantages they gain through their these training opportunities. Even though, their working conditions are suboptimal, resulting in many disadvantages, trainee doctors primarily perceive there to be a good fit between their own skills, values, and career needs through the postgraduate training programmes in which they are enrolled. They often expressed the view that the rigorous and specialised training programmes offered to them provide an excellent fit for their professional growth. These programmes offer a structured and academically driven approach that not only meets their expectations but also ensures they acquire necessary skills and knowledge, while fostering a sense of direction and scholarly excellence in their careers. This clear and structured pathway

offers clear career progression and a trajectory towards becoming a consultant, which tends to be the ultimate goal of most junior doctors. However, it is important to note that these benefits and positive experiences for trainee doctors arising from the training programme largely stem from the initiatives of professional training bodies such as the Royal College of Physicians and the Royal College of Psychiatry, as these colleges oversee the postgraduate medical training for doctors in Ireland's public health sector (Health Service Executive, 2021). They ensure that doctors are well trained and have the skills necessary to provide patients with a high standard of care. The colleges run well-defined programmes, and they collaborate well with hospitals, consultants, and clinical directors to provide comprehensive training and experience for doctors. Therefore, it is not the organisation (which is the hospital/HSE exclusively) that directly contributes to their level of embeddedness – rather support comes from the training body, although the training body cannot function without the cooperation of stakeholders from within the organisation.

The higher level of embeddedness for SpRs arising from improvements in overall working conditions (also linked to improvements in community embeddedness)

Among these trainees, those at the Senior Registrar (SpR) level were found to demonstrate greater embeddedness via the fit dimension. This is likely due to the fact that, at this stage of their careers, doctors are starting to feel a better fit with the organisation, particularly in terms of its perceived compatibility with their future career development opportunities, and it is also linked to improved alignment between their expectations and what the organisation has to offer (Holtom and Inderrieden, 2006). This can be largely attributed to the fact that the SpR participants in this study were in the final year of their training programmes which provided them with several distinct advantages aligned with their personal interests and needs (Mitchell *et al.*, 2001). At this stage, they had already fulfilled most of their training requirements and

passed all of their membership exams, and they had also reached a stage where their working conditions had gradually improved, with benefits including more reasonable hours, a protected research day off each week, designated private office space, and better opportunities for job flexibility. This study's findings suggest that these improvements in working conditions had a significant impact on improving the community aspect of junior doctors' work-life balance and overall quality of life. Meaning to say, there is a direct relationship between improved fit in organisation towards the improvement of link within the community. Indeed, doctors viewed these more reasonable working hours and improved working conditions as helping them to have a better quality of life, and, specifically, as creating more opportunities for them to become more involved in off-the-job activities, such as having more family time, becoming more involved in hobbies, investing in gym membership, and becoming involved in children's school activities. These perceptions link back to community embeddedness (Ng and Feldman, 2014), whereby doctors are better able to participate in communities when their working hours and conditions are improved. This is particularly important, as this study's findings indicate that improvements in work-related factors directly lead to improvement or better involvement of doctors in activities that cultivate community embeddedness (Mitchell *et al.*, 2001; Ng and Feldman, 2014), which has been found to be very important in explaining the intention of doctors to stay within this sample.

Trainee doctors' strong fit with the training programme was also found to be significant in relation to the dimension of sacrifice, resulting in their perception that there is a sacrifice involved in leaving the Irish healthcare system. Trainee doctors view the training programme as offering significant benefits which they are not willing to sacrifice by leaving the organisation. In other words, the programme's high standard of training is seen as a good fit for their career progression and this makes the idea of leaving highly undesirable. Furthermore, participants expressed a strong commitment to completing their training because there is a lack

of recognition for any international experience they might gain if they choose to leave halfway through the programme or return later. If they were to leave halfway through, they would have to restart their training again from the beginning on their return. The training programme is allied and intertwined with the Irish public healthcare system, which means that doctors cannot participate in it if they do not have continuous employment with the public system.

For those trainees who have reached SpR level, career benefits and the experience they have gained as an SpR at the end stage of the training programme further improve their intentions to stay. Generally speaking, future job security and career advancement were found to be more relevant to Specialist Registrar (SpRs), as they are heading towards the end of their training programme and are not willing to sacrifice the progress they have made so far. This leads to a higher level of reluctance among this group of doctors to leave their current organisation, due to the achievements and progress they have already made via a sustained effort throughout their training years. SpRs, moving towards the close of their training, expressed great confidence in their career progression as it had become a much clearer prospect for them, particularly because they now recognised their ability to secure a consultant position upon completing their SpR role.

The notable shortage of consultants, with nearly 1000 positions remaining unfilled within the Irish public healthcare system (Bourke, 2023; Cullen, 2023), contributed to their confidence in their own career opportunities in Ireland. This gap in the system presents a great opportunity for these doctors, effectively enabling their transit into consultant roles upon completion of their SpR training. This scenario highlights the alignment of training outcomes and current job market demands which can create a win-win situation for junior doctors: their aspirations to become consultants are matched by the public system's critical need for people in such roles. This facilitates smooth and relatively predictable career progression for those on the SpR

pathway. Rather than focusing solely on becoming consultants, some of the participants in this study also expressed an interest in venturing into academic careers, research, and fellowships, reflecting the fact that their career options at this stage were wider than before. As a result, their attitudes can shift and their focus on potential career advancement and the realisation of long-term goals within the system can increase. These factors, which intensify the level of sacrifice involved in leaving, are further supported by working conditions which are much improved when a junior doctor becomes an SpR (even though the overall working conditions remain the same in the HSE). Generally, the SpRs, as trainees, start to believe that all the hardships they have faced during their period of working as junior doctors are near an end and will ultimately lead to professional rewards and recognition. This shift in perspective helps to embed them into their organisations, and it also allows them to become more embedded/involved in community aspects of their lives. The overall improvement in an SpR's situation at work and their overall lifestyle bolsters their intention to stay (Mitchell *et al.*, 2001).

Organisational links amongst the non-trainee doctors

This study indicates that the organisational embeddedness dimension is lowest for non-trainee doctors, as they do not receive the same work experience or work benefits that trainee doctors do. However, links also appear to have some relevance for non-trainees. Many of them expressed a high level of appreciation for the people with whom they work, highlighting a deep appreciation for the supportive and positive relationships they share with their peers. Specifically, they recognised that it was often the consultants who made a difference to their day-to-day experiences and learning opportunities, especially in the absence of a proper performance management system. Consultants were found to play a critical role in compensating for systemic deficiencies by providing informal support and guidance to non-trainee doctors. This informal support appeared to help bridge the gap left by the absence of

formal training programmes and has a positive impact on doctors' learning and development. In particular, doctors highly valued the efforts some consultants made to provide learning opportunities for skills development for these doctors, regardless of their job status. Crucially, since most of the non-trainee doctors are international doctors, they particularly praised the welcoming and equal treatment they receive from native Irish consultants, which they perceived to be better than the support they received from international consultants or consultants in their own countries. The fair, sensible, and inclusive approach taken by most native Irish consultants was highlighted as a significant factor that contributes to a positive work environment for international doctors, who may face unique challenges in adapting to or working in a different healthcare system with an unfamiliar cultural context. This could, again, be linked to international doctors' generally positive perception of Irish natives (see the findings chapter 5), whereby they feel Irish people are kind, friendly, and welcoming. These attributes of Irish natives, which many international doctors appear to experience during their time in Ireland are seen to be reflected in the approaches taken at work by native Irish consultants.

6.6 Compensatory dynamics between fit, links and sacrifice

Apart from those fit, link and sacrifice being interrelated to another (as discussed earlier), this study also shows that certain components compensate for the absence of others. For example, for international doctors who experience a strong fit towards the community – where the superior living conditions in Ireland offer their poor fit within the organisation – tend to find balance. This suggests that even though their career pathways are challenging, the strong community fit helps to compensate for the low organisation fit.

Likewise, trainee doctors who experience significant challenges in career advancement due to low organisational fit often compensate for this experience with strong links at work. Despite

encountering inadequate work practices and perceiving a poor fit within the organisation (lack of training, similar practices, benefits), these doctors benefit from strong relationships, particularly with consultants. The quality of guidance, support and mentorship they receive fosters a sense of commitment to their job. These doctors are then motivated to stay because they value the quality of links, they have with their consultant and hope that these relationships will eventually aid to their career progression.

Generally speaking, although the level of doctors' organisational embeddedness does not appear to be substantial when its intensity is compared to that of community embeddedness, it is important to note that trainee doctors have a distinctly different experience from non-trainees within the Irish healthcare system. This can lead to higher levels of organisational embeddedness. Trainees are better embedded in their organisation than international doctors due to the benefits they receive from their training programme and the work experience and management support from which they benefit. However, it is important to note that trainee doctors' embeddedness is to some extent guaranteed, as they will definitely receive a set of benefits and improvements in their working conditions from SpR level onwards as their training progresses. However, for non-trainees, this embeddedness experience is inconsistent. While they appreciate the benefits of some links and supervision relationships, these experiences are dependent on the choices of others and can change at any time or differ according to hospital settings, and so these benefits are in no way guaranteed.

6.7 COVID-19 impact on hospital doctors

6.7.1 *COVID-19 and its impact on community embeddedness*

The second research question relates to the impact of COVID-19 on doctors' embeddedness and intention to stay. The occurrence of the COVID-19 pandemic during this study's data

collection phase led to the identification of findings that offer insights into how the pandemic affected doctors, and their organisational and community embeddedness.

Improved hope and trust in community fit for international doctors

Firstly, for international doctors who already appreciate living conditions in Ireland, the COVID-19 pandemic, which could have been a negative experience for many of these doctors, had some positive impacts on their community embeddedness. Primarily, it was observed that the Irish government's adept management during the COVID-19 pandemic appears to have instilled confidence and trust in many international doctors. They recognised the effectiveness of the government's prompt actions in relation to lockdown measures and stringent regulations in Ireland, which were seen as balanced and fair, fostering a sense of trust and safety among the international community. The confidence and trust that international doctors placed in the Irish government's capabilities during this sort of crisis can be seen as a testament to the country's robust governance structure and agile strategies. These positive experiences again formed a contrast with the political and economic instability in international doctors' home countries, where challenges included lack of preparation for the crisis (Biswas *et al.*, 2020), limited resources (Arifuzzaman *et al.*, 2021), weak political resolve, technical limitations (Ross *et al.,* 2015), and fake vaccines being provided (Mukherjee *et al.*, 2022), alongside extensive circulation of misinformation (Mohammad *et al.*, 2022). This was often coupled with inadequate capacity and funding and inadequate policies (Munharo *et al.*, 2020). Generally, the lack of governance capabilities resulted in slow, delayed, and ambiguous pandemic responses in some of these countries (Ahmed *et al.,* 2023). A very high number of deaths and significant economic damage were additional factors that put some low-income countries at greater risk (Cook, 2020; Devlin, 2020). As a consequence, international doctors went so far as to express feeling thankful for being in Ireland during the pandemic, knowing at least that their families were well-protected. Some had family members, including elderly parents, who had travelled

to Ireland before the pandemic and who were stuck in Ireland due to COVID-related travel restrictions. Many of these doctors felt that, since they were in Ireland, these family members were well protected too. The confidence and trust international doctors gained in the Irish government during the pandemic highlights the importance of a well-structured and responsive political system during times of global crisis. Therefore, considering the chaotic situation back home, where people did not feel safe due to high infection levels and a lack of proven clinical treatments, these doctors felt it was much better to be in Ireland.

Improved community links among Irish doctors

Some Irish doctors felt that their sense of belonging and attachment to the community and their strong desire to contribute and give back was further intensified when the COVID-19 pandemic took place. The pandemic appears to have acted as a catalyst that strengthened the emotional and moral ties of these doctors to their homeland. This situation can be looked at through the lens of community embeddedness as, in times of crisis, there is often a heightened sense of community and national solidarity (Mitchell *et al.*, 2001). This can reinforce bonds. Some doctors who had worked in New Zealand for a couple of years and returned to Ireland long before the pandemic expressed the view that they felt grateful and relieved about their decision to return to Ireland as they appreciated the emotional and familial ties this offered during tough times. Additionally, the COVID-19 pandemic further intensified the sentiment among Irish doctors that they wanted to stay and be there for their families. For example, the pandemic made some doctors feel more reluctant to leave their elderly parents or dependents without support. This view was echoed in the experience of some doctors in this sample who reconsidered their decisions to leave their jobs and the Irish healthcare system due to their concerns about their ageing parents' well-being in the face of the pandemic's uncertainties. This highlights the psychological and social costs of leaving a job, as outlined by Mitchell *et*

al. (2001) and Holtom and Inderrieden (2006), who have explored the intangible costs of leaving – including emotional distance from family, disruption of support systems, and separation from loved ones – which weighed heavily on these doctors' decisions.

The pandemic provided a unique context for this study, prompting many doctors to re-evaluate their priorities and to reaffirm their attachment to their home and loved ones. Significantly, it was not just professional obligations that intensified doctors' intention to stay, but a profound connection, sense of belonging to their roots and the community, and the importance of being with family and friends in their homeland. This type of response was strongly reflected in the case of Irish native doctors who were working in Australia when the pandemic started and chose to return to Ireland to be part of the 'Be on Call for Ireland' initiative (Power, 2020; Humphries *et al.*, 2021). These doctors, also known as COVID-19 returners, decided to come back to Ireland at very short notice, with many feeling compelled to offer their support to their native population and healthcare system during this critical time. In this context, the findings about elements of community embeddedness are likely to have been accentuated due to the unique circumstances at this time and may wane in the future, especially if the issues with working conditions in Ireland's healthcare system fail to improve.

6.7.2 COVID-19 and its impact on organisational embeddedness

The COVID-19 pandemic contributed to important findings in relation to organisational embeddedness.[4] Both trainees and non-trainees highlighted the significant transformation of the health system during the COVID-19 pandemic that resulted in doctors experiencing

[4] Please note that some of the following discussion is drawn from a paper currently under second-round review in BMJ open, which can be found in Appendix B.

positive changes, particularly in the first waves of the pandemic. These changes, which were considered totally new, especially in the context of the Irish public healthcare system, saw a notable improvement in working conditions. Working conditions appear to have become more aligned with doctors' expectations, abilities, and interests and were therefore often seen as producing a better fit for them (Ng and Feldman, 2007). These changes resulted from the pandemic and necessitated a rapid reconfiguration and restructuring of the hospital working environment and arrangements to manage the surge in COVID-19 cases (Kennelly *et al.*, 2020). Some of the key changes which were implemented in the Irish healthcare system included better staffing arrangements and improved work rotas, redeployment of doctors to hospital and ward-base care, a cultural shift towards health and safety, involvement of non-clinical managers in COVID-19 crisis management, advancements in the usage and operation of technology, and better recognition and valuation of doctors' contributions, all of which significantly improved doctors' experiences of work. Specifically, many changes not only addressed the immediate crisis but also led to collateral improvements in junior doctors' working conditions in relation to work-life balance, team cohesion, support received, and overall job satisfaction. In essence, doctors felt that the extreme working practices which had become normalised before the pandemic had been improved to create much more appropriate working conditions.

Doctors particularly noted and appreciated the increased availability of consultants within the hospitals where they were working, which had been a relatively uncommon occurrence before the pandemic. Prior to the pandemic, while doctors valued and maintained good links with their consultants, their interactions were often constrained by time limitations. Despite the general supportiveness of consultants, the reality of their demanding schedules, with heavy workloads and numerous roles and responsibilities, meant their time with junior doctors was always restricted. This was particularly challenging for non-trainees, who lacked structured learning

outcomes that required compulsory consultant oversight. Though consultants were seen as very supportive in general, they seemed to barely have time to provide significant guidance and support. However, doctors observed that pandemic-prompted changes enhanced accessibility to consultants and led to better support, more effective clinical supervision, and improved workplace relationships. These changes collectively contributed to a significant boost in workplace morale. Consultants generally had more time to dedicate to junior doctors, not only through overseeing their clinical duties but also by aiding in their personal career development opportunities. Support took forms such as assisting trainees' development of research papers and conducting audits. This support, which extended beyond clinical responsibilities, was not only immensely helpful but also provided a significant career boost, enriching the professional growth of doctors and aiding their career advancement. Accordingly, improved access to consultants is considered crucial, and is intensely appreciated by junior doctors, especially due to their junior status. As junior doctors are still less experienced professionals, proper teaching, guidance, and training are vital to ensure safe and high-quality care. Without such support, the transition from medical school to clinical practice/junior years is difficult and often stressful (Noble and Billett, 2017). According to the BMA (2016, p.745), 'every doctor should be prepared to oversee the work of less experienced colleagues', and this statement clearly articulates the duty of consultants in relation to guiding those who are less experienced. Therefore, for consultants, taking up teaching and training responsibilities is an integral part of their role and can even be considered as obligatory if organisational embeddedness among doctors is to be improved.

In addition to improved consultant support, junior doctors recognised a significant cultural shift regarding health and safety within the workplace, because the pandemic brought about a greater acceptance and understanding of the need for sick leave, in total contrast to the pre-pandemic situation. This shift brought a re-evaluation of priorities with the placing of doctors' health and

well-being above work commitments, which was rare before the pandemic. Historically, doctors had been very reluctant to claim sick leave or take time off, even when unwell, due to a work culture that placed their duties above their own mental and physical health. The pandemic prompted a reassessment that encouraged a shift towards a more balanced approach. It led the Irish healthcare system to become more familiar with the need for healthcare workers to take care of their own health as part of their professional responsibilities, as well as for the sake of the health of their patients.

Furthermore, the involvement of non-clinical managers in pandemic responses was regarded as a positive development that helped to improve the sense of fit for doctors. These managers, equipped with high levels of managerial expertise, demonstrated skills, knowledge, and capabilities which contributed to effective communication, operational decision-making, and team coordination in a dynamic and unprecedented context. Their ability to ensure staff preparedness and employ appropriate, responsive plans that were both timely and efficient was appreciated, and collaboration between clinical teams and these managers was found to be efficient. Most importantly, this fresh approach allowed doctors to fully focus on their clinical work and let the managerial aspects of the system be taken care of by experts in those areas, since doctors are very much challenged by non-core tasks which often contribute to heavy workloads (McGowan *et al.*, 2013). Examples of good management during this period included the implementation of efficient duty rotations, which featured replacement plans, team and rota coordination, and prompt email alerts that provided information and updates about risks, policies, and guidelines on COVID-19, thus showcasing the managers' effortless handling of these responsibilities.

The pandemic also accelerated moves toward greater flexibility and efficiency in the healthcare system via improved technology usage in hospitals, such as telemedicine and virtual meetings methods. Given physicians' widespread perception of the Irish public healthcare system as old-

fashioned, traditional, and reluctant to introduce technology and become familiar with digital solutions, this marked an important transformation in healthcare delivery. This fresh approach not only reduced the need for doctors' physical presence, which decreased the risk of exposure to the virus, but also provided continuity of care during the pandemic and supported uninterrupted service delivery even during the lockdowns. Along with all these approaches and initiatives, the acknowledgement and appreciation of doctors' efforts by management were also highlighted as significant by study participants. Doctors expressed the view that this sort of appreciation and recognition had not existed before the pandemic, and related gestures, though small, were believed to play a crucial role in boosting morale and motivation during a challenging period.

Overall, the changes brought about by the pandemic were largely viewed as producing an improved fit, typically because they were seen to create the types of improvement in the healthcare system that junior doctors wanted to experience. However, concerns remained about the sustainability of these improvements in the post-pandemic period. In fact, as the COVID-19 pandemic progressed, the positive work atmosphere that these doctors had experienced proved to be fleeting rather than becoming enshrined. The more positive work atmosphere doctors had experienced apparently deteriorated progressively as pre-pandemic strains and pressures returned over time. This was mainly because more and more doctors were being exposed to the virus and becoming infected resulting in them being quarantined and unable to work. This, in turn, led to a significant increase in doctors' workloads, due to the Irish health system's core issue, which is the shortage of doctors. The doctor shortage had been evident long before the pandemic (Birchard, 2000), and it is, to a great extent, though not wholly, attributable to long-term issues with staffing and excessive demands. A number of issues shaped these problems: first, the starting point, before the pandemic hit, was a severely understaffed hospital system, and, second, problems associated with the long-standing

dependence on internationally trained doctors worsened because of the inability to fill gaps through international recruitment (due to global mobility restrictions).

Although doctors were slightly disappointed that the changes and positive experiences produced during the pandemic were not sustainable for a longer period, the new norms of work and the positive experiences encountered (even during this short time) provided many doctors in this sample with a renewed sense of hope for the Irish public healthcare system and its capabilities. This newfound hope encouraged doctors to feel a sense of purpose, satisfaction, and confidence in the system, where previously they had thought that any sort of changes were almost impossible. However, as the more positive features of pandemic healthcare were not continued or normalised, the concern was that some of these more positive individual feelings would turn to anger if the improvements that were unquestionably required fail to materialise.

It is crucial to note that research has shown that hope in the workplace can empower individuals to persevere through difficulties (Shuval *et al*., 1996). This positive outlook allows challenges and problems to be viewed as opportunities for learning and growth. Most importantly, hope has been found to have a positive correlation with organisational commitment, which is negatively correlated with turnover (Bibby, Everest, and Abbs, 2020). Given the high level of turnover within Irish healthcare pre-COVID, some positive experiences may prove significant in retaining doctors in the near future. For many doctors in this study, there remains hope that the pandemic will lead to long-term changes and lasting investment in the Irish healthcare system.

6.8 Contribution to knowledge

Many researchers have sought to answer the question as to what determines people's intentions to leave by investigating possible antecedents of turnover. The literature defines withdrawal intentions by assessing the thought of quitting, intention to search for another job, and intention

to quit (Mobley *et al.*, 1979). The concepts of job satisfaction (Carsten and Spector, 1987), organisational commitment (Allen and Meyer, 1990), continuous commitment (Shore and Wayne, 1993), and job attachment (Koch and Steers, 1978) have helped to shape research in the field. General findings and knowledge accumulated in this area suggest that, when other opportunities arise, employees who are satisfied, attached, and committed to their jobs are likely to stay and those who feel otherwise will leave (Mitchell *et al.*, 2001). Yet, according to Mitchell *et al.* (2011), this approach has only yielded partial explanations for turnover, as some employees who are satisfied and committed might also choose to leave due to other factors. They suggested that this area would benefit from research that sought to uncover the other side of the story, focusing on why some employees choose to stay in their jobs. This is something which this study has strived to do. Specifically, in the context of the Irish public healthcare system, there has been very limited research on why doctors choose to stay (see Seathu Raman *et al*., 2024) although there have been many important contributions to the understanding of factors that lead to doctors leaving voluntarily (Humphries *et al.*, 2017). Most studies that have drawn on job embeddedness theory have emanated from the United States, which has led to calls for research from other countries and cultural contexts (Sessa and Bowling, 2020). This is the first study exploring job embeddedness in Ireland in the area of health workers. This thesis has sought to contribute to the existing knowledge in healthcare management by providing in-depth, qualitative accounts from Irish junior hospital doctors on why they intend to stay in their jobs; an area that has been noted in the broader employee turnover/retention literature as deserving of greater attention (Ghosh *et al.*, 2013; Boswell et al., 2017; Hom et al., 2019). The study unpacks the broad constellation of factors and forces that embed hospital doctors within their roles. The findings are notable in respect to how much influence they show non-work factors have in such decisions, where different types of community embeddedness are clearly evident and highly significant.

This study also makes a contribution by broadening the scope of job embeddedness theory and enhancing its applicability in a lesser-used context and in relation to its different organisational and community dimensions. Through the empirical accounts of doctors, this study has provided greater recognition, development, and expansion of the community embeddedness dimension within job embeddedness theory. This research has expanded and broadened the scope and dimension of job embeddedness theory by exploring it in a new and different sector (healthcare), with an occupational focus (hospital doctors across different specialisms), across different countries/cultures (Europe-Ireland) and demographics (mix of nationality, different gender, age, gender). Although the initial presentation of job embeddedness theory by Mitchell *et al.* (2001) posited that organisational embeddedness and community embeddedness combine to play a role in employees' retention/keeping employees in their organisations, the relationship between these factors requires greater scrutiny. Community embeddedness and its role in employee retention has received relatively scant attention in comparison to organisational embeddedness (Halbesleben and Wheeler, 2008; Sekiguchi et al., 2008; Hom *et al.*, 2009; Ng and Feldman, 2009). It is important to note that the lack of consideration for this aspect of embeddedness is inconsistent with Mitchell *et al*.'s (2001) original conceptualisation where it was proposed that both organisational and community embeddedness be weighted equally. However, while community embeddedness has been an insufficiently explored area, this does not equate to it being irrelevant. This study underscores the importance of continuing to explore the role that community embeddedness plays in employee retention, given that it emerges as being of greater resonance than organisational embeddedness in this context. In basic terms, community embeddedness is a powerful reason for hospital doctor retention. This finding also adds weight to calls for the need to consider job embeddedness in other contexts to determine the applicability of the theory and its dimensions on a wider level.

It is worth noting that research to date on job embeddedness has predominantly focused on the dimension of fit, and specifically job-related fit, with less attention being given to links and sacrifice (Mitchell *et al.*, 2001; Sessa and Bowling, 2020). In this study, both organisational and community embeddedness were evaluated in relation to all three dimensions. This approach is important because each dimension offers a valuable perspective that can enhance the understanding of the research problem. The findings also demonstrate that there were distinctions in some of these dimensions, especially with respect to whether the interviewee was an Irish or international doctor.

A further contribution was made through this study's use of a qualitative methodology. Through a conversation-based interview process, the study was able to capture participants' thoughts, ideas, feelings, and interpretations in their own words. The use of this method is deemed to provide an important contribution to the literature, as the overwhelming focus of the health management literature on turnover and retention (Seathu Raman *et al*., 2024) and job embeddedness literature has been more quantitative in nature. The quantitative approach makes it more challenging to capture the relationships between organisational and community embeddedness aspects and this may, in part, explain the limited attention that has been given to the latter. The qualitative methodology used in this study has therefore enabled a detailed understanding of the relationship between the organisational and community factors involved in job embeddedness, highlighting ways in which they relate to each other as well as differ.

Of further note is the fact that this study presents important empirical accounts of the lived, first-hand accounts of doctors' professional and personal experiences during a global pandemic, though this outcome was unplanned at the start. As the study was conducted during the later waves of the COVID-19 pandemic, it allowed appropriate time for doctors to reflect on the earlier parts of the pandemic and their experience of that phase, and it also allowed

insights to be garnered on evolving dynamics and perceptions as the pandemic progressed. In some respects, the most notable contribution from these rich empirical accounts was that doctors spoke about positive experiences while working under the most surreal and 'dangerous' conditions they would have ever known. Studies to date that have reported on COVID-19 experiences have tended to overwhelmingly report negative accounts. This study's findings indicate that the global pandemic served as a type of 'watershed moment' for many participants, and this appeared to have varying impacts on their organisational and community embeddedness. At the most basic level, it offered these doctors a glimpse of the possibility of positive changes to the functioning of the Irish health system and their working conditions. This aspect is particularly intriguing and counterintuitive, as the expectations might have been that a global pandemic would tend to create negative experiences. Therefore, by shedding light on these positive outcomes, the study offers a somewhat alternative or perhaps more nuanced account of junior doctors' lived experiences during unprecedented times. While there were positive aspects reported that were not sustained, these lived experiences nevertheless appeared to strengthen some elements of doctors' embeddedness.

6.9 Implications and recommendations

Several implications and recommendations for hospital management and doctors stem from this research.

All employees go through several stages during their employment with an organisation (Mitchell, Holtom and Lee, 2001) These include an entry phase, which is critical, as this is when employees familiarise themselves with the organisation's culture, norms, and expectations and acquire new knowledge pertinent to their roles. Next comes the settling-in phase – this period can vary in duration but is characterised by some stability in terms of employees' life on the job. Finally, employees may enter a phase of withdrawal which can

result from retirement, termination, or voluntary/involuntary turnover. This study adds to calls for greater focus on retention given that the overwhelming discourse has tended to centre on recruitment (Humphries *et al.*, 2019; Brugha *et al.*, 2020, 2021). While increased recruitment activity is vital to a higher quality and efficient public health system and will assist in reducing doctor turnover, this is insufficient. Given the cited turnover rates of junior doctors, and even if the funding is available for recruitment, there is an argument that the HSE and hospitals should consider making resources available where there are employees responsible for retention of key healthcare staff. The potential benefit of this would include there being someone who is responsible for such a critical aspect of good HR and management rather than the current approach where it is the role of many but nobody. The merits of having someone or people with key accountability for retention within hospitals is accentuated by the importance of community embeddedness. This study finds that community embeddedness plays a pivotal role in the retention of doctors in the Irish healthcare system, and so integrating doctors more deeply into the community can result in better retention. However, efforts to improve community embeddedness currently tend to rely on individual efforts made by doctors themselves, without formal support from their employer, the Health Service Executive (HSE). This study suggests the need for a significant shift that will lead to the organisation playing an active role in fostering doctors' community connections. This further extends into the organisational domain in the context of building links and community within the organisation where there are forces that arguably work against this, such as 6-monthly rotations. The HSE can look at strategies to help doctors develop better fit and links; aspects that are arguably even more important for migrant doctors. This would be a sea-change given there is evidence suggesting that limited supports exist in the early parts of the recruitment and onboarding processes in these key areas.

The entry phase for doctors' joining the Irish healthcare system should begins well before their arrival at the hospital. The period during which they are planning their transition from their home countries and arriving in Ireland is significant as it marks the beginning of their adjustment to a new country, culture, and environment. Therefore, it is essential to provide comprehensive onboarding support before and around the moment of their arrival to facilitate a smooth transition. Currently, the Health Service Executive (HSE) does not provide any onboarding/arrival support, leaving new doctors who move to Ireland to fend for themselves.

To enhance this support, several initiatives could be considered:

a) Pre-arrival orientation: conducting a virtual orientation session to prepare doctors for their move. This could cover practical aspects such as information on housing, banking, and transportation, as well as cultural expectations and norms within Ireland and the healthcare system. The potential to offer pre-move visits (or in any digital form) would also be of considerable benefit.
b) A welcome package: providing a welcome package that offers essential information and resources about living and working in Ireland will be also useful, as it will provide invaluable information as well as an indication of support for the newcomers.
c) Initial accommodation supports: facilitating arrangements for temporary accommodation can significantly ease the transition for doctors. This dedicated support will ease doctors' arrival by making it safer and more convenient, and it will also help to address the initial challenges related to securing permanent housing, especially given the ongoing challenges posed by the housing market crisis in Ireland (Reed, 2023).

HR departments within the respective hospitals can help international doctors become more engaged with the communities around them by connecting them with, or providing information that facilitates connections in, the community. This can be achieved by offering insights into

various local activities and groups. For example, HR can encourage doctors to participate in volunteering or community engagement activities such as the Volunteer Healthcare Professional programme and Toastmasters International which will aid in doctors' assimilation into the local environment. Additionally, hospitals can provide information to doctors about the international associations available to them in Ireland, such as Doctors in Ireland, the Irish Society of International Doctors, the Association of Irish Pakistani Physicians & Surgeons (IPPS), and the Sudanese Doctors Union of Ireland. This approach can be instrumental in enhancing the integration of and community networking opportunities for international doctors, especially for those doctors who have moved here by themselves and who are living alone in Ireland. By participating in these activities and groups, doctors are afforded chances to 'break the ice' and have opportunities to mingle in their communities with individuals they might not otherwise have met. Such interactions are crucial for building a supportive network and creating a sense of belonging, significantly enriching the lives of people who might not otherwise cross paths.

While these community aspects are important, there is no getting away from the need to improve working conditions as part of the strategy to get staffing levels to an appropriate level and to improve the retention of doctors (Chalikonda, 2023). There are issues at the wider HSE level and within individual hospitals that require improvements. While Ireland moved away from local hospital boards to the HSE, the reality on the ground for doctors and their employment is that each time they have to rotate they are faced with changes that regularly causes problems and distress. The problems arising exist at the most basic level in terms of issues around being paid on time and correctly. There is a strong argument for greater uniformity and standardisation of such practices to reduce the unnecessary stress and headaches faced. Similarly, there is a lack of consistency around performance management for all doctors, whether or not they are trainees. Trainee doctors are provided with better performance

management opportunities (e.g., they are more likely to receive useful supervision and have appraisals), while non-trainees are far more at the mercy of consultants affording them such time and support. This is highly problematic, given the key role such doctors play in providing a health system. There is a need to explore how to increase the access of international doctors to trainee pathways and/or provide alternative career development and progression opportunities.

Another area for change highlighted by this study is the requirement for trainee doctors to rotate between different hospitals and locations every six months during their postgraduate training programmes. While these rotations are essential to ensure junior doctors fulfil the requirements of the curriculum and gain exposure to a diverse range of clinical systems and experiences, the frequency of these moves, which often require a geographical move/physical relocation, is not considered ideal. This is more pronounced in light of the housing crisis in Ireland, which significantly exacerbates the challenges associated with moving for doctors. Importantly, research has demonstrated that frequent job rotations have several negative consequences on employees, such as decreases in productivity, poor psychological well-being, and job-related stress, which then reduce organisational commitment (Malinski, 2002; Shah et al., 2014; Lee et al., 2017). They may also directly or indirectly impact employees' levels of embeddedness, especially in relation to job fit and links (Peltokorpi, 2013; Jeong *et al.*, 2023). Furthermore, if junior doctors opt not to move residence (as the research findings suggest is preferable) and opt to commute to new training locations, this is time-consuming. While many prefer this option, as it allows them to remain within the same residence and community, it adds a significant burden, given their already demanding workload and long hours. Adding daily travel time (which could be 2-3 hours) only further deteriorates their physical and mental health and can also limit their involvement in activities outside of work such as leisure, personal commitments, and family time. Therefore, the continued use of 6-month rotations is worthy of

full investigation with respect to whether reducing the frequency may offer benefits and limitations and/or how to better support doctors who must move.

Frequent rotations can also be challenging for doctors with family responsibilities. They may have to make significant sacrifices each time they need to move, such as changing schools and activities for their children. This issue is even more difficult for women, new mothers of small children, or those who are breastfeeding, as they may face additional challenges in balancing their careers and personal lives. Overall, due to these rotations, achieving a proper work-life balance can be complex, and this situation, in turn, can adversely affect their sense of community embeddedness (due to limited time), which may negatively impact retention (Ng and Feldman, 2014). Therefore, while working excessive hours is problematic in itself, it also negatively impacts one's capacity to engage within the community, which, as this study has shown, helps to retain doctors.

The junior doctors involved in this study spoke positively about the benefits of having greater access to consultants in the early stages of the pandemic as this facilitated greater links at the organisational level. This access to consultants was highly valued because it provided essential support and guidance and assisted them in their professional development. Junior doctors view the opportunities to learn from, and be guided by, consultants as critical for excelling in their field as these supports help them progress from their junior status and build confidence as well as skills. The role of consultants extends beyond clinical duties to include teaching and training responsibilities, which are integral to their roles, whether or not these responsibilities are fully recognised or appreciated (Johnson, 2001). When this type of support is absent, it makes the transition from medical school to clinical practice challenging and stressful, and, of course, it places patients at risk. Improvements in the provision and consistency of consultant support for junior doctors are important. If the HSE and associated HRM practices recognise the importance. and promote the availability, of regular feedback and supervision for all junior

doctors, this will not only help to enhance the performance of junior doctors but will also strengthen the bonds between them and the teams in which they work, contributing to a more supportive work environment.

Despite ongoing efforts by scholars who have provided recommendations to improve working conditions, such as reducing doctors' workloads, adhering to the European Working Time Directive (EWTD), and improving the criteria for postgraduate training schemes by improving postgraduate training opportunities and health and well-being initiatives (McGowan *et al.*, 2013; Humphries *et al.,* 2014; Humphries *et al.*, 2015, 2019, 2020; Tyrrell *et al.*, 2016; Byrne *et al.*, 2021), there has been little sense of improvement beyond reports in this study which responded to changes in the earlier part of the pandemic. In basic terms, there is a need for greater investment in frontline medical staff.

On the individual level, doctors who are proactive in developing links, both inside and outside their employment context, appear more likely to be able to withstand some of the worst effects of their tough working conditions and to feel more content with their situation. However, there is a need for caution amongst doctors in terms of whether they are overly normalising the poor conditions in which they work. For example, the positive sentiments about Ireland's geographical advantages offers a clear element of danger in that working excessive hours and then driving relatively long distances to return to home and secure community benefits carries significant risk. These conditions clearly produce increased risks for doctors and the public, not only within the hospital domain but on the roads. Doctors are entitled to workplace wellbeing, and their strong commitment to their profession and vocation for care does not excuse 'organisational neglect' (Humphries *et al.*, 2024). Hospital management and wider HSE management would benefit from really listening to and hearing the experiences of frontline doctors and medical professionals, as this study supports the contention of Humphries *et al*. (2022) that there is a disconnect between management and medical staff.

Finally, the approach on hiring the non-clinical mangers on hospital levels which were deemed successful by doctors participated in this study are also highly encouraged. For over a decade, doctors have emphasized the burden to encompass a significant amount of non-core task mainly - administrative task. These tasks have overwhelmed doctors to the point where managing administrative work, including duty rotas, has become part of their responsibilities. Therefore, adopting a successful implementation from COVID-19, would be beneficial for doctors to reduce their workload. Essentially, these managers are managerially trained, therefore, they will be also capable of handling the HR related tasks suggested and this will not only address the administrative burden for doctors but also fill in the crucial gap in lack of line management within the health system (Humphries *et al.*, 2024).

7.0 Study limitations and avenues for future research

While this thesis has offered several contributions, it is important to also recognise some of its limitations. A key strength of the study is that it has focused on the organisational and community embeddedness of hospital doctors which has shed light on a less explored area, which is doctors' intentions to stay in an organisation. However, a small sample size was involved which greatly limits the generalisability of the findings. In basic terms, this study is unable to claim any broader representation of junior hospital doctors beyond the sample. The fieldwork was challenging, and adaptations had to be made due to the pandemic. For example, getting access to doctors was challenging given the real pressures they were all under, and this led to pragmatism in terms of the demands that could appropriately be placed on them. However, this does not mean the findings are irrelevant; instead, one needs to be cautious in evaluating the relevance of the findings on a wider scale. As such, there is much merit in future research to expand on the sample adopted here to allow wider interpretations to be offered.

The experiences and factors influencing the intention to stay may vary for other doctors, and this study might not fully capture all relevant factors. In addition, there is scope for future research to delve even deeper into the different dimensions of embeddedness. There is, of course, also the need to recognise that these findings stem from the midst of a global health pandemic and therefore there is no guarantee that the perspectives offered here, while authentic and based on lived experience, will hold. In that vein, further data collection is worthwhile, and adopting more longitudinal, rather than cross-sectional, approaches would also be valuable. This is likely to be especially helpful in further delineating doctors' level of embeddedness, as such study designs would enable changes to be tracked across different times and events. For example, how would perceptions change at different junctures around role rotations? The reliance here on a point in time, while offering important insights, does not enable full capture of the evolution of perspectives over time or properly reflect the impact of potential changes on participants' experiences. Future research would also benefit from a multi-respondent approach which may include organisational agents (e.g., HR), consultants, and so forth.

Another limitation on this study was that it was conducted during the COVID-19 pandemic, and so interviews were conducted online via Microsoft Teams to adhere to social distancing and pandemic-related protocols. Conducting interviews in this online setting may have made it harder for the researcher to pick up on non-verbal cues or nuanced responses that are key to fully understanding a participant's perspective, and it may also have affected the relationship established between the interviewer and interviewees. The researcher sought to reduce such challenges by asking each participant to switch on video functionality throughout their interview, which at least enabled observation of their body language and facial expressions and the making of links between tone of voice and the views expressed. Positively, research has shown that sensitive topics, such as doctors sharing their experiences of isolation and emotional stressors, can be more easily discussed via online platform (Davies

et al., 2020). It is important to note too that, while the impact of COVID-19 on this study's delivery was substantial, it also meant that the findings were able to shed light on the pandemic's impact on junior doctors' decisions to stay within or leave the Irish healthcare system.

Conclusion

8.0 Conclusion

This thesis has sought to investigate the intention to stay amongst junior hospital doctors within the Irish public healthcare system. Despite the system's well-known issues surrounding poor working conditions and high voluntary turnover, this thesis has explored the reasons why some hospital doctors choose to stay. To achieve this aim, it has used the lens of job embeddedness theory, a theoretical framework suitable for understanding retention. The study examined doctors' intention to stay by assessing their levels of organisational and community embeddedness, based on the dimensions of fit, links, and sacrifice.

The results, based on a qualitative approach study sample of 31 Irish and international doctors, revealed that community embeddedness was the primary determinant of doctors' intention to stay. In essence, the research provided comprehensive insights into the critical dimensions of fit, links, and sacrifice deriving from community embeddedness and demonstrated how they influence doctors' retention decisions. Notably, this study has highlighted the nuanced differences between Irish and international doctors in terms of community embeddedness across its three dimensions. From the perspective of organisational embeddedness, the study found that it plays a lesser role in doctors' intention to stay, and while some factors in the Irish healthcare system do create a difference for doctors, their influence often depends on a doctors' job status as trainee or non-trainee.

The COVID-19 global pandemic emerged in this study as another crucial factor that has impacted doctors' professional and personal lives and which has contributed to their decisions to stay or leave. The study has made a contribution by extending job embeddedness theory to the healthcare context, demonstrating the theory's applicability to the Irish healthcare context as well as the critical role of community embeddedness in doctors' retention decisions. In practical terms, the findings suggest the need for targeted strategies to improve doctors'

retention, which should consider community aspects along with organisational factors to better improve the retention of junior hospital doctors.

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[i] Please note that parts of the thesis, most notably large swathes of the literature review chapter, have been published during my PhD studies. See Seathu Raman *et al*. (2024).

Appendix A

Interview Guide

Compiled by:

Siva Shaangari Seathu Raman

Government of Ireland PhD Scholar,

Cork University Business School,

University College Cork.

The following is a guide to be used when interviewing participants of the following study:

The reasons for staying when so many depart: An exploratory study of junior public hospital doctors' retention in Ireland

The purpose of this study is to gain an understanding and contribute knowledge concerning the retention of hospital doctors retention in the Irish public sector. Specifically, this study seeks to comprehend doctors intention to stay in their job. All participants were junior doctors/non-consultant hospital doctors who were attached to the public hospitals in Ireland. The methodology employed: semi-structured covering a discussion of doctors backgrounds, organisational information (work aspect), and community related information (outside of work) alongside some questions related to the COVID-19 pandemic.

Interview Questions

Thank you for participating in this interview today. Your contribution and insights are very important. During the interview I am going to ask you questions related to your work experiences. Before we begin, I would like to assure you that everything you share with me today will be kept confidential. Should any quotes or excerpts from the interview be used at a later stage, they will be completely anonymous and confidential.

I would like to record our conversation for later analysis, is this ok with you?

This will help me to re-listen to our conversation to ensure that I have understood you correctly and to undertake systematic analysis.

There are obviously no right or wrong answers. What I am interested in is gaining an understanding of what motivates hospital doctors to stay or leave a job. So, this is really about your experiences.

1. To start, can you tell me about yourself and your background?
   follow-ups/probes

   - Your educational background – college etc.
   - How long have you been working as a medical doctor and how long have you been working in Ireland?
   - Why did you choose to work in the Irish health system?
   - Have you worked elsewhere? Can you tell me how that compares to your current experience in the Irish health system/to work in Ireland?

2. How do you like being a medical doctor in general? (passion, desire, calling).
   - Advantages and disadvantages that you perceive from this work?

3. How would you describe your satisfaction with your profession/role as a doctor?
   - Can you tell me some more about why you feel this way (e.g. particular incidents/ongoing issues/concerns that you would like to highlight)

4. How long have you been working in your current hospital? Can you tell me what it's like working in this hospital? (working environment, conditions, advantages, disadvantages, what you enjoy etc.)

5. Can you explain the nature of the department you work, the size of it, the specialisms in general, your specialization and your job role)?
   - Have you also worked in other hospital in Ireland?
   - Same/difference in experiences to those hospitals?

6. Can you talk me through what your typical "day at work looks like"? (day-to-day workload/tasks, patient treatment/consultations, patient load, working hours, on-call/extra shifts, task complexity, job related challenges and other related roles).
    - Are you working days fairly similar?
    - Or are specific days of the week assigned to specific tasks/schedules?
    - Are your working days frequently affected by unforeseen events or emergencies (what kind)?
    - How do these aspects affect your job quality?
    - To what extent do you see this as manageable or unmanageable?
    - What changes would you make regarding these aspects of your job?

We now focus a little on the global pandemic – COVID-19

7. Can you tell me if the Covid-19 pandemic has altered your job?
    - Can you give me some specific examples of how it has changed things (positive/negative)?
    - Is there any change you saw? How do you perceive this change?
    - How do you think this circumstance has made your decision to stay/leave?
    - What is the motivation? What was new after COVID-19.

8. How would you describe the level or degree of autonomy or control you have over your work?
    - Do you have a line manager/do you give instructions to others? What occupational groups do they belong to? Can you give an estimate of how much of your time compared to other duties does this take up?
    - What changes would you make regarding this aspect of your job?

9. Do you feel that your work in the hospital is well/adequately recognised? (by others in the hospital, colleagues, consultants/supervisor, hospital management). How would you describe the recognition you feel you receive for what you do?
    - What levels of support do you receive in undertaking your role? Can you tell me about the forms that this takes?

- Any specific examples that you would like to share in relation to this/specific recognition?
- What changes would you make regarding this aspect of your job?

10. What are your views regarding the career progression and development opportunities afforded to you?
    - Can you tell me if you believe that your current role allows you to use your capabilities/skills to fullest degree? (If negative) – why?
    - Do you believe there are sufficient training and development opportunities offered? Some examples/what is missing/should be offered more?
    - (If positive view expressed), to what extent would you see losing these if you were to change job as being disappointing to lose?
    - Do you see a clear career progression plan in place? Can you tell me more on why you think this way? What changes would you like to see made in relation to this?
11. What are your views on the remuneration and benefits you receive in your role?
    - Sufficient or not/aligned with the effort you put in….how/why etc.
    - What changes would you make regarding this aspect of your job?

12. Can you tell me how you view the hospital's HR practices in terms of affecting your working life? Positive/negative practices.

13. Can you tell me more about your job status in terms of are you on a contract or permanent? Details of how the contracts work. What is the duration of the contracts? If you are in a rotation – where/what year you are currently on your rotation etc.
    - Are you satisfied/dissatisfied with the nature of this (does if affect your job security) Why/not? What aspect is working/don't work (positive/negative about this rotation/contract)
    - Or Can you tell me a bit more on how you feel your contract status impacts on your job performance/satisfaction/well-being etc?
    - How do you perceive the role of your contract manifesting to your retention/turnover.

14. Can you describe your relationship with your co-workers?
    - Positive/negative/strong/weak? Do you interact regularly with them/work in team? Find out about nature of these
    - If you have a problem/situation where you need some support who would you approach and why?
    - Or are you hesitant to seek help at any stage? How do you feel about asking for help from them?

I now want to turn a little to non-work aspects. So from now on, its not about your organisation, its about you and your personal life?

15. Can you tell me a little more about your situation outside work, for example, do you like the area you live in? How's your life outside of work?
    - How important is this aspect in your life?
    - What do you appreciate and what you don't?
    - The advantages and disadvantages?

16. Do you feel integrated into your community outside of work? For example, are you active in any civic activities (sports, religious, local interest political groups)?
    - Can you tell me more about your involvement in those activities?
    - With your job commitment – how do you find time for these activities? And sports?

17. Can you tell me about the importance you place on your non-work relationships or community integration in your life?
    - Family, friends, extended family? How's your relationship with them?
    - Are such aspects things you consider when making career/job role decisions? (if yes), can you give me an example of where such non work matters have materially influenced a job decision?
18. What would you miss the most if you left your current area/community? (any important factor? non-work friends, neighbourhood, activities, situation outside)
    - Why do you think this aspect is hard to sacrifice

19. How does your rotation/process of work affect your non-work related issues such as childcare, school, housing etc. If yes, to what extent these factors impact you?
    - Can you provide examples?
    - How do you cope/handle with those issues

20. **Going back to COVID-19,** how do you think the pandemic has created an impact either positive or negative on your personal life?
    - Why do you think these changes occurred?
    - How do you think this impact has created a difference to your decision to stay or leave?

21. Moving back to the work setting, can you tell me about how you currently see your career evolving over short, medium and long term horizons?
    - Have you given any considerations over the past 6-12 months to move to another job? Or stay ? why? Explain? Examples?
    - (if no) Why? What makes you to continues staying?
    - (if yes) What/where are you looking to move to? Can you tell me what you would be seeking in a new role that your current job is lacking?
    - Has the pandemic had any influence on how you see your career plans? Or personal life?
22. Do you have anything else you want me to know about your work/the life outside of work?
23. Any questions?

Appendix B:





Participant Information Sheet – Non-consultant hospital doctors (NCHD)

Dear …….. (name of the participant)

I would like to invite you to take part in my research study. To inform your decision on whether to participate, this letter outlines the project and what it is involved.

My name is Siva Shaangari Seathu Raman and you may address me as Shaan. I am a PhD researcher within the HR Research Centre, Cork University Business School, UCC. This research is conducted by myself and supervised by three UCC supervisors, Professor Anthony McDonnell and Professor Matthias Beck.

My research seeks to understand the reasons behind why Irish hospital doctors both leave and remain within their jobs. Specifically, this research aims to understand the work experiences and motivations that inform intention to remain in post or contribute to the decision to leave amongst non-consultant hospital doctors (NCHD). I am therefore interested in understanding the nature of your work and working conditions, values, goals and perception towards your organisation (HSE and the hospital to which you are attached), your personal interest, passion towards your job as a medical doctor, and community network (family, friends).

While there has been much public discourse around attraction and retention issues in the Irish health system, we still know little about how work and non-work factors interact and influence the intentions of doctors, especially non-consultant hospital doctors (NCHD). Hence, this study seeks to address this knowledge gap and looks to provide possible solutions to improving areas of concern.

Participation, confidentiality, and anonymity

Your participation will involve a one-to-one interview conducted by myself via an online platform. The interview will last approximately about 45-60 minutes. With your consent, the interview will be audio-recorded and then transcribed by myself for analysis. Your identity will be kept anonymous and your information confidential at all times. All identifying information of participants will be erased from the recording device and transcripts. All files, including recordings and interview transcripts, will be kept on an encrypted password-protected laptop and filed in secure UCC storage for ten years; meeting the 10-year requirement in the UCC Code of Research Conduct. After 10 years, all data collected will be carefully disposed of from OneDrive by the researcher.

Some quotations from the interviews may be used in the PhD thesis and other publications but this will always be done without identifying personal information.

Voluntary Participation

Participation in this study is completely voluntary. You have the right to withdraw from the interview without repercussions at any time. You also have the right to withdraw permission to use the data within two weeks of the interview, in which case the material will be deleted.

Risks

No negative consequences are anticipated from participating in this study. However, if you feel that any question is of a sensitive or personal nature, you have the right to choose not to answer or bring the interview to an end at any time.

Ethics

This study has obtained ethical approval from the UCC Social Research Ethics Committee.

Should you have any questions or queries further, please do not hesitate to contact me at 119222027@umail.ucc.ie. You may also contact the research supervisor, Professor Anthony McDonnell at anthony.mcdonnell@ucc.ie.

If you agree to take part in this study, kindly drop me an email/text me at 0831318281 Shaan.

Thanks.

Appendix C:





Consent Form

I …… agree to participate the research study *'Irish hospital doctors' voluntary turnover and retention': A job embeddedness theory perspective.*

The purpose and nature of the study has been explained to me in writing.

I am participating voluntarily.

I give permission for my interview to be audio-recorded.

I understand that I can withdraw permission to use the data within two weeks of the interview, in which case the material will be deleted.

I understand that my anonymity will be ensured in the write-up and use of my data by disguising my identity.

I understand that disguised extracts from my interview may be quoted in the thesis and any related publications.

If you have any questions or concerns about your participants in the study, you may contact the researcher
Siva Shaangari Seathu Raman @ Shaan through phone +353 831318281 or email 119222027@umail.ucc.ie. You may also contact the research supervisor, Professor Anthony McDonnell anthony.mcdonnell@ucc.ie.

Printed Name of Participant: Date:
Signature of participant:

Appendix D:

The lived experiences of junior hospital doctors in the Irish public health system during the COVID-19 pandemic: a qualitative study

Abstract

Objective: This study explores the lived experiences of hospital doctors within the Irish public hospital system during the COVID-19 pandemic.

Design: An exploratory, cross-sectional qualitative approach involving in-depth interviews.

Setting: The Irish public hospital system.

Participants: 31 junior hospital doctors across a range of specialities and diverse personal characteristics.

Results: Doctors indicated substantially positive improvements in working conditions, perceptions of support, and a better atmosphere at work in the earlier parts of the pandemic. However, over time, these positive impacts became less evident. Doctors spoke movingly about the emergence of feelings of guilt and isolation as the pandemic progressed, and the impact of it and new ways of working evolved.

Conclusion: The improvements felt in the early stages of the pandemic, albeit not sustained, led to the emergence of hope amongst some doctors that positive change was possible within

the Irish health system after years of deterioration and that this could produce improved working conditions and positive patient care. These have been long-standing issues within the Irish health system. Our analysis intimates that approaches to managing major health emergencies in future must also give due consideration to the psychological and social impacts of any required work changes on those who are charged with dealing with the effects on the front-line.

Keywords: COVID-19, junior doctors, lived experiences, retention, working conditions

Strengths and limitations of this study

- This qualitative study provides a first-hand account of the lived experiences of junior hospital doctors during the COVID-19 pandemic in a health system regularly derided for poor working conditions and excessive staff turnover.
- The study offers an in-depth enquiry into the lived experiences of hospital doctors, drawing on their personal perspectives and narratives to provide valuable insights into their unique encounters and challenges throughout the pandemic.
- The cross-sectional interview design precludes us from offering insights based on the ongoing personal accounts of living and working through the pandemic on the front-line.
- The size of the sample limits the study's overall generalisability.

Introduction

The coronavirus disease (COVID-19) fundamentally altered the healthcare context as priorities rapidly shifted to combating the pandemic's severity and preventing further exposures.[1] Hospital doctors formed the most crucial element of the COVID-19 response, despite the grave

and increased personal health risks posed.[1-4] The speed and severity of the pandemic placed exceptional demands on hospital doctors in relation to the volume of work they faced, the pressure they encountered, and the need to perform work beyond their immediate duties.[5, 6]

In Ireland, the pandemic arrived at a time when the health system was arguably already beyond the point of being under severe pressure. Since the 2008 global financial crisis, the Irish healthcare system has deteriorated substantially due to financial constraints and the effects of historic underfunding linked to austerity-related budget cuts.[7, 8] This has resulted in issues including understaffing, lower bed numbers, and negative changes to salary levels for new entrants.[9] Irish public hospitals are also often found to be operating at near maximum capacity. For example, pre-COVID-19, there were more than 500,000 people on waiting lists for their first outpatient hospital visits.[10, 11]

Working conditions have long been reported as highly problematic and inappropriate for producing a safe environment in which to work and receive care, with regular reports of excessive working hours (typically in excess of 60 hours per week), and individual shifts exceeding 36 hours without a break.[7, 8, 12] These conditions, in turn, have created problems such as poor work-life balance and adverse impacts on physical and mental well-being amongst doctors and other health professionals.[8, 9, 13, 14]. Many training grants which create access for doctors to undertake their postgraduate training programs were also removed, resulting in limited opportunities and career progression.[15] This led to an emergent and consistent view amongst junior doctors that Irish hospitals were failing to provide appropriate working conditions, in addition to failing to ensure that reasonable, rather than excessive, demands were the norm.[8] In this context, the turnover of Irish-based hospital doctors was significantly increasing even before the pandemic, thus accentuating difficulties within an already understaffed healthcare system.[16-18] For example, from 2008 to 2014 an analysis of medical registration and visa data in five anglophone destination countries highlighted that 3,800

doctors left Ireland and terminated their medical registration in Ireland.[19] A survey that tracked doctors' completion of internships in the Irish health system in 2011 indicated that 45% of doctors who completed their internships were no longer working in the Irish health system, and it appeared that the majority of these had emigrated by that time.[7] A more recent survey from 2019 found that almost two thirds (64%) of internship students who were in the process of their internship training reported that they intended to leave Ireland after the completion of their mandatory year of working within the Irish healthcare system.[20] The key message here is that hospital doctor turnover is a long-standing, major issue in Ireland. When one considers that these issues were escalating unabated before COVID-19, the impact of an unexpected pandemic raised many additional challenges. The health system underwent a radical transformation where it required additional capacity to deal with the surge in COVID-19 patients.[21] The complex interplay of various risk factors ranged from treating patients, quarantining, and social isolation to the fear of contagion, job-related stress, emotional strain and concerns for the well-being of one's family. These not only impacted doctors' physical health but also had a significant impact on their mental and emotional well-being.[13, 21, 22] This period prompted several initiatives that sought to address demand and changes required in healthcare services. These measures included an expansion of capacity which saw the government collaborating with and contracting private hospitals, recruiting additional healthcare workers such as intern doctors, and launching the "Be on Call for Ireland" international recruitment campaign to bring retired and migrated doctors back to work. Staffing was increased by extending part-time staff hours, maximising agency usage, redeploying personnel, and encouraging those on career breaks to return early. Furthermore, changes were made in medical practice requirements, such as designating GPs as the first point of contact and adapting non-Covid healthcare services to ensure the continued delivery of urgent elective procedures, while non-Covid medical treatment check-ups were postponed. The utilisation of

technology, including telemedicine and phone consultations, was also maximised to provide healthcare services efficiently. In basic terms, there was a move to bring as many doctors and consultants as possible into front-line care work. In terms of funding, there was a substantial enhanced investment in funding of €435 million in the early months of the pandemic, along with additional spending shortly afterwards around online mental health services.[6] These measures appeared to be important in contributing to junior doctors reporting an improvement in workplace dynamics, collaboration, access to clinical support, and morale.

A focus on junior hospital doctors, also known as non-consultant hospital doctors (NCHDs), is important because they represent the majority (68%) of hospital doctors employed by the Irish public health system. They include hospital doctors at all stages from interns to specialist registrars (i.e. not consultants or specialist grades).[23] We focused on this cohort of doctors since poor working conditions and their associated challenges are found to be more prevalent for them, mainly because, at this early stage in their careers, these doctors still have junior status in their hospitals' organisational hierarchies.[8, 12, 24, 25] Some of these doctors are on postgraduate training schemes, while some are employed on 6–12 month contracts (known as 'stand-alone' posts). An additional factor shaping these doctors' experiences is that the Irish healthcare system is currently experiencing a shortage of junior doctors,[8] and a recent article has highlighted that it is increasingly difficult to recruit doctors in this cohort,[26] which means the system is heavily reliant on those junior doctors who are currently in place.

In this paper, we share the first-hand accounts of these doctors to explore how they experienced work during the COVID-19 pandemic. We also seek to understand the changes that occurred within a working environment that is well recognised as being excessively difficult and challenging. In so doing, we explore how doctors perceived and adapted to this unexpected macro-level health event which impacted every individual and organisation, as well as the wider community in Ireland and across the world. We also draw conclusions about the

learnings they offer for the management of the health system day-to-day and during future emergencies.

A qualitative study of lived experiences is an effective way to generate broad insights based on the unique and personal experiences of those engaged in a phenomenon.[27] The study of lived experiences through qualitative methods is well-established in the social sciences, where semi-structured interviews are used to gather data from individuals which helps to uncover deeper meanings as well as underlying trends.[28] In this type of research process, first-person narratives from those who have directly experienced a particular event are subjected to qualitative analysis in order to understand how the event affected people, organisations, and social systems.[28, 29] This approach was well-suited to our goal which was to capture doctors' pandemic experiences and draw conclusions from them which policymakers can use to make relevant changes that will improve the overall work situation of doctors and preparedness for other major health emergencies.[30] A handful of research studies have already used qualitative approaches to investigate the impact of the COVID-19 pandemic on junior doctors. These have mainly noted significant negative impacts, such as high levels of occupational stress,[31] poor confidence and social integration,[32] and powerlessness, as well as reduced ability to cope and increased consideration of resignation as an option.[33] While most studies have shown adverse negative impacts on junior doctors during the COVID-19 pandemic, one study conducted in Ireland demonstrated some positive changes, such as hospital reconfigurations which improved staffing levels.[34] However, this positive picture was evident solely during the first wave and therefore, it is important to establish if these became lasting changes as the pandemic unfolded. Our study contributes to the existing literature by exploring the lived experiences of junior hospital doctors in Ireland, with a particular focus on the third and subsequent waves of COVID-19, during which our study was conducted.

The prior study had suggested further investigation in subsequent waves of COVID-19.[34] The timing of our interviews allowed participants to recall pandemic events with good clarity and it enabled us to observe how the situation evolved throughout all stages of these waves, including post COVID-19 reflection. Furthermore, our study includes doctors from various demographics, with varied ages, marital status, and nationalities (Irish and international doctors). Interviewees also varied in terms of their professional status, as some were trainees registered on postgraduate training programmes, while others were not which is important due to the different career prospects this brings. Interviewees were also drawn from different specialities, and although our overall sample size means generalisability is problematic, our approach allowed us to gather insights based on a broad spectrum of experiences and expertise related to COVID-19.

Methods

Study design

We adopted a qualitative research design in the form of in-depth, semi-structured interviews with junior hospital doctors. This approach was specifically selected to gain rich descriptions of the phenomenon at hand, and the interview questions were designed to elicit answers from the participants which offered interpretation of the meaning of the events they described.[35, 36] Additionally, qualitative methods allowed us to uncover more nuanced findings than the more common quantitative approaches. The qualitative research process played a crucial role in helping us to gain clarity about ‘how’ and ‘why’ questions alongside the values, language, and meanings of the participants, and this approach also allowed the doctors to express their opinions in their own voices. An additional factor in our choice of methodology was the fact that qualitative approaches have been proven to offer useful ways to contribute to policymaking

and policy implementation.[35-37] This kind of impact is not only an intended outcome of our study but is essential to the improvement of the Irish healthcare system.

Patient and public involvement

Patients and/or the public were not involved in this research's design, conduct, reporting, or dissemination plans.

Participants and recruitment

Participants were recruited through a multi-tiered recruitment strategy and no direct relationship was in existence with participants prior to interviews. Sampling was primarily purposive, followed by snowball sampling. This provided a diversified sample of junior hospital doctors that enabled us to gain a wide perspective on the types of lived experiences at work. Doctors (see Table 1) were based in urban and rural hospitals, with diversity evident in terms of personal characteristics such as age, gender, marital status, specialisms, and whether they were trainees or non-trainees. All doctors had a minimum of one year's service at time of interview.

Data collection

During the period August 2021 to April 2022, a total of 31 interviews were undertaken by the first author who had received training in qualitative methods. The interview guide provided a basic structure for the discussion of the topics we sought to cover but enabled the interviews to unfold to best reflect each participant's own lived experience. Prior to undertaking the fieldwork, a pilot interview was also conducted. We began the interviews by asking doctors general questions about themselves and their backgrounds, before moving to questions that focused on topics such as working conditions, satisfaction, turnover intentions, and embeddedness within the community, alongside what it was like to live and work on the front-line through such an unprecedented global health event.

Prospective interviewees were contacted via email and provided with an information sheet and study consent form which detailed the study and its motivations along with what involvement was required. Prior to commencing the interview, the study aims, ethics and confidentially were reiterated and additional information was provided where necessary. Interviewees were asked to sign a written consent form prior to being interviewed. Interviews were conducted through a video platform and ranged from 40 to 45 minutes in length. Lockdown restrictions necessitated the use of an online platform rather than face-to-face interviews, and the video element allowed us to capture a significant portion of the interpersonal and non-verbal data that a face-to-face interview can provide. All interviews were audio-recorded with permission, as per the ethical approval granted by the authors' institution, and were then transcribed verbatim. The interviewer also took notes during each interview.

Data analysis

Thematic data analysis, aided by NVivo, followed the approach recommended by Clarke and Braun (38). Interviews were transcribed verbatim. The transcribed interviews were read and re-read several times to ensure a good understanding of the data. These transcriptions underpinned the process of extracting the information related to the aims of this paper, and these elements were then condensed through a process of open coding. The preliminary coding process was broadly inductive, which allowed for the development of initial codes, informed by the existing literature. New codes were subsequently developed through an iterative process. Once open coding was performed, the primary themes were identified. The data analysis commenced simultaneously with data collection, which continued until data saturation achieved.

Age	Sex	Speciality	Job Status

34	M	Obs-Gynae	Trainee
36	M	Anaesthetist	Trainee
35	F	Surgery	Trainee
31	F	Paediatrics	Trainee
34	M	Psychiatry	Trainee
38	F	Obs-Gynae	Non-Trainee
32	F	Paediatrics	Non-Trainee
34	F	Obs-Gynae	Trainee
40	M	Emergency Medicine	Non-Trainee
33	F	Psychiatry	Trainee
42	F	Emergency Medicine	Trainee
33	M	Anaesthetist	Trainee
39	M	Surgery	Non-Trainee
34	M	Clinical Microbiologist	Trainee
40	F	Surgery	Trainee
34	M	Paediatrics	Non-Trainee
31	M	Paediatrics	Non-Trainee
27	F	GP Trainee	Trainee
33	F	Internal Medicine	Trainee
38	M	Surgery	Trainee
45	F	Psychiatry	Trainee
32	F	Psychiatry	Trainee
36	F	Psychiatry	Trainee
35	F	Anaesthetist	Trainee
30	F	Obs and Gynae	Trainee
29	M	Surgery	Trainee
26	F	Internal medicine	Trainee
32	F	Paediatrics	Non-Trainee
40	F	Surgery	Non-Trainee
41	F	Paediatrics	Non-Trainee
27	M	Anaesthetist	Trainee

Table 1[i]: Demographics of participants according to age, sex, speciality and job status

Results

A total of 31 hospital doctors from diverse backgrounds, encompassing various demographic characteristics, medical specialities, and job statuses within the Irish healthcare system were interviewed (Table 1). Our findings illustrate junior hospital doctors' positive and negative experiences during what were the first two waves of the COVID-19 pandemic. It is notable that, in spite of increased pressures, doctors frequently spoke positively and movingly about

different aspects of their roles and how they felt during this time. However, the second core theme which ultimately emerged was that positive improvements experienced in the earlier parts of the pandemic were not sustained, and many struggled with how aspects of their roles, especially the ways they could interact with patients, had fundamentally altered.

A newly improved support system and work atmosphere

Doctors frequently spoke about the improvements they experienced in terms of work atmosphere during the first phase of the pandemic. The main improvement related to a restructuring of work arrangements which led to many doctors being redeployed to hospital and ward-based care. This led to more doctors being available, and this was seen as greatly improving their experience of and at work, due in no small part to doctors' perceiving their duty rotations as being more manageable. In essence, several doctors felt that extreme working practices, which had become normalised before the pandemic, had been improved to create a much more appropriate scenario.

Several interviewees referred to the increased availability of consultants within the hospitals where they worked. They observed that this provided them with better support, clinical supervision, improved workplace relationships, and workplace morale. They also spoke about appreciating the assistance they received through improved oversight of their clinical work, and they talked about other personal career development opportunities (e.g. progressing research papers) which emerged because of the increased availability of consultants. Notably, these interviewees observed that this marked a substantial change from the situation in pre-pandemic times. They reported that they had previously lacked this kind of support and had to work alone, and they also discussed how challenging this was for doctors, especially, junior doctors, who were still building expertise and experience. Furthermore, several junior doctors shared the view that consultants demonstrated high engagement levels and leadership skills

during this most challenging period. Interviewees felt that this combination of greater support, more clearly defined roles, and increased resourcing led, in turn, to an improved overall work atmosphere and culture.

> During Covid, actually there were more doctors around. This was unfamiliar before Covid. It was great to have more people.… So, normally, we have two SHOs [senior house officer], one Reg [registrar], and one intern [internship student]. But with Covid allocation, we had three SHOs, two Regs, and two interns. That's really good.… Also, that time, the consultants were seen more than usual. (P.4)

> I do think that consultants have become more engaged and, as a result, are probably taking on more leadership and management roles, which is good as well…. It has just reminded people that what we do on a day-to-day basis is kind of firefighting and we suddenly were able to work so much better and deliver much better outcomes for people. (P.20)

Interviewees also perceived an improved work atmosphere, which they attributed to a more considerate management approach. Specifically, several spoke about how management became more considerate of the long working hours junior doctors undertook and the extremely stressful conditions in which they were operating. In basic terms, doctors reported experiencing palpable empathy in the workplace, which was not something they had perceived to be in existence prior to the pandemic.

When consolidating their views on the day-to-day challenges faced by doctors during this phase of the pandemic, interviewees suggested that management in some hospitals tried hard to provide more adequate resources, as well as offering greater encouragement and communication than had previously been experienced. This view tended to emerge primarily amongst those working in urban tertiary hospitals (offering highly specialised medical care). Junior doctors mentioned that those managers who were from non-clinical backgrounds, but who were managerially trained, demonstrated skills, knowledge, and capabilities that helped maintain effective communication, operational decision-making, and team coordination in a dynamic and unheralded context. Specifically, these managers were seen to manage staff preparedness effectively and employ appropriate, responsive plans that were both timely and

efficient. For example, there were mentions of efficient duty rotations, including replacement plans; team coordination; and prompt email alerts, providing information and updates about risks, policies, and guidelines on COVID-19.

> Involvement from managers, like the hospital management who are not specifically your team or consultants, was good and prompt. They managed well and this arrangement to work on pods, team-based, was a good and safe approach. (P.3)

> When Covid came first, I was in [name of urban hospital] and it was actually managed very, very well in [urban hospital]. The CEO would send out daily emails and they would have a daily meeting that you could attend. We knew what was going on, we knew what the lay of the land was, the staffing was organised, there was a proper kind of level of – of management. So, the CEO is non-clinical so they'd come from a managerial background – but in [the urban hospital] they worked well with the clinical staff to make decisions. (P.4)

These approaches equipped doctors with information that allowed them to comprehend the outbreak and understand the steps that needed to be taken at different junctures more effectively. Junior hospital doctors stressed that this was new. They spoke about how, previously (i.e. pre-pandemic), they had never had 'managers' to assist with doctors' non-clinical tasks and requirements. The efforts and interventions of these managers were considered helpful, as they allowed doctors to focus on their clinical responsibilities and roles, while management aspects were overseen by those individuals with relevant expertise, doing what they were employed to do. There was a view expressed by many that these changes illustrated that constructive changes were possible to improve the long-standing problems of the Irish healthcare system, both for them as working professionals, and for better patient care.

> You see, we saw some changes and improvements during Covid. That gave me some confidence, that things we thought were impossible previously were brought to our attention that it is possible. (P.28)

> The system is bizarre, but we did see some changes during Covid, some positive I would say, but, I swear, I don't know if things will be the same or even be worse than before Covid. But, at least seeing that things can be done differently – there is a way, we have a hope on maybe things will change for better in future. Just hope, you see. But no one knows. (P.15)

The regression to pre-pandemic norms and the emergence of feelings of isolation and guilt

As the COVID-19 pandemic progressed, doctors spoke about how the positive work atmosphere they had experienced proved to be fleeting rather than becoming enshrined. The more positive work atmosphere they had experienced deteriorated progressively over time, and interviewees reported the return of pre-pandemic strains and pressures. This was in no small part due to the shortage of doctors that was evident long before the pandemic, which was to a great extent, though not wholly, attributable to long-term issues with staffing and excessive demands. Doctors also shared detailed insights about how, as the pandemic progressed, more doctors were being exposed to the virus and becoming infected or were close contacts, resulting in them being quarantined and unable to work. This, in turn, led to a significant increase in doctors' workloads. This situation appeared to be considerably worse for doctors who were directly involved with COVID-19 patients (i.e., those working in intensive care units and emergency departments), where staff shortages coincided with an increased number of patients being infected with the virus. A number of issues shaped these problems: firstly, the starting point before the pandemic hit was a severely understaffed hospital system, and, secondly, problems linked to the long-standing dependence on internationally trained doctors worsened because the ability to fill gaps through international recruitment was now unavailable due to global mobility restrictions.

> In the beginning stage of Covid, the staffing was really good and they get to manage each team well. But after some months, more people were getting Covid, so then staffing was getting worst. Certainly, it's been difficult and I think there was definitely a moment in late December, early January, where it became very unsafe in the maternity hospitals, because so many senior staff had to go off. And that staffing levels became very unsafe, more so than they were already. (P.25)

> Covid had probably been particularly bad. After a couple of months we got into it. It feels like it's now into, we're the end of 2021, and this is going on now for almost 2

> years now, isn't it, and I find myself being extremely busy now…. There were peaks and troughs, so, for different waves, and now its second wave, and I've been working, like, all my calls have been in ICU. For me, I guess, I'm working a lot more now than when Covid started. I don't get as much time off, and I had to cancel my leave plans because people were unwell. (P.12)

Perhaps most notable were the fears and sense of guilt doctors expressed about having to go into quarantine due to the additional pressure this would create on their peers who were able to work.

> We were scared to fall sick. I obviously felt incredibly guilty leaving my peers and my colleagues without someone. (P.30)

Additional pressures were created by the ongoing requirement for doctors to obey the COVID-19 working arrangements accompanied by other protocols, such as having to stay in their own bubble/cluster. This led to a lack of inter-team and collegial communications and/or interactions, as well as restricted break times, and limited use of common rooms. Doctors spoke movingly about the lack of personal connection and social support they experienced at work, and they expressed the view that this left doctors with increasing feelings of isolation. Interviewees also spoke about how limited and/or lost interaction with co-workers for prolonged periods led to them not having others to vent to or turn to for solace. As a result, the excessive work pressures they experienced were increasingly faced alone. Doctors contrasted this with the extra supports they had experienced in the early part of the pandemic.

> When Covid started, I moved out to (location), since I have very sick parents at home. I stayed alone then. In work, we have to stay in our own bubble, so we can't have our regular chat with others. I took my lunch in my car for more than a year with zero interaction with others. At the beginning it wasn't bad but after a couple of months it was hitting hard and [I] felt really lonely. (P.16)

> Solo lunch, no communication. So, all of that time we couldn't see anyone, we couldn't mingle with anyone until we were vaccinated….'Oh please break up, please break up!', the compliance officers would say. 'Oh split up, You're in a cluster', you know? The whole department just shut up… so relationships broke between colleagues. (P.6)

This was more challenging for international doctors who lived alone, many of whom reported not having family in Ireland, as well as for those doctors with high-risk family members who feared transmitting the virus, and who therefore had to separate themselves from family and friends. Likewise, doctors also reported that having to staying in PPE all day, wearing goggles and tight face masks, not only made them feel uncomfortable (i.e. sweating, breathlessness) but also, at times, reduced the intimacy that used to exist between doctors and patients. This was something that impacted doctors greatly on an emotional level and which they felt added to the pressure and stress they were experiencing;

> A lady lost her baby at 22 weeks. I couldn't hold her hand and say I'm sorry for what has happened to you. (P.1)

Discussion

The COVID-19 pandemic posed significant challenges to healthcare systems worldwide. Hospital doctors were required to work relentlessly to provide care for patients who were infected with the virus, while putting their own health and safety at risk.[39, 40] Previous studies have reported that the surge in demand during the pandemic led to an increase in workload and hours,[33] a high risk of infection due to their close exposure to infected patients,[41, 42] deteriorating workplace cultures and conditions leading to poor well-being,[43] as well as shortages of personal protection equipment (PPE), which further aggravated already challenging situations.[44, 45] Some studies have also highlighted that healthcare workers suffered from poor mental health and emotional distress, limited coping mechanisms, and feelings of trepidation.[39, 46-49]

Our study demonstrates that the work experiences of junior hospital doctors in Ireland during COVID-19 were complicated and had different phases. Doctors reported that they had experienced some improvements in their work environments in terms of better staffing,

support, effective management, and a sense of fulfilment, purpose, and satisfaction that arose from their contribution to making a difference which was so widely appreciated in communities across the country. Our finding, whereby junior doctors spoke positively about the benefits of having greater access to consultants in the early stages of the pandemic, is notable for several reasons. First, is that teaching and training is an integral part of the consultant role, whether or not that is fully recognised or appreciated.[50] There is, in part, an obligatory aspect to this, in terms of assisting less experienced professionals, but also, it is vital to ensuring safe, high-quality patient care. Without such support, the transition from medical school to clinical practice is difficult and overly stressful.[51] In addition, it is important to consider how today's junior doctors can proceed to be the consultants we require in the future if such supervision and support is missing.[50] Despite this, there are several challenges such as insufficient numbers of consultants being available to provide the required training and support to those less experienced,[52] and individuals being placed into such roles who do not possess the attributes to do so well. Our findings are in line with another study which discussed the enhanced level of staffing, particularly in the first wave of COVID-19, which resulted in positive work experience for doctors.[34] This suggests that greater emphasis is required on ensuring not only sufficient access to consultants but that senior doctors have the attributes and willingness to impart key values, attitudes, and behaviours.

COVID-19 indeed presented substantial challenges and risks to individuals.[53], and these challenges stemmed from various factors, including exposure to the virus and the effects of lockdowns from many kinds of uneven starting points, resulting in enduring consequences on health inequalities. Essentially, the pandemic may serve as a 'watershed moment' for many individuals from various perspectives. In the case of the Irish healthcare system, the pandemic certainly started from an 'uneven starting point.' However, the positive transformation doctors experienced during the pandemic potentially created a critical turning point which may lead to

positive changes or even greater increases in those leaving. Although doctors were frequently working in poor and deteriorating conditions which made them particularly vulnerable to the virus,[8] the new norm of work and the positive experiences encountered provided many in our sample with a renewed sense of hope for the healthcare system and its capabilities. This newfound hope enabled doctors to feel a sense of fulfilment, purpose, satisfaction, and confidence in the system and had potential to become a watershed moment. However, as the more positive features were not fully continued, the concern is that some of these more positive individual feelings may end up in anger if the improvements that are unquestionably required fail to materialise. It is crucial to recognise that research has shown that hope in the workplace can empower individuals to persevere through difficulties. This positive outlook allows challenges and problems to be viewed as opportunities for learning and growth. Most importantly, hope has been found to have a positive correlation with organisational commitment, which is negatively related with turnover.[54] Given the high level of turnover within Irish healthcare pre-COVID, this turning point of positive experiences may prove significant in retaining doctors in the near future.

However, while hope and positivity were reported, there was also an overwhelming acknowledgement of the profound stress and emotional toll that resulted from the pandemic and, as the pandemic moved on, improvements were not sustained. It was doctors' enduring sense of commitment to their profession and patients which helped them endure as working conditions progressively worsened and the pressures increased. This again demonstrates doctors' strength of commitment to their profession and patients, in that they adapted and kept going, demonstrating the highest levels of resilience, in spite of substantial stress and psychological and physical challenges. This can be linked to the notion of a 'calling' or 'vocation', which prompts people to demonstrate unwavering commitment to their work through active personal engagement that centres on the work's intrinsic benefits.[55, 56] It is

clear that doctors have invested extensive period of their lives into the field of medicine, commencing with their medical school education, continuing through years of training, and culminating in a career that has consistently been their sole occupation.[57] Therefore, the profound impact and the passion towards their profession helps keep them committed. While this commitment is fundamentally critical to the health service, it can have many negative impacts on these individual doctors' own well-being.

Nevertheless, there remained a hope that the pandemic would lead to long-term changes and lasting investment in the Irish healthcare system. The extent to which this hope will endure and whether such changes will occur remains unknown and must continue to be a topic for further study.

Perhaps, most notable was how movingly doctors spoke about the isolation that they increasingly felt as the pandemic advanced and they were only allowed to associate within small groups of colleagues. While talking about the impact of the loss of collegiality, doctors also demonstrated its continued value to them when they spoke about feeling guilt when they had to quarantine as this led to further shortages of available doctors for duty and exacerbated the burden on their remaining colleagues. These findings indicate the importance of relationships and support networks, and they suggest that such matters should form a central part of discussions on dealing with future pandemic situations. While our study found that doctors felt guilty about being unable to work, other studies have revealed that doctors often feel guilty for being powerless within the healthcare system, such as when they are unable to prevent multiple deaths despite their best efforts.[58] Comparative studies that explore the experiences of doctors across different approaches to the pandemic would be helpful in this regard. Our small sample means that we fully recognise the limitations around generalisability. Additional data collection would have been advantageous including follow-up interviews at

different junctures. Quantitative studies would also have helped to establish whether the findings here had wider applicability.

Conclusion

By exploring the multifaceted dimensions of junior hospital doctors' experiences during the pandemic, this study indicates that the pandemic triggered both positive and negative changes to their working environments. However, the increase in negative effects did not diminish the hope of some doctors that positive changes were possible which would create a more appropriate working environment and healthcare system. These findings underscore the importance of establishing good working conditions for doctors, as cultivating sustainable positive changes will help them effectively navigate through any unprecedented events. Any such changes may also improve the retention of key talent in the Irish health system. It is imperative that policymakers, hospitals, and professional organisations enact and implement measures that improve the working conditions of hospital doctors in Ireland. There is an opportunity to evaluate the positive changes that were perhaps forced rather than planned in the early part of the pandemic to see how real improvements could be made in a healthcare system long derided for its poor conditions. Not all of these changes are necessarily profound or excessive in cost terms, and the improvements they could produce in doctors' working conditions will not only safeguard their professional work but also their overall well-being. We argue that these changes may also assist in bringing about a much-needed reduction in the long-standing problem of hospital doctor turnover in Ireland.

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Contributors

The corresponding author confirms that all the authors mentioned in the manuscript meet the requirements for authorship, and no other individuals who fulfil these criteria have been omitted. AM initiated the idea of the study. SS (female PhD researcher with MSc) designed the study protocol with the support of AM and MB. Data were collected, and the initial data analysis was undertaken by SS, followed by AM and MB developing a preliminary coding framework. SS, AM, and MB reviewed refined categories and finalised the themes. SS, with support from AM, prepared the draft article with review by MB, with the final approval for this version to be published being given by all authors. SS is the guarantor responsible for the overall content.

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Conflicts of interest

None declared.

Competing interests

None declared.

Patient consent for publication

Not required.

Ethical Approval

The study has been approved by the Social Research Ethics Committee (SREC), University College Cork, Ireland, with reference number Log 2021-132

Data availability statement

The data underlying this article cannot be shared publicly due to the need to protect the privacy of individuals who participated in the study.

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