

DECLARATION

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This Dissertation/Research Project entitled: An investigation of why osteopaths choose to leave the profession, is submitted in partial fulfilment for the requirements for the Unitec degree of Master of Osteopathy.

CANDIDATE'S DECLARATION

I confirm that:

- This Dissertation/Research Project represents my own work;
- The contribution of supervisors and others to this work was consistent with the Unitec Regulations and Policies.
- Research for this work has been conducted in accordance with the Unitec Research Ethics Committee Policy and Procedures, and has fulfilled any requirements set for this project by the Unitec Research Ethics Committee.

Research Ethics Committee Approval Number: 2008.806

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An investigation of why osteopaths choose to leave the profession

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A research project submitted in partial requirement for the degree of Master
of Osteopathy, UNITEC Institute of Technology, 2009

ABSTRACT

Introduction

Osteopathy as a career provides opportunities in primary health care and can be very rewarding. Qualifying as an osteopath involves intensive study and application as well as a temporal and financial commitment by both the individual and the educational institution. A career in osteopathy carries no guarantees of permanency. Anecdotal evidence suggests that there is a small but significant loss from the profession. However, there is a paucity of research into this phenomenon. This study examined the phenomenon of osteopaths leaving the profession.

Method

This study employed a mixed method design of retrospective data review and interpretive thematic description. Descriptive historical data relating to numbers of practising osteopaths and attrition rates were gathered from osteopathic registration bodies in New Zealand, Australia, the UK and the USA to provide a background to the research. The purpose of the retrospective review was to discover what data were available and not to infer relationships within the data themselves. Purposive snowball sampling was employed to recruit interview participants.

Results

Key themes regarding leaving the profession were identified. These were divisible into factors over which an individual had no control (extrinsic) and factors related directly to the person's personality and suitability for the practise of osteopathy (intrinsic). The theme of burnout was identified as a combination of both extrinsic and intrinsic factors. The overarching theme is that leaving the profession is a process resulting from both extrinsic and intrinsic factors and occurs over a period of time.

Conclusion

The participants' decisions to leave the profession were usually initiated by accumulating factors and sealed by a specific event. This research has implications for educational institutions, for professional bodies and for individual osteopaths. These implications

involve selection criteria for students, education curricula and professional support for practising osteopaths. Lastly, this research identifies key areas and factors that give individual osteopaths a better understanding of this phenomenon in relation to themselves and to the osteopathic profession.

ACKNOWLEDGEMENTS

I would like to thank the six participants who took part in this study. Your generosity in sharing your experiences with me made this research possible and for this I wish to sincerely thank each of you.

I would like to sincerely thank Esther McGee, who has provided much support and encouragement to me throughout the previous five years and patiently edited the final copy of this thesis. I would like to thank Charles Cooper for courteously providing his personal whiteboard and for his encouragement to “just get it done”. Charles also provided valuable feedback on my writing and the contents of this dissertation.

I would like to thank my supervisors. Dianne Roy, who I am sure it has been said before, is the best supervisor one could wish for. Dianne, your dedicated support, encouragement and patience has made the process of research one which has led me to learn and grow far beyond what I had expected. Clive Standen, whose knowledge of the osteopathic community made this research possible. Clive, thank you for your insight which always leads me to clearly see what it is I am looking at.

Finally, when writing a research project it is useful to speak your thoughts aloud and even more so to have someone that you can bounce ideas off. For this I want to thank my parents who tolerated me interrupting what they were doing at any time of day and night. These discussions served to further my understanding of the research presented here. I would like to thank them for their support and encouragement, not to mention the hours of editing, without which I would not have been able to finish this thesis. This thesis is dedicated to you!

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CHAPTER ONE – INTRODUCTION

Introduction

“The U.S. Department of Labour estimates that today’s learner will have 10-14 jobs by the age of 38” (Fisch, 2007).

As Fisch (2007) points out in his presentation “Shift Happens” a job for life is a thing of the past. No longer are students preparing to enter a single profession or career, but rather the job market is transforming and demanding individuals with a varied job experience to fill vacancies that have not previously existed. Osteopathy as a career requires dedication and consistency of practice as well as a lengthy education process; it is not a short-term job choice. If entering into the profession requires careful consideration, then so must the decision to leave.

Osteopathy is rapidly growing within New Zealand and internationally. Alongside this growth, anecdotal evidence suggests that there is a significant number of practitioners leaving the profession, many within the first few years following registration. There is, however, a dearth of research identifying exactly how many osteopaths are leaving and/or their reasons for doing so.

The research described in this dissertation is an interpretive descriptive study of why osteopaths choose to leave the profession. It provides an understanding of some of the reasons why individuals may change careers and the various situations and events that can lead to the cessation of practice. Furthermore the study provides discussion on how these factors can be addressed in the selection, education and ongoing support of osteopaths where it is necessary and possible to do so.

In this chapter the concept of leaving a profession is defined and briefly discussed. A brief development of my interest in this topic is presented, followed by the rationale and aims of the study. A summary concludes this chapter as well as providing an outline of how this dissertation will be presented.

Background

It is now widely recognised that a career for life is a thing of the past and that most people will have several careers during their working life (Hall, 1996). It is also known that there is a worldwide shortage of health professionals, the implication of which is a lack of skilled care for the general population and subsequently a decrease in the availability of health care (Chen et al., 2004). The 2006 World Health Organisation (WHO) report, showed that this shortage exists mostly in poor countries and that the shortage is comprised of both a lack and a geographical maldistribution of skilled health care professionals (World Health Organization, 2006).

In the 21st century, osteopathy is gaining public recognition and acceptance as a bone fide health care profession and forms a part of the health workforce. While the size of the profession is small compared to the professions of medicine, nursing and physiotherapy, osteopaths are primary health care (PHC) providers. Osteopathy, therefore, is well situated to form part of the WHO's proposed transition to a more PHC based health care system especially in underserved rural areas (Mortiz & Carter, 2004).

The 2008 WHO report declares that current health care policies do not generate equitable health services and generally fail to gain the best health outcomes for their money (World Health Organization, 2008). Therefore, the WHO is driving towards a PHC basis for health care. It is postulated that PHC allows a holistic approach to the individual as well as focusing on preventative rather than curative measures to alleviate the health care burden.

The global shortage of health care professionals as well as the future management and direction of health care resources is important to the profession of osteopathy. To address the shortage it is necessary to look at why it is occurring, specifically why qualified individuals choose to leave their profession.

“Leaving the profession” defined

Put simply “leaving the profession” means that an individual decides to cease being a part of their profession. This section aims to give the reader a clear understanding of what “leaving the profession” means in the context of this research project. The process by which this definition was reached is outlined below.

To begin defining the phrase “leaving the profession”, it is useful to analyse the two terms used; “leaving” and “profession”. The Webster’s dictionary (Gove, 1981) gives sixteen definitions for “leave”, none of which are specific to leaving a profession. According to Webster’s dictionary, leaving in its most contextual definition, is “to go away from, to terminate association with or to withdraw from” (p. 1287). The Oxford English Dictionary states “to depart from, quit or relinquish” (Craigie, 1981, p. 1594). Webster’s definition of a profession is “a calling requiring specialised knowledge and often long and intensive academic preparation” (p. 1811). A profession defined by the Oxford English Dictionary is “an occupation which one professes to be skilled in and to follow” (p. 2316). So a simple definition of leaving a profession could be:

“To terminate association with or withdraw from a calling or occupation which one professes to be skilled in and to follow.”

As a point of interest, this begs the question; can one ever completely leave a profession? It is possible to be expelled or barred from a profession, or even to be given restricted rights within a profession. Perhaps it is simply that an individual may choose to stop practicing their profession, but may always be a non-practising member. For example, registration for the osteopathic profession in New Zealand is for life but in order to practice an annual practising certificate is required. Those that are not practising are still registered members of the profession. However, a full discussion on this topic is beyond the scope of this research.

The issue with the definition of leaving a profession presented above is that it includes all individuals who leave a profession due to whatever reason. For the purpose of this research project, this definition was not quite pertinent. Firstly, it included those individuals who had left because they had retired from the workforce. Secondly, the

definition was not specific to osteopaths who had left for reasons involving their osteopathic education, the osteopathic profession or the practice of osteopathy.

Based on these considerations the following definition of leaving the profession was developed for use within this study:

“To terminate association with or withdraw from a calling or occupation which one professes to be skilled in and to follow, prior to retirement age and with a view to continuing in the workforce in another career or job.”

This definition provided a good framework for finding participants for this research who would give insight and meaningful data of the experience of leaving the osteopathic profession.

Why study the topic of leaving the profession?

There were a number of motivations that led to me researching this topic. Initially, I was considering research into the phenomenon of burnout. I was considering investigating self-care practices, as I was experiencing elements known to precede burnout during my practice in the student clinic. I was often left feeling tired and drained after a day working with patients and was interested in whether this was a common experience and whether some osteopaths had identified or developed methods to deal with these experiences. On mentioning this to my supervisors, they pointed me in the direction of a research study which had already investigated this topic (Wells, 2005).

In further discussion with my supervisors, the point was raised that the result of limited or no self-care and burnout could be leaving the profession. Concurrently, I had also been experiencing doubts as to whether I wanted to continue with osteopathy and whether osteopathy was suitable for me. Were these considerations normal? Do all osteopathic students and practitioners experience these? Are these factors that can cause an individual to cease practicing? While informally discussing these thoughts with my colleagues, lecturers and clinical tutors it became apparent that most had experienced or were experiencing these doubts. These discussions led me to wonder: is considering leaving

predictive of finally leaving the profession? What factors contribute to the final decision to leave the profession?

In a recent interview, the osteopath Steven Sandler, DO stated that you have to believe in what you do, in osteopathy (Sanet, 2005). Is belief, above all else, enough to continue the practice of osteopathy? Or are there factors that may overshadow a person's passion and belief in their vocation, that are considerable enough to make them consider leaving or eventually to leave?

Rationale for the study

As a career, osteopathy can provide opportunities in health care as well as allowing for personal development. Qualifying as an osteopath involves intensive training, study and application as well as a financial commitment by both the individual osteopath and the educational institute involved. On completing the preparation for a career there are no guarantees of permanency. There is anecdotal evidence that suggests there is a small but significant loss from osteopathy for reasons other than death or retirement. Yet, there is a paucity of research into this phenomenon.

Even though the osteopathic profession has experienced growth over the last 30 years, it is still a comparatively small profession in relation to other allied health care providers. As such, any exodus from the profession has the potential to diminish the availability of osteopathy to the public. Currently, there is very little understanding of this phenomenon in relation to the osteopathic profession. Understanding why osteopaths choose to leave the profession may provide insight into the issues that underlie such a decision. Some of these issues may not need to be addressed but equally there are changes that can be implemented in the selection processes for new students, the education and training and the ongoing support for qualified osteopaths. There is a responsibility to the profession and to each individual osteopath to do so.

Attrition of osteopathic practitioners means that there is a loss of skilled care that can be provided to the general public and a loss of accumulated experience from the professional body of osteopathic knowledge. One way of addressing the shortage of health care

providers is to look at those factors that lead to attrition from a profession. If there are measures that can be taken to improve the longevity of practice this will, in a small way, address the shortage of health care practitioners. These measures may improve the wellbeing of individual osteopaths and ensure that the knowledge base of older, more experienced osteopaths is not lost from the profession. The public would also benefit by having larger numbers of osteopaths available and by having access to osteopaths with greater experience.

Aims of this study

This study had two primary aims:

- To collate statistical data relating to osteopaths who have left the profession, in order to show the extent of the phenomenon.
- To explore the reasons a qualified osteopath may have had for leaving the osteopathic profession, specifically those who left with no intention of returning to osteopathic practice but pursue another career or profession.

Summary

In order to be able to utilise a definition of leaving the profession for this project, leaving a profession was defined as “terminating association with or withdrawing from a calling or occupation which one professes to be skilled in and to follow, prior to retirement age and with a view to continuing in the workforce in another career or job”. Anecdotally there is knowledge of osteopaths leaving the profession. The current study begins to address the lack of research into why osteopaths may choose to leave. The reasons for leaving are discussed in terms of how they affect individual osteopaths and how the profession may begin to go about addressing those factors that can be altered.

This dissertation has been written in five chapters. Chapter One introduces the concept of leaving the profession, my own interest in this topic and the aims and rationale of this study. Chapter Two reviews the literature which discusses the current global health

workforce shortage. It looks at the research within the professions of medicine, nursing and physiotherapy regarding leaving their respective professions and the relevance to osteopathy. The available research within osteopathy that looks at this phenomenon is also discussed. Chapter Three outlines the method and methodology used in this study. Consideration is given to where the data for the retrospective analysis were gathered from, how the study participants were selected, the process of the interpretive descriptive nature of the data analysis, the ethical considerations for this research and the question of rigour. Chapter Four presents the findings of the study and discusses themes and concepts that emerged from the interviews. In Chapter Five the study's key findings are discussed in relation to the literature identified in Chapter Two. The implications for the osteopathic profession are outlined, the limitations of this study are considered and recommendations for further study are offered. Concluding thoughts are presented at the end of this chapter.

CHAPTER TWO – LITERATURE REVIEW

Introduction

Osteopathy is a rapidly growing profession within New Zealand and internationally. Alongside this growth anecdotal evidence suggests that a significant number of practitioners are leaving the profession, many within the first years following registration. There is however, a dearth of research as to exactly how many osteopaths are leaving or their reasons for doing so.

As there is minimal research within osteopathy this literature review draws upon literature from the medical, nursing and physiotherapy professions to illustrate reasons for why practitioners may leave their professions. While research regarding this phenomenon abounds within a number of professions and organisations, only literature relating to those specific health professions listed above will be reviewed here. The aim is to highlight factors that may be related to osteopath's decisions to cease practicing, in light of the similarities in the environment within which general practitioners, nurses, physiotherapists and osteopaths practice.

A review of the literature was conducted via internet, database and hand searches. The primary search engine used for the internet searches was provided by 'Google' at <http://www.google.com>. Ovid, PubMed, ScienceDirect and EbscoHost were the primary databases used for the literature search using a comprehensive list of keywords including career exodus, career path, job satisfaction, stress, burnout, leaving and attrition with reference to medicine, nursing, physiotherapy and osteopathy. In addition, the reference sections of the originally retrieved articles were hand reviewed for related literature that had been previously missed or omitted. A date range from 1980 to 2008 was used.

Research within the fields of medicine, nursing and physiotherapy

It is to be expected that there will always be a proportion of individuals who will leave their profession. This may be inevitable and need not be a source of concern. However, while research suggests that this is indeed the case, it also suggests that there are a percentage of professionals leaving because of factors that could have been addressed. This section of the review presents the research from medicine, nursing and physiotherapy.

Medicine

The subject of physicians leaving medicine has been one of much investigation and debate in recent years. There has been much research into the various factors that may affect this phenomenon. A full review of all the research involved is beyond the scope of this thesis and so only key papers will be discussed. While reviewing research of the medical profession the focus is specifically on literature relating to general practitioners (GPs) as they, like osteopaths, are primary health care providers. Throughout this review the terms primary care physician and GP have been used interchangeably.

It is apparent from the literature that a proportion of doctors do leave medicine. Goldacre, Lambert and Davidson (2001) looked at trends in the careers of medical graduates from 1974, 1977, 1983, 1988 and 1993. Depending on cohort and years from graduation, between 0.4% to 3.6% of men and 3.5% to 12.2% of women, were found to not be working in medicine. The percentage of physicians leaving medicine was generally highest in the first five years of practice. This study suggests that new graduates are most likely to leave the profession in the initial years of practice. Lorant, Violet and Artoisenet (2007) performed an eight year follow-up study of physicians leaving health care practice in Belgium. They followed 19,840 physicians who had five years of experience from 1994 to 2002. Their findings showed that 5% of physicians had left medicine in the eight year period of the study. Gender differences in leaving medicine were almost non-existent amongst the younger physicians. However, as age increased women were more likely to leave. There were also varying results according to specialty, with physicians in surgery or radiotherapy more likely to leave than GPs. The conclusions were that some groups within medicine are more susceptible to leaving and that the findings should be taken into

consideration for the planning of the future medical workforce. In addition, this study was written in French meaning it was not possible to appraise and critique this study fully. However, for the sake of completeness it was included in this literature review. Richmond (1993) reports that there is an UK consulting agency, Medical Forum, which provides advice to physicians desiring to leave practice. Medical Forum provides advice to physicians and medical students about alternative careers outside of medicine such as law and business. The existence of such an agency provides further evidence that there are physicians leaving their profession who continue in other careers.

When considering why physicians leave the profession it is important to consider the phenomenon of physician surplus. A surplus of physicians in the workforce exists but these numbers are unevenly distributed across specialities and geographical locations (Reamy, 1998; Rivo & Kindig, 1996). There is an overabundance of specialist physicians and poor geographical distribution of primary care physicians in the USA, Central and Eastern Europe and in the newly independent states of the former Soviet Union. This has been a topic of much interest for the medical profession in the USA and the European Union and those who plan and manage the health care systems. For example, Reamy (1998) discussed the management of physician resources, comparing former Soviet states and Eastern European countries to the USA and Canada. This review highlights that with the exception of Norway and Sweden, there has been a decline in the numbers of GPs in all Western countries.

Medicine is seeing a deficit in physicians in primary care, in rural areas and in poor and dangerous countries (World Health Organization, 2006). The 2008 National Shortage Occupation List in the UK lists a shortage of salaried GPs (Home Office, 2008). This deficit of primary care physicians has partly resulted from a shift away from primary care as a career choice for medical graduates. Lambert, Goldacre, Edwards and Parkhouse (1996) looked at career choices in medical school graduates in 1993 and compared their choices to graduates in the 1970s and 1980s. One of the conclusions was that the number of medical graduates choosing to enter general practice had dropped from 44.7% in 1983 to 25.8% in 1993. It is also notable that the number of graduates who choose not to enter a medical career had increased from 0.5% in the previous four samples (1974, 1977, 1980 and 1983) to 1.4% in 1993. 19.3% of graduates reported having considered or were considering leaving the practice of medicine. Buddeberg-Fischer et al. (2006) recently

performed a similar study in Switzerland, reporting on the career choices of medical graduates in their first three years of residency. The numbers of students choosing primary care as their first choice remained fairly constant over the three years of the research. Despite this consistency the authors argued that there were too few residents choosing primary care as a career choice. This means that there will not be enough primary care physicians to ensure that the Swiss population has adequate basic health care in the future. However, this assessment was made in comparison with an article that is only available in German so it was not possible to verify this claim.

The reasons that contribute to the decision to leave the medical profession have also been extensively researched. While there are a number of small reviews of the literature, there is as yet no comprehensive review. For example, Beedham (1996) attempted to clarify the trends and the reasons surrounding this phenomenon. Based on his review, Beedham hypothesised that leaving could be a consequence of entering medicine for inappropriate or emotional reasons. Some practitioners may have experienced disillusionment with medicine, had inadequate preparation, lacked professional support, or experienced a stagnant, unstructured career. Career mobility and occupational choice were also identified as important to remaining in medicine. Beedham's study helps to provide a valuable background to this topic, but as it is not a comprehensive review or a research study it is not possible to rely too heavily on its results.

Williams et al. (2001) investigated the role of job satisfaction, job stress, mental and physical health and how they contribute to a physician's intentions to withdraw from practice. They proposed a conceptual model showing that job stress can impact upon job satisfaction, mental and physical health and that these factors can influence the intention to quit, decrease work hours, change speciality or leave patient care. In total, 1,735 physicians were surveyed using a combination of the Perceived Stress Scale and five-point Likert scale with questions regarding health and intention to withdraw from the profession. It was found that higher perceived stress leads to lowered job satisfaction. Job satisfaction had the largest association with intention to quit, decrease work hours, change speciality or leave direct patient care. Associations between poor mental and physical health and intention to leave were limited. It was more likely that the physician would change specialty or withdraw from patient care than leave practice entirely. Williams et

al. identified that the study was limited by the use cross-sectional data. It provides a useful but static conceptual model of the relationship between these factors.

Appleton, House and Dowell (1998) performed a quantitative survey investigating job satisfaction, practice characteristics and mental and general physical health in GP principals in Leeds. The Warr-Cook-Wall questionnaire to assess job satisfaction and the General Health Questionnaire (GHQ), a standardised tool for investigating mental health, were used in this study. The results of the GHQ found that 52% of respondents reported having probable psychiatric morbidity, although no further psychological follow up to verify this finding was done. Psychiatric morbidity was inversely related to job satisfaction. GPs were least satisfied with their hours of work, recognition for their work and the rates of pay. Appleton et al. (1998) went on to compare the results of this study with two previous national surveys from 1987 and 1990. It was found that there was an overall decrease in job satisfaction from those surveyed in 1987 and 1990. Dowell and associates performed the same study in New Zealand (Dowell, Hamilton, & McLeod, 2000). Their study surveyed 480 GPs of whom 391 responded (81.5% response rate). Satisfaction scores were generally high, with urban and group practitioners scoring above rural and solo practitioners. Fifty-seven percent of those surveyed often contemplated leaving general practice although it is not clear whether this would mean leaving medicine completely or changing specialty. Thirty-one percent scored greater than three on the GHQ-12 showing high levels of psychological symptoms and 9.9% scored greater than eight, indicating significant psychological distress. Excessive paperwork, health reforms and bureaucratic interference, excessive hours and on-call work were all major contributors to stress and job dissatisfaction.

In Australia, Ulmer and Harris (2002) used the same methods as the previous two studies to investigate job satisfaction amongst GPs. Satisfaction scores were reported as generally high, especially in rural GPs, which is in contrast to the findings of Dowell et al. (2000). They also report a high level of psychological disturbance in GPs. However this paper failed to present a detailed account of their results and as such failed to provide evidence to support their claims. What none of these papers did was quantify the numbers of GPs who were satisfied with their careers.

From this research it is clear that job satisfaction plays a role in a physician's decision to remain in the profession. Job satisfaction has also been suggested to have a direct bearing on quality of patient care (Grol et al., 1985). Investigation into what contributes to job satisfaction has also been performed. For example, McGlone and Chenoweth (2001) conducted a postal survey of a random sample of GPs in Victoria Australia, investigating the role of job control on job satisfaction. Job control was defined as occurring on three levels: personal, interpersonal and political. Job control in general practice was defined as "control over daily activities of general practice, control of the healthcare system as it relates to general practice and perceived community and government attitudes towards general practice"(p. 91). They found that 50% of GPs reported being satisfied with their work. The most powerful predictor of satisfaction was the level of perceived job control over how they ran their practice. While job demands did influence job satisfaction, this was only the case where low job control was reported. This indicates that having a demanding job is not in itself a source of dissatisfaction. Landon, Reschovsky, Pham and Blumenthal (2006) surveyed 16,581 physicians in the USA with the aim of examining whether physician practice and demographic characteristics and career satisfaction are related to physician decisions to leave the practice of medicine or decrease their practice hours. This study found that dissatisfied physicians were two to three times more likely to leave medicine.

Nursing

In the past 30 years the profession of nursing has been the subject of much research into the phenomenon of exodus from a profession. As with the medical profession, the large body of literature means that a full review of the literature is not possible here. A review of key papers is presented to give an overall background of this phenomenon within the nursing profession.

The nursing profession is currently experiencing a global shortage of nurses. This shortage is in part due to the fact that there is a significant portion of nurses leaving the nursing profession. The phenomenon of nurses leaving the profession, or intending to leave has been investigated and been linked mainly to job satisfaction and job stress.

In a report for the International Council of Nurses, Buchan and Calman (2004) reviewed the international nursing shortage. This report shows that there is indeed a shortage of nurses, with sub-Saharan African countries reporting the largest shortage. So far the nursing shortage has been difficult to define as countries with vastly different nursing populations are reporting practitioner shortages. For example, in the USA there is a nurse:population ratio of 700 nurses to 10,000 population whereas in Uganda the nurse:population ratio is 6 to 10,000. Both of these countries are reporting a nurse shortage. This apparent disparity likely means that the shortage of nurses is contextual to the countries that report them and the health policies that they employ. Janiszewski Goodin (2003), on performing an integrative review of the nursing shortage literature in the USA, found that there were four main contributors to the shortage. These were: the ageing of the nursing workforce, declining enrolment to nursing schools, changing work environment and the poor image of nursing. In the USA the average age of registered nurses is 45 years old, with more than 40% older than age 50. The data also revealed that there will be a mass departure of this ageing portion of the nursing workforce from the profession over the following 10-20 years. This will further contribute to the nursing shortage in clinical, academic and management settings.

A contributing factor to the nursing shortage is that of turnover. For this review turnover is defined as: the process whereby an individual leaves a job, organisation or the profession. A review of the literature about workforce turnover in nursing by Wai Chi Tai, Bame and Robinson (1998) categorised factors that contribute to nurse turnover into socio-demographic, organisational and social support factors. Their review concludes that staff from a low socio-economic background, those with higher income or longer work tenure and those who are older are less likely to consider leaving their job. Job satisfaction and tension, organisational commitment, perceived job possibilities and supervisor's behaviour were factors that are involved in turnover behaviour. Support from family, friends and supervisors at work predictably reduced the likelihood of turnover. Zeytinoglu et al. (2006) found those nurses who were not working in their preferred area of practice were working unpaid and longer than agreed hours and those who were experiencing high levels of stress were more likely to leave employment and the profession. Hayes et al. (2006) in a recent literature review, found that job dissatisfaction

and intent to leave were the reasons most consistently reported as impacting on nurse turnover.

A study by Cowin and Hengstberger-Sims (2006) describes three issues that may affect graduate nurses' self-confidence and retention rates; reality shock, work readiness and interpersonal conflict. Reality shock describes the sudden comprehension that the reality of the workplace is different to what they had imagined. As Cowin and Hengstberger-Sims (2006) state "What makes reality shock a potentially dangerous issue is when the mismatch between workplace expectations and reality is so great the new worker re-evaluates their choice of career and decides to quit" (p. 61). Work readiness is related to whether nursing education has prepared them sufficiently for work. The last issue, interpersonal conflict, is where the self-confidence of a graduate nurse is tested by aggression from older, more experienced nurses, causing the younger nurse to experience stress and a loss of self esteem.

The Nurses Early Exit (NEXT) study investigated nurses leaving nursing, analysing data gathered from over 25,000 nurses in 10 countries in Europe (Hasselhorn et al., 2005). The NEXT study proposed that there is a structural and a real shortage of nurses. The former refers to when more nurses are required to adequately care for the patients, but no resources (staff vacancies) are available (p. 2). A real shortage (vacancy) exists where vacancies cannot be filled due to a lack in the supply of nurses (p. 2). This is the only study that was located stating that premature departure from nursing is the main cause for the nursing shortage.

The penultimate stage of the turnover process, prior to actually leaving, is the employee's behavioural intention to leave employment (McCarthy, Tyrrell, & Lehane, 2007). According to McCarthy et al., in a study that investigated registered nurses intent to stay or leave employment or the profession, the intention to leave appears to be a stronger predictor of turnover than organisational commitment, satisfaction with the work and job satisfaction. Three hundred and twenty-five nurses were quantitatively surveyed in 10 hospitals in the Republic of Ireland. Twenty-three percent of the sample expressed intent to leave. The most statistically significant predictors of "intent to leave" were having few or no kinship responsibilities and low job satisfaction. This is in keeping with the findings of a recent study investigating young nurses' intention to leave the profession in Finland

(Flinkman, Laine, Leino-Kilpi, Hasselhorn, & Salanterä, 2008). Flinkman et al. found that out of 147 young nurses (defined as less than 30 years old), 26% often thought of leaving the profession. This was associated with personal burnout, poor opportunities for development, lack of professional commitment, low job satisfaction, work–family conflicts and higher work demands (comprised of longer work hours and increased work pace).

Demographic factors also appear to have an influence on whether a nurse will leave the profession. Borkowski, Amann, Song and Weiss (2007) found that in the USA nurses who were male, White-non-Hispanic and had less than a master's degree were more inclined to leave the profession. Barron and West (2005), analysed data from the British Household Panel Survey from 1991-2001. This study found that being male, being younger, having a degree and being born in the UK predisposed to leaving the nursing profession. This is in contrast to Borkowski et al. (2007) who found a correlation between a lack of tertiary education level and leaving. A proportion of nurses do leave to care for their families, although there is the possibility that they will return to the profession. Certain job characteristics contribute to leaving the profession, including low pay, managerial responsibility full-time work and lack of opportunities to use initiative. Barron and West (2005) found that nurses who leave are most likely to do so early in their careers. It is possible that the more one invests time, money and self in a career, the less likely one is to leave.

Summer and Townsend-Rocchiccioli (2003) discussed intrinsic causes or “what is not being met inside the nurse that causes him or her to leave the profession?”(p. 164). They proposed that a lack of recognition, dissatisfaction with the job and the bureaucracy of management possibly contribute to the decision to leave the nursing profession. However, this article is based solely on speculation rather than research and so while it does provide information to consider, it does not provide any solid data. Duffield, O'Brien Pallas and Aitken (2004) surveyed nurses who were working outside the profession. Five factors contributed to those nurses leaving the profession. These factors were legal and employer issues, external values and beliefs about nursing, professional practice issues, work and home life and contract requirements.

Job satisfaction has been a topic of interest to the managerial world since the 1950's when Herzberg formulated the two-factor theory of job satisfaction (Herzberg & Mausner, 1959). While this theory has dominated much of the research, satisfaction and dissatisfaction are no longer seen as two separate entities but as opposite ends of the spectrum (Lu, While, & Barriball, 2005). Lu et al. (2005) reviewed the literature regarding nurses' job satisfaction. Their review found that unfulfilled expectations regarding nursing work and increased levels of work-related stress are all contributors to low job satisfaction. Nurses with tertiary education appear to have lower levels of job satisfaction, which correlates with the findings of Barron and West (2005) above. Lu et al. (2005) conclude that there is a lack of a comprehensive model of job satisfaction in nursing. Zangaro and Soeken (2007) conducted a meta-analysis of 31 articles investigating nurses' job satisfaction. They found that there was a strong negative correlation between job stress and job satisfaction and a strong positive correlation between nurse-physician collaboration and job satisfaction. Autonomy had a moderately positive correlation with job satisfaction. Aiken et al. (2001) found job dissatisfaction among nurses was highest in the USA (41% of nurses) followed by Scotland (38%), England (36%), Canada (33%) and Germany (17%). One third of nurses in England and Scotland and more than one fifth in the United States planned on leaving their job within 12 months of data collection. What is striking is that 27–54% of nurses less than 30 years of age in all countries surveyed planned on leaving the profession within the following 12 months.

Physiotherapy

Leaving the profession has not been the subject of much research in the physiotherapy profession. Much of the research that has been done is dated, having been done during the late 1970's through to the early 1990's. Literature regarding job satisfaction and burnout, which are factors known to affect attrition of personnel in other professions, is examined in relation to the physiotherapy profession. In addition, the literature from North America refers to physiotherapists as physical therapists. For simplicity both terms are synonymous in this dissertation and both are referred to by the abbreviation of PT.

As with the nursing and medical professions, there is currently a shortage of physiotherapists being reported in the literature. In an early study identifying this

shortage, Wilson, Langwell, Deane, Chui and Black (1982) analysed data from 13 states in the USA to identify whether there was a shortage of PTs. Their conclusions were that there was a both a shortage and a maldistribution of PTs. However, the authors did recognise that they had based their conclusions on a self designed model which they accepted as flawed and untested. In a more recent study, the American Physical Therapy Association looked at vacancies and turnover of PTs in acute care hospitals, in skilled nursing facilities and in outpatient private practice (American Physical Therapy Association, 2008a, 2008b, 2008c). Vacancy rates were 13.8%, 18.6% and 13.1% respectively. Turnover amongst full-time physiotherapists was 85.2% and one out of 10 facilities surveyed reported a 100% turnover rate in a 12 month period. Both of these statistics are remarkably high.

On the website Workplace run by the Australian Government, the report on the physiotherapy workforce lists a shortage or recruitment difficulty in all states and territories except for Western Australia for which there is no report (Department of Education Employment and Workplace Relations, 2008a). In Australia, a study found that ageing of the workforce and subsequent retirement of the older generations in the physiotherapy profession is contributing to the workforce shortage (Schofield & Fletcher, 2007). The authors predicted that 41% of the 2001 workforce will have retired by 2026. Anderson, Ellis, Williams and Gates (2005) explored workforce data from the physiotherapy profession in New South Wales from 1975-2002. Their findings were that the current shortage in the profession may be due to a slowing in the growth rate of the profession while the demand for services continues to rise. In addition, from 1975-2002 between 3-5% of registered physiotherapists have been inactive. Inactive meant working in another field, not working or currently looking for work in the profession. In a recent study on the physiotherapy vacancies in New Zealand, Taylor (2008) found that there is currently a shortage of physiotherapists. Taylor (2008) does highlight that this is despite an increase in the number of practising physiotherapists and that the shortage may be due to the growth of services offered by private practice and District Health Boards.

Harkson, Unterreiner and Shepard (1982) surveyed physiotherapists in the USA to determine the relative importance of personal and work-related factors in relation to job turnover. The authors found that 73% of respondents had had two to five jobs in their first two years in practice. The most important factors affecting job turnover were having no

opportunity for promotion and having insufficient salary to meet financial needs. Other factors that rated highly were the desire to pursue a different area of physical therapy, few opportunities for personal development and little feeling of accomplishment in their work. Shanahan (1993) reviewed the literature related to the physiotherapy shortage and turnover of physiotherapists compared to nursing. The review found that high turnover is associated with discontinuity and poor quality of patient care. There is also a potential to lose revenue because there is not enough staff to provide services.

There has been significantly less research into the phenomenon of physiotherapists leaving the profession compared to the research that has been done in the fields of nurses and physicians. A literature search identified only three studies into this phenomenon. One was outside the date range that was specified but because of the dearth of literature, it has been included.

Gomez (1978) (as cited in Gwyer, 1995) studied 475 PTs in California to determine the rate of attrition from the profession and to describe the characteristics of attrition. Gomez found that the attrition rate varied over time: negligible immediately after graduation, increasing gradually until a sharp increase in the fifth decade. Male therapists were more likely to stop practising if they were involved in non-physical therapy academic studies, held academic degrees and rated pay and control over work methods important. A notable statistic is that 44% of male PTs left the field because of professional disillusionment. In addition, the higher the salary, the greater was the probability of continuing to practise. In contrast, for female PTs the higher the salary, the greater the probability they would stop practising. Gomez hypothesised that this was due to the higher-paid female therapists feeling boxed in because of the limited career ladder. However, this would possibly also apply to males therapists and does not completely explain the contrasting results. Interestingly, the greater the number of non-physical therapy jobs the female therapists held since licensing, the greater the probability they would continue to practice. It was not possible to find the original study as it was an unpublished dissertation; therefore the findings were gathered from a secondary source.

Gwyer (1984) (as cited in Gwyer, 1995) studied the attrition of PTs in a random sample of 404 graduates from various colleges in the USA. Attrition was defined as the cessation of clinical practice. Eleven years after practice, 72% of all respondents were active in

practice. The mean work tenure was nine years with 42% of the graduates reporting having worked continuously since graduation. Longer work tenure was associated with a higher commitment to the profession and greater satisfaction with the rewards of the job, with physical therapy as a career choice and with the pay. The most important determinant of work tenure was the opportunity for work outside physical therapy. The higher the therapists' perception of the availability of jobs in a field other than physical therapy, the shorter was their work tenure. In addition, men had longer work tenures than women. The authors concluded that their model accounted for 21% of the variance in work tenure. Other factors must influence work tenure as well, as 79% of the variance was not accounted for.

Wolpert and Yoshida (1992) examined demographic differences between practising and non-practising physiotherapists and reasons for leaving the profession and factors that might influence return. Three groups of physiotherapists were surveyed: those who had not renewed registration to practice (cancelled); those who were registered but not practising (inactive) and a group of actively practising therapists (control). The majority of those not practising were not working outside the home and approximately half planned to return. For the cancelled and inactive group the most important reason cited for not working in physiotherapy were raising a family, the desire for new challenges, retirement and health reasons or burnout. Other important reasons were lack of recognition, authority and autonomy, dissatisfaction with the profession and lack of promotion options. The most important factors preventing return were more challenging pursuits elsewhere, frustration with the profession and inadequate remuneration.

Speakman, Pleasant and Sutton (1996) designed a survey investigating job satisfaction in relation to physical therapy clinical practice using 10 self designed statements. The statements concerned paperwork, challenge, physical demand, professional autonomy, fulfilment and stress. The authors concluded that the statements were important to the study of job satisfaction and the participants reported being minimally to moderately satisfied with the practice of physical therapy. This study had one shortcoming which was validating and utilising the statements using the same participants. The authors appear to have assumed the statements would be valid before testing them. It would have been more appropriate to first pilot the statements and then use the statements to investigate job satisfaction. Ogiwara and Araki (2006) conducted the same study with the same

statements as Speakman et al. (1996) in Japan. They found that the excessive paperwork and physical/mental stress both contributed to poor job satisfaction. Participants of this study only rated the statements as being moderately important in measuring job satisfaction, in contrast to their American colleagues. This study has the same shortcomings as was outlined for Speakman et al. (1996). The methodological design flaw makes the results of these two studies less significant.

Eker, Tüzün, Daskapan and Sürenkök (2004) conducted a similar study in Turkey. However, unlike the two studies mentioned above, they first conducted a pilot study to ascertain the validity of the statements they were using to measure job satisfaction. The final survey comprised a 32-item list with respondents rating their agreement on a five-point Likert scale. The study found that less than half the study's participants were satisfied with their job (45.5%). Leadership, interpersonal relationships, salary and advancement were found to be the best predictors of job satisfaction.

Another factor that has been shown to influence leaving a profession is burnout. Wolfe (1981) discussed the possibility of burnout existing in the physiotherapy profession before there was any formal research. Wolfe (1981) defined burnout as “a feeling of emotional and physical exhaustion coupled with a deep sense of frustration and failure” (p. 1046). Wolfe discussed the manifestations and causes of burnout and raised the question that an unknown quantity of PTs may be experiencing burnout. The manifestations of burnout are described in a progression from early stage burnout to late stage burnout. In early stage burnout, the individual is faced with a high workload to which they can respond by increasing or decreasing their work effort, but with no increase in productivity. The person, in their desire to help their patients, may not see the toll this is exacting and fatigue will often ensue. Simultaneous with the fatigue, distancing behaviours develop such as the therapist emotionally and physically distancing and detaching themselves from the process of patient care. As burnout progresses the individual tends to draw a sharp boundary between work and home and work life is not discussed. The individual may experience anger, frustration, substance abuse and physical ailments. Finally, they may decide to leave direct patient care, leave the institution or the profession. Wolfe (1981) also describes what can precede burnout. Precedents include the inability to successfully resolve patients' issues, work overload and ambiguity in the demands placed upon the individual. Not being able to make full use of therapeutic skills

because of a lack of time or limitations placed upon them from an organisation or profession were also factors that could lead to burnout.

On the basis of Wolfe's literature review regarding burnout, Schuster, Nelson and Quisling (1984) surveyed physiotherapists in the USA about whether they were experiencing burnout. The authors defined burnout as "the temporary or permanent experiencing of physical and mental exhaustion plus notable diminished motivation and productivity as a result of excessive commitments of energy, resources and strength" (p. 300). The criterion for inclusion in this study was being a full-time PT with a minimum of 30% of work time involved with patient care. Out of a sample group of 250 PTs, 160 fitted the inclusion criteria. The findings were that 53% (84) of the inclusion group reported feelings of burnout, thus showing that burnout does exist amongst PTs. Scutter & Goold (1995) looked at the prevalence of burnout in physiotherapists who had been qualified for less than five years in South Australia. Sixty percent of the sample was found to have moderate to high levels of emotional exhaustion, which is a key characteristic of burnout. The authors also postulated that burnout can cause physiotherapists to leave the profession.

Research within the osteopathic field

Within the osteopathic field, there has been little research regarding leaving the profession or the issues and factors that affect this phenomenon. Only one study was identified that investigated osteopaths leaving the profession (de Jager, 1998). There are also studies that indirectly relate to leaving the profession which look at burnout, job satisfaction and self-care (Flaherty, Carter, & Cameron, 2004; Webbe, 1999; Wells, 2005).

De Jager (1998) surveyed osteopaths who had left the profession prior to retirement using a self-designed questionnaire. The survey was first piloted and edited and then mailed to 73 osteopaths listed on the Register of Osteopaths in the UK as not practising. Forty-two questionnaires were eventually analysed. Seventy-six percent of respondents listed osteopathy as being their first degree and 80% had not had another career prior to osteopathy. Overall, 69% reported being extremely or fairly satisfied with osteopathy as

a career. The median age of qualifying as an osteopath was 24 years old with the median age of ceasing to practise being 31 years old. The study found that a change of career, raising a family, burnout, financial stability and instability, geographical move, lack of career structure, professional isolation, ill health, disillusionment with osteopathy and boredom were all reasons for leaving the profession. For women the most reported reason for leaving was raising a family. For men, a change of career was the most reported reason. Respondents were not limited to listing one reason and some gave more than one. When asked whether they felt they had made the right decision to leave, 88% responded that they had. The majority of respondents (63%) reported that they envisaged returning to practise osteopathy in the future. This study provides an excellent quantitative exploration of why osteopaths leave the profession. The imbalance of female participants compared to male may have been a shortcoming in the design of the study (thirty-five women compared to seven men). While this may reflect the fact that women leave the profession more than men there is no evidence that this is the case.

Webbe (1999) carried out a comparative study in the UK to measure burnout rates within the osteopathic profession, comparing his findings to other health professions and evaluating the relationships between burnout, demographic and work variables within osteopathy. Webbe (1999) defines burnout in the context of osteopathy as “the inability to match the emotional demands of osteopathic practice with the emotional energy of the osteopath” (p. 4). A modified Maslach Burnout Inventory (MBI) questionnaire was used to measure three dimensions of burnout: emotional exhaustion, depersonalisation and personal accomplishment. Seventeen percent of responding osteopaths reported high levels of emotional exhaustion. The results showed low levels of burnout compared to professions working mainly within the National Health Service and comparable levels to PTs working mainly in private practice.

In Australia, Flaherty et al. (2004) investigated job satisfaction and occupational stress in osteopaths with more than five years experience. The vast majority of osteopaths surveyed (92%) reported being satisfied with their chosen career. This is a remarkably higher percentage than that reported for GPs, nurses and PTs above (Aiken et al., 2001; Eker et al., 2004; McGlone & Chenoweth, 2001). The most frequent source of stress for osteopaths was administration of the practice and staff. The main occupational sources of stress were workload and economic pressures. Workload was described as too much work

in a limited time and referred mostly to administrative factors. Economic pressure was related to earning enough money.

Wells (2005) investigated osteopaths self-care practices and interviewed osteopaths who practised self-care as a means to minimise stressors, maximise health and well-being and to potentially enhance professional longevity. Wells defined self-care as, “a process whereby an osteopathic practitioner functions on his or her own behalf in health promotion and in illness prevention and treatment” (p. 3). The participants used self-care practices such as exercise, support networks, finding the balance between home and work, leaving work at work and using barriers when dealing with patients. Self-care can be both restorative of health and preventative of ill-health.

Summary

There is currently a global shortage of health care professionals in the fields of medicine, nursing and physiotherapy. The reasons for the shortage of these professionals are complex. Contributing to the shortage is the fact that health care professionals are leaving their professions. Leaving a profession is a phenomenon dependent on many factors, some of which are unique to each field and some which apply across the professions and to all health care workers. Those factors identified within the medical, nursing and physiotherapy professions may also be the same for osteopaths. However, there is currently only one study to date that has looked at osteopaths prematurely ceasing to practice (de Jager, 1998). No literature could be found that related to the phenomenon of a shortage of osteopathic practitioners. Because of this paucity of literature an exploratory qualitative study researching the lived experience of leaving the osteopathic profession is justified.

CHAPTER THREE – METHODOLOGY TO METHOD

Introduction

This chapter describes the methodology and method that was used in this study. The basis of a mixed method design of a retrospective data review and interpretive description will be described as well as the data collection. How the study results were obtained is shown thus providing validity through a clear audit trail.

Methodology to method

Where there is a lack of relevant information an exploratory study is recommended to gather new information (Brink & Wood, 2001). This study employed a mixed method design of a retrospective data review and interpretive description informed by the processes described by Thorne, Kirkham and MacDonald-Emes (1997). “This method of research is grounded in an interpretive orientation that acknowledges the constructed and contextual nature of much of the health–illness experience, yet also allows for shared realities” (p. 172). While Thorne et al. specifically mention the health-illness experience, all experiences can be viewed to be constructed and contextual as well as occurring in a shared reality. Therefore using this method was appropriate to the phenomenon of the experience of leaving the profession. A retrospective review was employed as a data gathering exercise to ascertain what statistical information existed regarding osteopaths leaving the profession, thus providing some background to the issue. It was not the purpose to analyse or infer relationships within the data.

The personal experiences of osteopaths were explored, interpreted and described via the use of the interpretive descriptive method, which allowed for explanation and elaboration of why these participants left the profession (Wilson, 1989). This method provided an excellent means to investigate why these health professionals left the osteopathic

profession. Each research participant had the opportunity to explain, in his or her own terms, their personal experience of leaving the profession and the reasons that contributed to the decision to leave. Each person creates their own meaning from their experience so it was essential to have a data collection method that allowed for flexibility and spontaneity of information gathering (Brink & Wood, 2001; Thorne et al., 1997; Thorne, Kirkham, & O'Flynn-Magee, 2004; Wilson, 1989).

Sample

For the retrospective data review the sample comprised of data relating to the number of practising and non-practising osteopaths as well as any data available about the loss of osteopaths from the profession. Data were sought from registering bodies and administrative organisations in the UK, New Zealand, Australia and the USA. While participants for the second part of the study were not recruited from the USA, data from the USA were included in the retrospective review. This was done to give a broader perspective on the state of osteopathy on a global scale with regard to this phenomenon.

For the second part of this study purposive snowball sampling, a sampling technique that is used to study hidden populations (Faugier & Sargeant, 1997), was used to recruit six individuals in New Zealand, Australia and the UK who had left the osteopathic profession. Purposively selecting the sample group ensured that data gathered were meaningful to the phenomenon of leaving osteopathy. Individuals who have personally lived with an experience are often the best source of knowledge about that experience (Thorne et al., 1997). "If the aim of the study is primarily explorative, qualitative and descriptive, snowball sampling offers clear practical advantages in obtaining information on difficult-to-observe phenomena" (Hendricks & Blanken, 1992, as cited in Faugier & Sargeant, 1997, p. 791). Osteopaths in the USA were excluded for reasons explained within the inclusion and exclusion criteria below.

Participants were found using one of three strategies. Firstly, one participant was found by sending emails to practicing osteopaths in the UK using the 2007 General Osteopathic Council (GOsC) register (see Appendix A) introducing myself and the research topic and asking whether they or someone they knew had left the profession. The email was sent

only to those who had graduated before 2003 thus helping to ensure that any potential participant fit the criterion of having practised for a minimum of three years. While I received numerous replies, eventually only one participant was found using this method. Secondly, I was told of five other eligible participants by faculty members at Unitec, of whom four agreed to be interviewed. Thirdly, one individual who had left osteopathy was known to a participant and, with their permission, their contact details were passed on to me.

A total of six participants were interviewed. Contact was established with each participant via email or telephone depending on the contact details that I had. For those first contacted by email, an information sheet was included (see Appendix B) and the person asked whether they would consider participating in the study. First contact was established via telephone in one case. Once an email address for this participant was obtained an information sheet was sent to them. A total of seven possible participants were contacted, of whom six agreed to be interviewed. Once a participant indicated that they were happy to continue, they were invited to ask any questions they may have had regarding the research or interview process. The Unitec Research Committee ethics committee had decided that for overseas participants written consent in an email as well as recorded verbal consent would suffice for the requirements of informed consent. For the one face-to-face interview the participant was asked to sign a consent form (see Appendix C).

Inclusion criteria

Inclusion criteria were based on whether potential participants were qualified and had been registered and practising for at least three years as an osteopath in NZ, Australia or the UK and had since left the practice of osteopathy and entered another career. Qualified was defined as having completed an educational programme. Registered was defined as having joined the profession through membership of a professional body and/or registration board.

Exclusion Criteria

Individuals were excluded if they were on parental leave or were taking a break with the intention of returning to osteopathy practice, no longer required an income from

osteopathy (e.g. they had become financially independent) and had qualified but never practised. The reason why those that leave because of parental leave or financial independence is clear and those that never practise would not be able to provide meaningful data on the phenomenon being investigated. These criteria were thus implemented to ensure a clearer insight into the factors and decisions for leaving because of the practice of osteopathy or because of choosing another career.

Osteopaths who qualified in the USA were also excluded from this study. Osteopaths in the USA are called Doctors of Osteopathy (DOs). All DOs are qualified and licensed as medical practitioners. The role, context and niche of a DO within the health system in the USA are the same as a medical doctor and they can become general practitioners, surgeons and specialists. This is a very different role to that of an osteopath in NZ, Australia and the UK. Because of these differences, those factors involved in DOs leaving the profession were possibly sufficiently different and complex, to indicate that the inclusion of American DOs would be beyond the scope of this study.

Data collection method

Data were sought from New Zealand, Australia, the UK and the USA regarding practising and non-practising osteopaths. This data were sought from the osteopathic registration boards within each country, osteopathic research organisations via email and literature or online publications. The aim was to discover what statistical data were available regarding inactivity or attrition of osteopathic practitioners.

When performing qualitative research into a new or under-researched phenomenon, an interview is considered the most appropriate method to elicit the personal perspective of participants while allowing for the flexibility required to pursue themes and clarify inconsistencies that arise from the data (Brink & Wood, 2001; B. Taylor, 1994; Thorne et al., 2004). Semi-structured interviews were chosen as the method for data collection. Semi-structured interviews allowed flexibility when responding to the information which was provided and reduced the control on the data that were supplied. Therefore, semi-structured interviews were used to investigate the experience of leaving the profession and the reasons surrounding each participant's decision to do so.

Project design

The original design of the project incorporated the use of Skype™ to interview overseas participants. Skype™ is a free program that allows the user to make free calls from computer to computer over the internet if talking to another person using Skype™ or at low costs if calling a mobile or landline. Skype™ is available for download from www.skype.com. Four participants were eventually interviewed using Skype™. One of these participants did not have Skype™ initially. This participant was provided with the internet address of where to download Skype™ as well as instructions on how to install the program. One interview was conducted over the telephone and another face-to-face. The interviews ranged in length from between 25 minutes to 80 minutes with an average length of 60 minutes.

The interviews were recorded using two separate methods. For Skype™ a program called PowerGramo™ was used. This program is available from www.powergramo.com. A professional version was bought by the School of Health Science at Unitec. PowerGramo™ is a program specifically designed to record Skype™ calls. With both programs running simultaneously, PowerGramo™ will start recording automatically as soon as a Skype™ call is underway. Each participant was reminded at the beginning of the interview that they were already being recorded. Reminding them gave them an opportunity to withdraw consent if they were not happy being recorded. The second method was using a personal dictaphone which was used to record the phone and face-to-face interview. Interestingly, the PowerGramo™ recording was of much higher quality than that of the dictaphone.

While it was originally envisaged that I would conduct up to 10 interviews, I decided, after consulting my supervisors, that I would cease interviewing after six interviews as replication of data were occurring. When examination of the data reveals that no new themes or categories are forthcoming, then saturation has occurred (Bassett, 2004; Morse & Field, 1996). Through comparison of the themes arising from the initial interview with subsequent interviews, it became apparent that there were no new themes emerging from the sixth interview. The decision was then made to cease interviewing participants and begin the final analysis and writing-up process.

As the interviews were semi-structured, an interview schedule of questions was prepared (see Appendix D). I had initially thought that I would rely heavily upon this schedule; participants would often answer more than one question in response to a single question meaning I only used the schedule if the participant required prompting. Once I gained some experience with the interview process the style became more conversational. Participants were encouraged to elaborate and clarify on their responses.

Data analysis method

Thematic analysis was the data analysis method which was in keeping with the exploratory nature of the research (Rice & Ezzy, 1999; H. S. Wilson, 1989). In thematic analysis common themes are identified that emerge from the data after repeated reading and rereading of the interview transcripts. Repeated immersion in the data before coding, categorising or creating linkages allows for synthesising, conceptualising and re-contextualising rather than merely sorting and coding (Thorne et al., 1997). Through sifting through the data, themes, concepts and factors were identified and built upon using an inductive process. The in-depth interviews produced a large volume of data. These concepts and factors were then coded thematically to assist the analysis (Morse & Field, 1996; Rice & Ezzy, 1999; H. S. Wilson, 1989).

Initially the intention was to have the interviews transcribed by a typist but I decided to do the transcribing myself. This afforded me an extra opportunity to become familiar with the transcripts and the data contained within. Throughout the transcription I kept a journal in which I wrote any ideas or thoughts that arose in regards to each interview. While this journal was informal, it did inform the process of thematic analysis. It was this initial analysis that helped inform the decision about when to stop participant recruitment and data collection. Transcription of each interview took between three to four hours.

Information from my interview reflections (journal notes written after an interview and during the process of analysis) and the interview transcripts themselves were both included as data for the analysis process. Interpretive description helped to identify the emergence of themes, concepts or factors which contributed to the experience and decision to leave the osteopathic profession.

The final process of thematic analysis began by replaying the first interview and re-reading the electronic and a printed version to familiarise myself with the contents and underlying themes. Themes were then identified and noted in a separate computer document. A table was constructed and quotes and examples were added that illustrated the themes that had been identified (for an example, please see Appendix E). The final step was to compare and categorise the themes in the table to gain the most concise layout and ensure there was no repetition. Once each interview had been analysed in this way, the themes identified in the first interview were compared and contrasted with those in the second and subsequent interviews. I then used a whiteboard to list each theme that had emerged from the analysis. In this way a master document of analysis was compiled from each of the six interviews. This document was a compilation of each of the similar themes, with relevant examples and quotes and this formed the basis of the findings discussed in Chapter Four of this dissertation.

To ease the readability following the data analysis “conversation fillers” (such as um, er, aha, you know, like and so forth) were deleted from the text and from quotes within this document.

Ethical considerations

A full ethics proposal was submitted to the Unitec Research Ethics Committee and was subsequently approved. Ethical issues for this study related to anonymity and confidentiality, data security, withdrawal from the study and the risks and benefits of participating in this study.

Anonymity and confidentiality

I personally transcribed each interview, which helped to maintain anonymity and confidentiality by negating the need for a transcriptionist. I was the only person with access to the information which was stored on my personal computer in password protected files. It is possible that a reader of this dissertation may feel they recognise one of the participants. Every effort to ensure the anonymity of the participant has therefore been made. Every participant was assigned a gender neutral sounding pseudonym. In

order to preserve anonymity, identifiers, such as geographical and practice locations, which did not affect the overall interpretation of the data, were not discussed.

Storage and destruction of study materials

All interview recordings, transcripts, email correspondence including the emails with the consent for the interviews, thematic analyses and my personal research journal have been kept on my personal computer for which only I have the password as well as being placed in password protected files. The single consent form from the interview that was conducted face-to-face is kept in a filing cabinet to which only I have access. The printed copies of the transcripts that were made for the data analysis have been destroyed.

The audio files, electronic transcripts, the single signed consent form and the emails giving consent for the interviews will be kept for five years in accordance with Unitec New Zealand's regulations for research projects. After this time, all computerised files comprising the transcripts and audio files will be deleted and the consent form and any other written information will be shredded.

Withdrawal from study

All participants were informed that they could withdraw from the study at any point prior to commencement or during the interview. Any participant could withdraw their data up to two weeks following the interview. Each participant was given a copy of the interview transcript and was given the opportunity to withdraw some or all of the data as well as being able to make corrections if they felt that part of the transcript did not adequately explain their experience or point of view. This information was conveyed to each participant in the information sheet and at the end of each interview. Two of the participants made grammatical changes to the transcripts and another participant sent a follow-up email iterating a point they had forgotten to make in the interview. None of the participants asked that anything be removed or altered.

Risks and benefits of participation in this study

A risk of participating in this study was that in retelling the experience of leaving the profession, an individual may have had to recount a painful, unsettling or disturbing event, which contributed to their decision to leave the profession and thus become

uncomfortable with the discussion. While this was the case for a number of the participants, none was distressed by the recounting or recollection of these memories. If one had been distressed, the interview would have been stopped, until the participant was able to recommence or until they decided to cease the interview completely. This was not the case for any of the participants.

By discussing the experience of leaving the profession, it may have been possible that a participant expressed emotions or thoughts that they had not previously confronted, thus leading to a “cathartic experience” (Heron, 2003). One participant did comment that they had not previously reflected much on the events that led to the cessation of practice. While they did not experience such a ‘catharsis’ during the interview, this may have occurred, as it may have for any of the other participants, in the hours or weeks following the interview.

The question of rigour and credibility

I have endeavoured to outline a clear audit trail throughout this dissertation by illustrating how the participants were selected, how the data were collected and how the analysis process ensued to ensure that my research findings have credibility. I have outlined in Chapter One my own interest into why osteopaths leave the profession developed and how the definition of leaving the profession for this study’s purposes was developed. A clear audit trail is important for trustworthy research (Thorne et al., 1997).

In this chapter I have outlined how the process of reading and re-reading of interview transcripts allowed me to immerse myself in the data and how this allowed me to identify themes. This immersion in the data as well as revisiting the interviews meant that I was able to keep the themes that emerged in context to what was actually said by the participants, which is necessary as qualitative research is context dependent (Brink & Wood, 2001; Rice & Ezzy, 1999). This was done to ensure the authenticity of the themes that emerged.

In the audit trail of written material, interview transcripts and audio files, credibility and the application of rigour are evident. Each participant had the opportunity to validate their

transcript by reviewing it prior to data analysis. This was done to ensure that each transcript was an accurate reflection of the interview and that the participant was satisfied with the process, thus adding credibility and reliability to the study (Brink & Wood, 2001; Rice & Ezzy, 1999). Thorne et al. (2004) states, “the best interpretive descriptions will pass what has been referred to as the ‘thoughtful clinician test’, in which those who have expert knowledge of the phenomenon find that the claims are plausible and confirmatory of ‘clinical hunches’ at the same time as they illuminate new relationships and understandings” (p. 17).

Summary

This study is an exploration into the under-researched phenomenon of leaving the profession. Interviews are considered in such circumstances to be the most effective mechanism to elicit the personal experience of participants, allowing for flexibility in data collection by allowing the pursuit of themes and clarification of inconsistencies (Brink & Wood, 2001; Rice & Ezzy, 1999; B. Taylor, 1994). As a background to the research project, a retrospective review was also performed to gain insight into how much this phenomenon is being documented within the osteopathic communities of the USA, the UK, Australia and New Zealand.

Semi-structured interviews were used to gather data from six individuals who were purposively selected. Each participant was purposively selected to ensure that they each had had personal experience of leaving the profession. This ensured that the information that was gathered was meaningful to the context and phenomenon of leaving the profession (Thorne et al., 1997). As the interviews were semi-structured, an interview schedule was used as a checklist. This list was used when prompting was needed during the interview to draw out the participant’s experience of leaving the profession.

The data analysis method used in this exploratory study was based on an interpretive descriptive method, founded on phenomenology (Thorne et al., 1997). After repeated immersion in the data through reading and re-reading the interview transcripts, thematic analysis identified common themes that emerged from the data (Rice & Ezzy, 1999; Thorne et al., 1997; Thorne et al., 2004) .

Anonymity of participants was preserved by altering names and not making mention of practices and geographical locations. Specific details that may identify certain participants have also been omitted without compromising the presentation of the findings. Consent for was sought and gained for each participant and each participant was given opportunity to withdraw from the study at various stages.

Credibility and the application of rigour to the process of research and analysis are evidenced by the audit trail outlined in this chapter. Each participant was given the opportunity to validate their interview transcript prior to data analysis commencing. This was to ensure that the transcripts accurately reflected the persons experience, what they had communicated and were satisfied with the process (Bassett, 2004; Brink & Wood, 2001; Rice & Ezzy, 1999). The ultimate test of credibility will come when osteopaths who have left the profession or those who are contemplating leaving the profession read this dissertation. If they find that the information is plausible, based on their own experiences, then credibility will have been achieved (Thorne et al., 2004).

The next chapter presents the findings from the data analysis detailed in this chapter. These findings are described and interpreted to illustrate the experience of leaving the osteopathic profession.

CHAPTER FOUR – PRESENTATION OF FINDINGS

Introduction

In this chapter the findings from the retrospective review and the interpretive analysis of the interviews with the six participants will be presented. The data from the retrospective review provides a background to the phenomenon of osteopaths leaving the profession in the USA, UK, Australia and New Zealand. The analysis revealed themes, grouped under extrinsic or intrinsic factors that contributed to the decision to leave. The chapter discusses the education and preparation for an osteopathic career, those factors that led to the decision or act of leaving, the experience of leaving and the how each participant reflects upon their experience of leaving the profession.

The six osteopaths who participated in this study each had between four and ten years of professional experience, with an average of six years. They received their education in schools/institutions in Australia and the UK including Victoria University in Melbourne, the British School of Osteopathy and the European School of Osteopathy.

After extensive analysis it was decided that the best manner in which to present the themes was to categorise them into extrinsic and intrinsic factors. Burnout has been described on its own as it occurs as the result of the both intrinsic and extrinsic factors. The overarching theme “leaving as a process” shows that leaving is the final decision in a process that is influenced by variety of extrinsic and intrinsic factors and burnout.

The themes identified as extrinsic factors are: lack of preparation for practice life which includes reality shock and insufficient business training, lack of support in practice, uncertainty of income, frustration with the scope of practice of osteopathy, issues of professionalism and singular events.

The themes identified as intrinsic factors are: desire to explore other careers, maturity, life experience and entering the profession at a young age, lack of certainty, evidence and confidence, desire for greater income and boredom with osteopathic practice.

In order for the themes to be clearly understood it is necessary to understand the words that were chosen as outlined above. The word extrinsic was chosen to indicate those factors that act upon the individual from sources outside of the person. Barring the choice of education and practice locations, the individual had no choice as to these factors that acted on them to leave the profession. In contrast, the word intrinsic is meant to reflect the factors that directly related to the individual's personality and suitability for the practice of osteopathy; these are factors that come from within the person.

The way that the themes were categorised was by asking the question, "Is this an extrinsic or intrinsic factor?" In the case where the theme was actually a combination of both, it was categorised under the factor that had the most bearing upon it. Burnout did not fall under the category of extrinsic or intrinsic. And finally there was the overarching theme: "leaving as a process".

Retrospective review

As part of this research project, statistical data that pertains to osteopaths who have left the profession were collated in order to show the extent of this phenomenon internationally.

Every year in New Zealand a survey is conducted by the New Zealand Health Information Service (NZHIS). This survey gathers statistical data regarding the osteopathic workforce and includes demographics, employment settings and activity. The 2006 survey showed that 450 osteopaths purchased an annual practicing certificate (APC) which dropped to 360 APCs in 2007 (New Zealand Health Information Service - Te Paronga Hauora, 2006, 2007). In 2007, of the 276 surveys that were returned, 4 respondents reported not actively practising osteopathy. Further statistical data were gathered by personal correspondence with the acting registrar for the Osteopathic Council of New Zealand (OCNZ) Mike Fitzgerald (personal communication, July 17, 2007). According to the OCNZ, in 2007 there were 424 osteopaths registered in New Zealand, of which 90 were listed as inactive. That is a large proportion, comprising 21% of New Zealand registered osteopaths. These inactive osteopaths may be working in fields

unrelated to osteopathy, may be practising as “manual therapists” and are thus not technically active as osteopaths or are currently practising overseas.

Gathering statistics from Australia was more complicated as osteopaths are not registered with a national board but with individual state or territory boards. There are six states and two territories in Australia and the equivalent number of boards. In some states osteopaths are registered under a joint chiropractic and osteopathic state board (for example South Australia and Tasmania). Statistics from these boards include chiropractor numbers and would not give a clear understanding of osteopaths who had left the profession or were currently inactive. After contacting the Osteopathic Board of Victoria, the assistant registrar, Pat Trubiano, informed me that there were 552 osteopaths registered in Victoria, but that the board did not distinguish between active and inactive (personal communication, July 19, 2007). However, the Australian Osteopathic Association (AOA) in an economic report estimated that approximately 95% of the 1,410 registered osteopaths in Australia are currently practising. There is no indication what this estimate is based on (IDA Economics Pty Ltd, 2008).

In the UK, data were gathered through personal correspondence with Carol Fawkes who is attached to the National Council for Osteopathic Research (NCOR) in London (personal communication, May 21, 2008). This data is presented in table 1.

Table 1 Osteopaths who leave the profession in the UK per year

Year	Number of osteopaths who had left the profession in the UK
2000-2001	17
2001-2002	46
2002-2003	48
2003-2004	111
2004-2005	81
2005-2006	116
2006-2007	106
2007-2008	142

Without having statistically analysed this data, a trend of increasing numbers of osteopaths leaving the profession appears evident over the previous 10 years. However, the increase in the number of osteopaths who are leaving may be relative to the increase

in the numbers entering the profession or the relative age of a cohort. As of yet unpublished preliminary analyses by the Exeter Research Group in the UK shows that 10-11% of new graduates leave the profession within the first two years of graduation (Fawkes, C., personal communication, May 21, 2008). However, according to the General Osteopathic Council (GOsC) in the UK, there were 250 graduates from osteopathic colleges in the UK in 2008 of which 199 registered with the GOsC (Buckingham, B., personal communication, March 21, 2009). Thus it would appear that the number of osteopaths entering is greater than the number of osteopaths leaving the profession.

According to two reports from the American Osteopathic Association (AOA) and American Association of Colleges of Osteopathic Medicine (AACOM) there are currently between 59,000-64,000 DOs in the USA (American Osteopathic Association, 2008; Levitan, 2007). Of these it is estimated that between 10-11% of DOs in the USA are inactive. However, it is not mentioned, nor reported, what this inactivity is due to.

The statistics collated above suggest that there are currently a proportion of osteopaths who are leaving the profession. There also is a proportion that is inactive, either working outside of clinical practice or not working in paid employment. From this preliminary look it is clear that maintaining a data base of practicing and non-practicing osteopaths varies between countries. The statistics that were available do show that there is a proportion of osteopaths inactive or that have left the profession in the USA, UK, Australia and New Zealand. There must be reasons for why osteopaths leave the profession, as the factors presented below show.

Extrinsic factors

Preparation for practice life

Education as an osteopath is intended to prepare the student for a career as an osteopath. This involves education in osteopathic philosophy and techniques but also includes preparation for the vast range of demands that an osteopath can experience such as the reality of practicing as an osteopath and the business aspects of running an osteopathic practice. A well-rounded osteopathic and clinical education is important because it

ensures that the public has access to competent and safe health care. For the student it is important because it enhances pre-existing skills and equips the individual with new skills that are necessary for the practice of their profession. It is not feasible to prepare the student for all possible situations that arise in clinical practice. What is possible is to educate the individual how to learn to resolve difficult situations involving either patients or situations related to practice life.

Reality shock

As outlined in chapter two, reality shock can be experienced by graduate nurses as they make the transition from their education programme to the working environment (Cowin & Hengstberger-Sims, 2006). Anyone who enters a new workplace may suffer from a reality shock or a sudden comprehension that their imaginings and perceptions of their new workplace had been different to the actual circumstances. What makes reality shock a potentially dangerous issue is when the mismatch between workplace expectations and reality is so great that the new worker re-evaluates their choice of career and decides to quit (Cowin & Hengstberger-Sims, 2006). While there is no research into this phenomenon within osteopathy, some of the participants in this study described experiences of reality shock upon first entering practice. As Courtney said:

...my understanding of the clinical experience when I left college was a very cocooned one and it was a very artificial one in many ways. People were saying, when you're out on your own you'll be doing this all by yourself, but until you actually do that, you don't actually appreciate it. (p. 11) – Courtney –

This quote illustrates that despite the clinical experience before graduation, practising in the “real” world is different. Prior to entering osteopathic practice the individual may have been unaware of what the daily practice life of an osteopath actually entailed. This may be because of the difference in practice in a student clinic to practise in a professional clinic. In order to resolve this issue Lindsay points out:

Perhaps an idea of what to expect long term, so maybe hearing... different osteopaths of 20 years practice, 10 years, five years, come in and tell us about their experience. That would have been really cool ... Or ten of us can go to that

person's practice and they're happy to talk to us in their morning tea. I think that would have been really valuable for me. (p. 18) – Lindsay –

Education can never completely prepare a student for the reality of a career. This theme reflects that prior to graduating and entering the profession, lack of exposure to practice life as an osteopath can lead new graduates to experience reality shock on entering working life.

Insufficient business training

For most practising osteopaths a large part of life as an osteopath is running a practice. Knowledge of how to run a small business is relevant when starting an osteopathic clinic. A lack of business education in their osteopathic degree was reported by five out of six participants.

I felt that we did not have anything in advance of leaving the BSO that talked about your life as an osteopath and how to deal with that from the business side. It seemed as though there was a really big gap there. (p. 7) – Courtney –

Not being prepared for the business aspect of practising as an osteopath was likened by Lindsay to “*putting somebody out there, into battle for want of a better word ... without any armour*” (p. 14). Participants reported not having sufficient business experience to make the right choices for themselves from a financial point of view. An example of this is this decision mentioned by Frances:

I was not business savvy enough at that stage and agreed to working in their second clinic. It was a new clinic and there were cash flow issues because it was a new clinic, you hardly saw patients there. That constituted about a third of my treating time. I'd say that came down to me not being business savvy enough to make the right decision and say “no” to treat at that clinic. (p. 7) – Frances –

Frances made a decision that adversely affected her financially. She was not equipped with the knowledge or experience that would have led her to make a different decision regarding the options she had. She may have said “no” to working there or negotiated an arrangement so that she was not economically disadvantaged working there. Again, it is not possible to equip every student for every possible situation that may occur in practice,

however, this theme illustrates that these participants were not prepared for the business aspect of osteopathic practice.

Lack of support in practice

Experiencing a lack of support was reported by four out of the six participants in this study. This lack of support caused these participants to feel increasingly isolated and alone. Osteopathic students practice in a student clinic environment where their decisions are supported and discussed with clinical tutors; this is the case in osteopathic colleges such as the one at Unitec in Auckland, Victoria University in Melbourne and the British School of Osteopathy in London. Once the new graduate enters practice, each individual osteopath treats each patient in isolation from their peers even if they work in a group practice. As Courtney said *“I think the issue for me was the fact that it was increasingly isolating ...although there were osteopaths around, it did still feel a bit like you were doing it in your own little bubble.”* (p. 9). Courtney experienced this isolation working in an environment with other osteopaths. This indicates that working with others does not guarantee professional support. As Courtney continued to explain:

...to be fair, the osteopaths in the practice were always available for if you had a problem, if you wanted to talk through a case, if you wanted them to pop into the treatment room and help. There was that there, but it felt as though there had to be a reason. (p. 10) – Courtney –

So as Courtney clarified, support was given when asked but was not forthcoming otherwise. Similarly Vic mentions:

You come out, you have no one to help you and it really struck me that it is very lonely working as an osteopath. Although you are with the patients all day, there is no one else, you do not have colleagues around you and I found it quite isolated. (p. 6) – Vic –

This illustrates the point that once a new graduate enters practice, there is very little support available for them to fall back on. A graduate can go from a supportive environment with clinical tutors and lecturers, to one where they have little or no support from the profession, professional organisations or senior osteopaths within their practice.

An interesting perspective on this theme relates to a lack of formal career paths. The medical, nursing or physiotherapy professions offer a graduate a number of formal career pathways. Medicine, for example, offers the graduate doctor a range of specialties or general practice options upon graduation. Within osteopathy there is a possibility of following a career in clinical practice, research or education. There is the possibility to specialise, for example, by treating only the young or old, only working with visceral, structural or cranial techniques, or specialising in veterinary osteopathy. However, within these career paths, there is no formal framework. As Courtney mentions:

The onus seemed to be very much on the students to go and forge their own career path, which I do not have an issue with, I think students should have responsibility for doing that. But it would be helpful if there was some kind of frame work... that they could fall back on. (p. 23) – Courtney –

What Courtney was identifying was that the lack of formal career pathways means that there is no formal manner of assimilating graduate osteopaths into an osteopathic career. In the medical profession, for example, a medical graduate can enter a hospital as an intern and there is a clear progression as an intern, resident, specialist and then consultant. There is a system of support that gives the individual an outline of what to expect in a career as a physician. This does not exist in the osteopathic profession. The lack of formality that exists in osteopathy may serve to attract autonomous types of people. These autonomous individuals desire independence from formality in their decisions on how they forge their career. It could be argued that the individual who desires a formal career pathway is not suited to the profession of osteopathy and may have wandered into the “wrong profession”. Equally the argument could be that some individuals require this form of support to progress in the profession and the profession is currently not supportive of these individuals. For those who require support that a career pathway offers, this may be a source of dissatisfaction. This is how the lack of a formal career path contributes to the lack of support for new graduates.

Uncertainty of income

Practising osteopathy as a career has the potential to provide a steady income. The manner in which an osteopath is paid is usually per patient. This means the more patients

that an osteopath sees the more they earn. However, the inverse also applies, if fewer patients are seen then financial income decreases. As Courtney describes:

One of the things that I didn't like ... was it was very much feast or famine, some months you'd be fantastically busy and there would be loads and loads of money ... I never ever dared really spend it because I was always waiting for the day when there would be no patients and it would be a nightmare.

(p. 13) – Courtney –

What this causes is an uncertainty of income. Income will fluctuate depending on how many patients one sees in a week and this also applies to taking holidays or sick leave. If the practitioner is not seeing patients, then there is no income. This means that if the osteopath is on holiday or takes sick leave, they “lose” the income they would have made had they been seeing patients. This is what Lindsay experienced:

The trap for me was that I could only work a certain number of hours a day and if we went off on holiday, a week here, or a week there, doing stuff that I really wanted to do, then the income would stop but the bills would still keep rolling.

(p. 8) – Lindsay –

While there is flexibility in working as an osteopath in regards to choosing when to work, this is limited by running a business that provides a service to patients. Part of running a business is delivering a better and more affordable service than competitors so that the public will want to come and consult you. For example, if you only work according to schedule that allows you take care of your children, this may limit you in your ability to provide a service to your patients. From this point of view, the work that you perform as an osteopath cannot be performed at “any old time of day” because you depend on patients being able to come to your practice at that time. The opening hours of your practice are dependent on when patients can come for an appointment. If it is not possible to open your osteopathic business at the optimum times for patients, this causes the business to miss out on possible revenue.

An aspect of this uncertainty of income relates specifically to raising families. While it is no longer the exclusive role of women to stay at home and take care of the children, this remains a possibility for many women. Anecdotally, it appears women are often told that

osteopathy is a great career because it affords a perfect opportunity for parental leave and it is possible to structure your work around your children. As one participant reflected:

I have two children and in terms of the stability that I now have with maternity pay and sick pay and annual leave and flexible hours and everything else, it fits much more than I thought it would, having children, being employed by someone else. When I was in college everyone used to say “oh being an osteopath is marvellous, self-employed and flexible for women with families. You can work as little or as much as you like”. But I don’t know that that is always the case. And I can remember when I was working in the early days when we were building things up, we had to work evenings and we had to work Saturday mornings, because that’s when patients wanted to come and see you. When you’re trying to build up the practice you’re not going to say no. And that isn’t always the best time when you’ve got young families. (p. 16-17) – Courtney –

This participant found that she was not able to choose her working hours because these were often dictated by the time that best suited patients. This experience would indicate that the times when osteopathic services are in demand, in the evening and on the weekend, interferes with family commitments. The practitioner may have to decide between the financial benefits of practising at these times or their family commitments.

Frustration with the scope of practice of osteopathy

Based on the definition by Chitty (2005), “a scope of practice is a set of legally established boundaries and guidelines, for the practice of any health care professions, to protect the public from health care professionals who exceed their education and competence” (p. 194). Osteopaths in the UK, Australia and New Zealand have very well defined and similar scopes of practice. The scope of practice for American DOs is significantly different to those of their osteopathic colleagues outside the USA instead having a scope of practice similar to physicians or medical doctors. One of the participants, Lee reported that while he felt his clinical training was excellent, there was very little opportunity to put this into use and this was very frustrating for him. Lee reported becoming frustrated with the level of clinical knowledge being taught in college

and the fact that applying most of it would be beyond the scope of practice of an osteopath. As Lee reflected:

I was getting frustrated by the fact that I was learning all this stuff and I did not think I was going to be able to use it. And to me, to have knowledge and then not to be able to translate that knowledge into something is a waste of time and I'm not the personality type who likes to waste my time. I wrestled with that component of the education very early on. (p. 7) – Lee –

What Lee was indicating here is that having being taught to a high level of clinical knowledge and competency and then not being able to use that knowledge caused great frustration. Lee had stated earlier in the interview:

I found that incredibly frustrating and incredibly limiting as far as being a professional went and I kept coming up against these cases all the time that I found as or more interesting than many of the musculoskeletal cases I had. But I couldn't pursue that any further without going to medical school. (p. 6) – Lee –

When Lee went into practice, this quote reflects that he did experience frustration at not being able to use the full set of his skills in osteopathic practice. This is an example where the scope of practice prevents the knowledge imparted by education from being applied in a practical manner. The issue here is complex and may lie with the education, the scope of practice or the manner in which osteopathy is practised. The high level of clinical education may be surplus to the requirements of practising as an osteopath. This is debatable because this level of clinical knowledge is arguably what makes osteopaths primary care providers. Being able to diagnose or recognise pathology increases the safety of what osteopaths do and also increases the likelihood that clinical issues are recognised in a patient. The issue of expanding the scope of practice of osteopathy is currently a point of debate within the osteopathic profession, especially around the issue of prescription rights (Burns, Kiatos, & Cameron, 2005; Grundy & Vogel, 2005). Also there is the possibility that clinical knowledge can be used or disregarded by the individual, depending on the how the individual may choose to practise osteopathy.

Issues of professionalism

In any profession it is important to develop and maintain a collegial network. A network is defined in Webster's dictionary as "the cultivation of productive relationships for employment or business" (Gove, 1981). This can involve getting to know others in the same profession or in related work. As osteopathy is such a small profession it is likely that all osteopaths in an area will be acquainted with those osteopaths working in the vicinity. This can contribute to the sense that as an osteopath you belong to an extended professional community. A network offers an avenue to share information between individuals. This can be beneficial for both patients and osteopaths, for example valuable clinical knowledge or osteopathic techniques can be shared through the community in this manner. Networks can also be used for unprofessional behaviour such as gossip or spreading information about members of the profession. This was Frances' experience when applying for positions at other clinics:

I was also trying to get work at other osteopathic clinics and I found the profession to be really "cliquey", in that when I told osteopaths who were interviewing me that I was already working they would call the principal osteopath and say do you know Frances is interviewing with us, have they told you? (p. 7) – Frances –

This quote illustrates the unprofessional use of a network. The issue is one of friendship versus professionalism. A friend would have their friend's interest in mind by informing them that their employee is seeking to leave their employment. As a professional, informing on the employee is unprofessional behaviour and violates the individual's personal discretion as to when they inform their employer that they are seeking alternative employment. As Frances aptly says:

There's a balance, there's professionalism and there's friendship and I think that within osteopathy, because of the cottage nature of the profession, that osteopaths are able to focus more on the friendship side than the professional. It's not to say that osteopaths aren't professional, because they are. But in terms of decision making, sometimes it's outweighed by the friendship nature of the profession. (p. 8) – Frances –

This quote illustrates that in this case, the balance between professionalism and friendship was weighted in the latter's favour. This experience caused Frances to feel excluded from the professional community, contributing to the total experience of the profession and to the eventual decision to leave.

Singular event as a catalyst to leave

For two of the participants, leaving the profession was preceded by a significant event(s). While one had been considering leaving already, it was a single event that precipitated the act of leaving. Frances experienced two such events that were pivotal in to the decision to leave the profession. However, the first of these events occurred at the beginning of his career. Early in her career Frances experienced sexual harassment by a fellow practitioner:

There was an incident where I was being treated by the principal osteopath and I believe and I strongly believe until this day that there was a bit of sexual harassment happening there, as in they were treating my wrist and they put my hand over their thighs and I think that was their crotch ... And so I quickly left that practice. I gave them a week's notice, being kind, I should have just left then and there (p. 7) – Frances –

Frances said, “*That was my experience of leaving, at the start*” (p. 13). This was the point in time when Frances felt that the process of leaving the profession began. This is interesting as it brings to light the concept that leaving may not be an instantaneous action but rather that it may be a process occurring over a period of time. This process as exemplified by the above example can be initiated by an event. For Frances the decision to finally leave the profession was after a second significant event where a conflict with colleagues in the clinic involving bullying occurred:

Within the last practice I was at I faced bullying by one practitioner and I tried to get around that by focusing purely on delivery of service to patients. But it got to me in the end. So I decided very quickly to leave the profession. I just had had enough of the unprofessional side of the profession (p. 9-10) – Frances –

Lindsay also experienced a specific event that led to the decision to cease practising:

What happened was everything came to a head in a fortunate way and I can say this now, it was particularly unpleasant at the time. Two others and I got knocked over while we were walking across a pedestrian crossing. A car was going reasonably fast and just wiped three of us out and I couldn't practise for 6 months because I had a complicated fracture of my clavicle. (p. 9) – Lindsay –

Despite the severity of the event, Lindsay views this positively in retrospect.

Being struck by that car was a very good wakeup call for me that it was time to do something new, which I probably never would have done if I hadn't have had that 6 months out to look at things. I'm really very grateful for that, in a funny sort of a way. (p. 19) – Lindsay –

This illustrates another interesting concept. Leaving a profession may be viewed as a positive experience in that person's life despite being precipitated by a severe event. Some view their careers as an osteopath as a valuable experience which taught them skills that they use in their current careers. For example, Courtney says:

Now whatever the problem is, I'm quite happy in terms of my decision making and problem solving approach. I will deal with what's in front of me and I'll make a decision and I'll stick with it and I will be accountable for that decision. I don't have an issue with that because I've been exposed to those situations where I've been left on my own in a treatment room with a patient thinking "right what am I going to do now?". (p. 14) – Courtney –

This quote illustrates that although a person may leave the profession they may look back on their tenure in the profession as a positive experience. It is possible that for these people they view osteopathy as a "springboard" that to further careers.

The decision to leave the profession may be influenced by factors that act on an individual from an external source. However, there are also factors which involve the person's personality and desires; these are not extrinsic but intrinsic factors.

Intrinsic Factors

Desire to explore other careers

In current times, it is considered normal to have many different careers over a working lifetime (Fisch, 2007). This may be because people do not feel the need to continue with a job that they do not enjoy or in Vic's case, there was simply a desire to do something different: *"I just wanted to do something that was good for the planet, which has been a motivation for a while and I wanted a regular office job."* (p. 3). As Vic went on to explain, this was a realisation that had been reached through working as an osteopath:

For me, I think it's just a personality type. I like order, I like organisation, I like certainty. And although that's why most people do osteopathy in the first place, to get away from that kind of thing, I've gone the opposite way. I didn't really have another job before osteopathy and just found that I didn't get on well with the lack of structure and very varying hours, evenings and weekends. (p. 2-3) – Vic –

What this is indicative of is that working as an osteopath can play a role in personal understanding and progress. Learning about personal strengths and weaknesses can be of great benefit when considering a suitable career. This demonstrates that those that leave may view osteopathy as a useful step towards another career.

Maturity, life experience and entering the profession at a young age

"One of the big drivers for me leaving was probably the fact that I just started it too young anyway." (p. 8) – Courtney –

In a profession that is based on helping other people, experience is of great benefit to the practitioner. This applies to experiences both in and outside the osteopathic profession. The sentiment that maturity and life experience contribute greatly to osteopathic practice was conveyed by five of the six participants. As Courtney said *"the perspective that they [mature students] are able to have and their experiences really help. Not just managing the business and the responsibilities that come with that but also in the way they approach treating patients."* (p. 8). Lacking life experience was perceived as a disadvantage by Courtney, who entered practice at the age of 22. This was also the case for Vic, who said in a similar manner:

At our college there were a lot more mature students and I think that does help, better people skills, more life experience. I think you carry more confidence into practice with you. I was relatively young, I was 23 or 24 when I went into practice and found it quite daunting. (p. 6) – Vic –

The five participants who talked about this had entered their osteopathic education either after a gap year or straight from a secondary education. One had a previous degree and worked in an office for a year prior to beginning his education. Lee was one of the participants who had started osteopathic college straight from high school. As Lee recounted:

You come out of high school and you haven't really had a chance as an 18 year old to think what is it that I really like to do in life? It's the one thing that I like about the American system, everybody goes and does 4 years of general college, you get the opportunity to choose a broad spectrum of subjects, have a good think about what it is you like to do in life and then you go off to grad school. And I didn't get that time to stop and think. (p. 16) – Lee –

This quote reflects a number of issues. Firstly, that there was not enough consideration prior to commencing an osteopathic degree whether osteopathy was an appropriate career choice. Secondly, the choice to become an osteopath may have been based on a poor or misinformed decision of what being an osteopath entails. Thirdly, as Lee said, “*people are so big on pushing you when you're 18, 'you've got to choose a good career, you've got to choose a good career'.*” (p. 16). The choice to become an osteopath was the default result of being pressured into a career. Lastly, while osteopathy (or anything else) may have been someone's choice of career at 18, this may change with time. All of these situations can contribute to a person's final decision to leave the profession, simply because they do not want to be an osteopath.

Lack of certainty, lack of evidence, lack of confidence

A common saying is that “osteopathy is part art, part science”. As in any art there is an element of uncertainty, compounded by the fact that osteopathic practice is concerned with a very uncertain element, the human being. Vic noted that in osteopathy it is, “*very difficult to pin down things and be sure and have certainty and that was just something*

that I personally just didn't get on well with." (p. 2). The uncertainty that Leslie experienced lay in whether he was the practitioner best suited for a particular patient:

One of the reasons that I found osteopathy challenging was always the thought: hang on, am I the best person for this? Might Joe Blogs up the street actually be better for this patient, or might it be that the chiropractor up the road, might it be that a physiotherapist might be better for this particular sports injury? There's actually no real way of identifying that, if you see what I mean? (p. 8). – Leslie –

For Leslie, the doubt caused by not being able to verify that what he was doing was appropriate for each patient, undermined his confidence in osteopathy and of his ability to practice as an osteopath. As Leslie said, *"if that's something you regularly think about, it can erode your confidence in the efficacy of what you're doing"* (p. 9).

As well as requiring the practitioner to embrace uncertainty on a daily basis, osteopathy is a profession that lacks a wide evidence base for its practice and many of the manual techniques that are used have not been validated by research as yet. Leslie said, *"I was not a 100% happy with practising as an osteopath in current circumstances ... with the evidence base that there was at that time."* (p. 25). Lee mentioned that he had problems accepting, *"The Greenman principles of segmental dysfunction that I just didn't agree with and just couldn't get my head around when I was at school."* (p. 8). The lack of certainty compounded by the lack of evidence caused a lack of confidence in what they were doing. This lack of confidence made it difficult for these participants to continue practising osteopathy.

Desire for greater financial reward

Osteopathy provides an opportunity to have a career as well as to support oneself financially. However, the level of financial reward needed or wanted may exceed what can be achieved through an osteopathic business. While it may be possible to earn more by working more, this can put the individual at risk of increased stress and burnout. As Lindsay's statement aptly illustrates:

I was working about 80-85 hours a week. I've got big goals in my life and felt that if I just worked long enough hours I could get there, which is a complete

trap, it didn't work ... And I just got really tired and I was starting earlier, finishing later. (p. 8) – Lindsay –

Lindsay continued on to say, “*it was a trap, if I didn't go onto that production line every day, I didn't get the money to be able to do what I wanted to do.*” (p. 11). Despite considerable effort from the practitioner, the manner in which the practice was set up meant that it did not provide the financial remuneration that Lindsay required for the lifestyle that she desired. In clarifying what she had said, Lindsay said “*it's not osteopathy, if I had had any job it would be the same, if I had any traditional business it would be the same*” (p.11). For Lindsay a large factor in ceasing to practise was the insistence on a level of financial return that an osteopathic practice was not able to provide.

Boredom with osteopathic practice

In the practice of any profession, there is always an element of repetition. It could be the routine with which one examines a patient or applies a treatment technique or the paperwork that is involved in running a practice. As with anything that requires repetition there is the risk of boredom. The possibility exists that through following the same routine or style of practising the practitioner becomes bored with their work. Lindsay says:

What I found, even though it was very satisfying work, is that I would treat somebody and obviously I'd see them the next month or the next 6 months if they were not fine by then and it would be a similar problem. So I'd feel like I was on a factory line, just doing the same thing, day in, day out. (p. 10-11) – Lindsay –

For Lee, boredom was a significant factor for leaving osteopathic practice:

I actually think the thing that drove me out of osteopathic practice was sheer and utter boredom, in the end. It was just a lack of stimulation. It was a feeling like I was doing the same thing, over and over again. I had days when I came to work very engaged and I had days where I came to work not so engaged and I didn't feel like my treatments were any different, I didn't feel like my outcomes were much different. (p. 9)

For Lee, boredom was experienced as lack of stimulation that came with repetition. As he said, *“It’s just I didn’t get the stimulation that I needed out of it.”* (p. 14). This is an example of how in order for a job and career to remain interesting and engaging, it needs to stimulate and challenge the individual. If the individual becomes bored with a job then there is a possibility that they will decide to leave.

Burnout

While the factors above have been categorised as either extrinsic or intrinsic, burnout is a factor that could not be classified under either category. Burnout has been well-documented amongst health care workers (Scutter & Goold, 1995; Wolfe, 1981) and has been the subject of a research thesis in osteopathy (Webbe, 1999). Burnout as defined by Maslach and Jackson (1981) is *“a syndrome of emotional exhaustion and cynicism that occurs frequently among individuals who do ‘people-work’ of some kind”* (p. 99). As Webbe (1999) showed, osteopaths also experience burnout albeit less than their medical and nursing counterparts. Burnout in the context of this study is seen to be caused by a combination of intrinsic and extrinsic factors. While burnout was not measured using any validated research tools, it would appear that it did play a role for some of the participants in their decision to leave the profession.

When Lee was reflecting on why he left the profession he said, *“I foolishly tried to do a miniature root cause analysis on ‘why did Lee get sick of being an osteopath’ and I thought ‘I was sick of dealing with people, sick of patients’.”* (p. 9). One aspect of burnout is negative, cynical attitudes and feelings about one's clients as well as fatigue (Maslach & Jackson, 1981). As described earlier in this chapter, Lee mentions being frustrated by the scope of practice of osteopathy as it did not allow him to fully utilise the clinical knowledge that he was taught in his education. As described in Chapter Two, one of the causes of burnout is ‘qualitative underload’ where an individual is unable to fully use their training either due to time constraints or by limitations placed upon them by an organisation or profession (Wolfe, 1981). Also Lee stated that boredom played a large role in his decision to cease practising. As Wolfe (1981) describes, boredom has been shown to be a precursor to burnout. From these statements, not wanting to deal with

patients, experiencing ‘qualitative underload’ and boredom, it is very possible that Lee was experiencing some level of burnout which influenced his decision to cease practising.

One of the primary precursors to burnout, as mentioned in Chapter Two, is an inability on the behalf of the individual to perceive success in the treatment of their patients. Courtney’s statement aptly illustrates this point “*When patients don’t get better or get worse, you can’t take that on yourself, but I can certainly remember feeling as though that was happening*” (p. 14). Courtney was aware of taking this upon herself, but nonetheless she still did take it on herself, thus it possibly contributed to burnout. When patients do not improve or get worse, the practitioner may increase their work effort or the amount they contemplate a patients case, as Courtney’s says:

I used to spend an awful lot of time worrying... I used to leave the practice and on the train on the way back home, I’d be thinking ‘Oh I haven’t done this, did I do that, have I not done that’. On more than one occasion I phoned the practice to say ‘can you just put a note on the case notes to say X, Y and Z’ and it made me feel very uncomfortable and that wasn’t particularly healthy.

(p. 14) – Courtney –

The increase in work effort may be without a resultant increase in efficiency. Leaving “work at work” as a form of self-care described by Wells (2005) is something that new graduates often do not do. Worrying about work-related issues outside of work caused Courtney to experience more stress. Another example is provided by Vic who reported that even outside of work hours it was difficult to “switch off”, “*because my patients would have my mobile number, I would make appointments, you know, all the time*” (p. 2).

While none of the participants mentioned burnout specifically as a reason for why they left the profession, it is likely that some were experiencing some level of burnout when they were left. This leads to the conclusion that burnout, due to both intrinsic and extrinsic factors, is a contributing factor in the decision to leave the profession.

The overarching theme – the process of leaving

The overarching theme that brings all of the abovementioned themes together is that leaving is not a singular event but a process. It is a process that occurs over a period of time and is due to and influenced by both intrinsic and extrinsic factors. The final culmination of this process is the act of leaving the profession and cessation of practise. For some participants leaving was due to a distinct event, an active decision or life circumstances that caused them to leave and not return to practise.

Throughout the interviews, all of the participants discussed various factors for why they left the profession. For example, from analysing and interpreting Courtney's interview, reality shock, lack of support in practice, uncertainty of income, maturity and life experience and burnout contributed to leaving the profession. There is, however, no reference to any one as the reason for leaving. Courtney said that when the decision to cease practising was made:

...it wasn't a monumental, right, that's it, take off my clinic coat and hang it up and walk out. It was just I needed to have some time to do other stuff and see what happens ... there wasn't an active decision not to go back, I think the passage of time makes it increasingly difficult to go back. (p. 12) – Courtney –

So for Courtney leaving the profession was not the result of an active decision. For Courtney the interplay of these factors led to taking time off and subsequent life circumstances then have not led to a return to practising osteopathy.

Another example is that of Vic, who realised “*by year three when we went into clinic, I was thinking at that stage, this is not really what I want to do for the rest of my life* (p. 3-4). The process of leaving began for Vic whilst she was still in her educational programme. On reflection Vic said “*gradually I'd not been happy and I think having changed I realise now, I was quite unhappy for quite some time*” (p. 7). From interpreting the data in Vic's interview, factors such as a lack of support, maturity and life experience, lack of certainty and some level of burnout all contributed to leaving the profession. When Vic finally left, unlike Courtney, it was because of an active decision to do so:

I had a sort of New Year's Eve crisis where you sit and evaluate everything and think, 'I don't like this'. I had a bit of a meltdown ... thought I have to change something and then pretty quickly after that I thought, 'right I've got to focus on something different, find something else that I'm interested in and want to do and feel I'll be good at'. So that's how that worked. (p. 7) – Vic –

So while both Vic and Courtney experienced a variety of factors occurring over a period of time, the way they left the profession was different. For Vic it was an active decision, for Courtney it was a passive decision.

As both the examples illustrate, leaving is the result of the interplay between intrinsic and extrinsic factors coupled with life circumstances, occurring over a period of time. When an individual does leave the profession or ceases to practise, they can do so either actively or passively.

Summary

This chapter has presented the findings of the study into why osteopaths leave the profession. Statistical data were gathered from the USA, UK, Australia and New Zealand regarding osteopaths leaving the profession. Six osteopaths from the UK, Australia and New Zealand were interviewed. Each participant has left the profession due to various reasons, but shared common experiences in the process of leaving.

The retrospective review revealed that overall there is little “hard” data available regarding how many osteopaths leave the profession in the USA, UK, Australia and New Zealand. Overall there is very little data available regarding this phenomenon. The data most often relates to inactive osteopaths and this is usually an estimate rather than a reliable fact.

Reasons for leaving the profession can mostly be divided into extrinsic and intrinsic factors. Extrinsic factors act on the osteopath from sources outside of themselves. Intrinsic factors relate to the individuals personality and suitability for the practice of osteopathy: factors that come from within the person.

Extrinsic factors can involve education such as a lack of preparation for practice life, which can cause reality shock or insufficient business training. There were also factors that related directly to the practice of osteopathy such as a lack of support in practice, uncertainty of income, frustration with the scope of practice of osteopathy and issues of professionalism. Singular events that occurred to the practitioner also influenced the decision to leave the profession.

Intrinsic factors which relate to the person themselves include maturity, life experience and entering the profession at a young age, a lack of certainty, lack of evidence and a lack of confidence, the desire for greater financial reward and boredom with osteopathic practice.

This chapter has identified some data regarding osteopaths' inactivity and leaving the profession in the USA, UK, Australia and New Zealand as well as a number of factors that are responsible for osteopaths leaving the profession. In the next chapter the literature associated with medicine, nursing, physiotherapy and osteopathy are compared and contrasted with the findings of the retrospective data review and the findings described in this chapter.

CHAPTER FIVE – DISCUSSION AND CONCLUSION

Introduction

This chapter discusses the key findings for why osteopaths leave the profession and compares them with literature from medicine, nursing and physiotherapy and the limited literature from the osteopathic profession. The limitations of this study are discussed as are the implications for the profession. Avenues for further research are proposed. This chapter finishes with the concluding thoughts for the dissertation.

Review of the findings

Most of the findings are corroborated by the literature as occurring in one or more healthcare professions, some findings were unexpected and may represent factors that are unique to osteopathy. These factors relate to osteopathic education or to the practice of osteopathy. The main theme, that leaving is a process, strongly suggests that leaving the profession is the final result of a process occurring over a period of time. It is a decision influenced by personal choices, osteopathic education and practise and important events. The themes in Chapter Four were categorised as extrinsic and intrinsic factors. Burnout was considered to be a result of the interaction between intrinsic and extrinsic factors. The interaction of these factors over time contributed to these participants deciding to leave the profession.

Comparison with the literature

As discussed in Chapter Two, the reasons why osteopaths leave the profession is a previously underexplored area of research. Consequently, research literature from a range of healthcare professions was reviewed and used as a resource.

This study supports the findings of de Jager (1998) who conducted a quantitative survey investigating why osteopaths had left the profession in the UK. Many of de Jager's findings are consistent with the sentiments expressed by the participants in this study such as professional isolation, boredom and financial instability. The one finding in de Jager's study absent from this research was that none of the participants mentioned raising a family as a reason for leaving the profession, although one participant did cite this as a reason for not returning to practice. This is very likely because those participants who were on parental or maternity leave were excluded from this study whereas those individuals were not excluded from de Jager's study.

Shortage of health care professionals

Through the retrospective review no statistical data were found that supports the claim that osteopathy is experiencing a shortage of qualified professionals. Osteopathy as a profession is not consistent worldwide and there is little international exchange of information which makes gathering statistical data regarding osteopath numbers difficult.

This is in contrast to what is being presented in the literature regarding medicine, nursing and physiotherapy. The medical profession is experiencing a specific shortage of primary care physicians such as general practitioners (Buddeberg-Fischer et al., 2006; Home Office, 2008). The nursing profession is reporting a shortage of workers mainly in Sub-Saharan Africa but also in the USA, Europe, Australia and New Zealand (Buchan & Calman, 2004; Department of Education Employment and Workplace Relations, 2008b; Janiszewski Goodin, 2003; Kim, 2009; Williams et al., 2001). In physiotherapy there is a shortage being reported in the USA, Australia and NZ (American Physical Therapy Association, 2008a, 2008b, 2008c; Department of Education Employment and Workplace Relations, 2008a; L. Taylor, 2008).

There may be two reasons why there is no shortage being reported for the osteopathic profession. There simply may not be a shortage, hence it is not being reported or it may be there is a shortage without the profession being aware of it. There are over 100 osteopathic schools worldwide, suggesting that the optimum level of practitioners has not been reached yet. The proliferation of osteopathic schools that has occurred may be due to an increased demand for osteopathic healthcare practitioners or because osteopaths are

filling the vacuum of primary care practitioners created by the shortage of primary care physicians.

Osteopathy is a small profession, especially in comparison to nursing and physiotherapy and thus it could be considered to be in a perpetual state of shortage. This shortage is a numerical one, as the osteopath-to-population ratio is very low in most countries. For example, in NZ there are currently 427 osteopaths of which only 357 have active practising certificates (Fitzgerald, M., personal communication, July 17, 2007) and there is a total population of 4.3 million people (Statistics New Zealand: Tatauranga Aotearoa, 2009). This means the osteopath to population ratio is roughly 0.8:10,000. In Australia there are 1,410 osteopaths (IDA Economics Pty Ltd, 2008) and a population of 21.5 million (Australian Bureau of Statistics, 2009) meaning that there is a ratio of 0.7:10,000. In comparison, in New Zealand about 45,600 nursing practice certificates were issued in 2007-2008 (Nursing Council of New Zealand, 2008) meaning there is a nurse:population ratio of 106:10,000.

In order to place these ratios in perspective, both the osteopathic ratios in New Zealand and Australia are less than the nurse:population ratio in Uganda of 6:10,000 where there is a large numerical shortage of nurses. Of course, as osteopathy and nursing fulfil very different niches within healthcare, this is not the most meaningful comparison. Unlike the other professions cited, there is no understanding of what is the optimum ratio for osteopathy and it is therefore not possible to conclude a shortage based on these ratios.

The transition from student to practitioner

A large number of factors in relation to leaving the profession appear to relate to the transition period from osteopathic student to osteopathic practitioner.

The findings of this study show that some participants experienced a lack of preparation for practice life which resulted in reality shock. Reality shock has been well documented in the nursing profession since the term was coined by Kramer (1974). Kramer proposed that reality shock was a reason for nurses to leave the profession and referred to reality shock as the feelings of bewilderment which students experienced when their expectations did not match the realities of the real world. While no mention of this phenomenon could be found in the osteopathic literature the concept of reality shock is a

continuing topic of research in the nursing profession (Cowin & Hengstberger-Sims, 2006; Ross & Clifford, 2002). Reality shock has been found to cause a lack of self-confidence and self-esteem in newly registered nurses (Ross & Clifford, 2002). Cowin and Hengstberger-Sims (2006) describe reality shock as the comprehension that the reality of the workplace is different from which had been imagined or expected. Whether reality shock was the direct cause of any of these participants leaving the profession is not clear, what is clear is that some did experience a mismatch between expectations and reality. The stress that this caused may have played a role in these participants leaving.

The finding that a lack of business training is a factor involved in leaving the profession may be unique to this study, as there is no mention of this in the reviewed literature. While an unexpected finding, it is not unreasonable. Running a practice depends on sound osteopathic knowledge and application with good results as well as a solid foundation in small business management. Therefore it is possible that due to poor business acumen a proportion of osteopaths are disadvantaged financially and they are not successful. The possibility that osteopaths may leave the profession because their businesses fail and they are unable to make a sufficient livelihood is cause for concern.

The finding that some participants felt unsupported in clinical practice correlated with findings reported within the medical and nursing professions (Beedham, 1996; Wai Chi Tai et al., 1998). As Vic said:

...it's the lack of confidence when you first graduate and you come out and you've got no one to help you. It really struck me that it is very lonely working as an osteopath. Although you are with the patients all day, you don't have colleagues around you and I found it quite isolated. (p. 6) – Vic –

The lack of support felt in practice is accentuated by having left an environment of a student clinic where support from clinical tutors and lecturers is readily available. Outside the USA, where osteopaths practise in a manner similar to medical physicians, there are no mandatory supervisor or mentor programmes in the osteopathic profession. This is unlike the nursing profession where supervision programmes are well established (Butterworth, Bell, Jackson, & Pajnikihar, 2008). In their review of nursing supervision literature, Butterworth et al. found reports that clinical supervision increased nurses' self-confidence, self-awareness, thought processes, job efficiency and satisfaction. It also

improved their coping mechanisms, professional and personal relationships and decreased the sense of professional isolation. They suggest that, “structured opportunities to discuss case related practice, personal and educational development are vital to nurses, their practice and patient safety” (p. 270). Another potential benefit generated by clinical supervision is that of improved care of patients although this has proven difficult to demonstrate (Butterworth et al., 2008). Supervisor support has also been found to reduce the likelihood of nurse turnover (Wai Chi Tai et al., 1998). For junior nurses, clinical supervision is a valued form of support in their first years of practice (Teasdale, Brocklehurst, & Thom, 2001). This lack of clinical supervision in osteopathic practice may contribute to feelings of professional isolation and lack of support. As Courtney said:

...it is such a small profession, people know people and there is the opportunity to make contact and speak with friends and colleagues...but to actually formalise it more and to have the structures whereby that help is available.

(p. 21) – Courtney –

The lack of support extended to the reaction or non-reaction of fellow osteopaths when individuals did leave the profession and there was no official attempt by an organisational body to discover why they were leaving the profession. Courtney said, “*I suppose the feeling is, ‘Well the profession is not actually that bothered if you are no longer part of the profession’.*” (p. 18). Another example is Lindsay’s experience, “*a lot of my peers thought I was completely nuts and sort of looked at me slightly nervously and backed away, in fact I was shunned by some osteopaths.*” (p. 15). Both these examples illustrate that there has been little interest in osteopaths who leave and that there is little understanding as to why they leave. When there is poor understanding, the phenomenon of leaving may be seen to be a threat to the validity of osteopathy as a profession and the individual as a member of that profession. It may cause individuals to wonder, “What is wrong with osteopathy that caused that person to leave?” The result of this perceived threat may lead people to react by distancing themselves from the person who left. The knowledge of why osteopaths leave the profession may prevent leaving as being seen as threatening.

Frustration with the scope of practice of osteopathy was an unexpected finding as this is not referred to in the reviewed literature. However, on further searching of the literature it

correlates with the current debate within the profession regarding expanding the scope of practice to include prescription rights (Burns et al., 2005; Grundy & Vogel, 2005). Both Burns et al. and Grundy and Vogel investigated the attitudes of osteopaths to prescription rights in Australia and the UK respectively. Both studies found that their participants were divided on whether this would be beneficial or detrimental to osteopathy. Some participants felt that osteopathy was a complete system of healthcare that stands as an alternative to orthodox allopathic medicine and that prescription rights would detract from osteopathy. Another participant in Grundy and Vogel's study, while agreeing that osteopathy was a complete system of health care, argued that there was room for prescription rights as prescriptions could be made according to osteopathic philosophy. Lee's quote from the current study aptly illustrates one side of this debate: "*Our profession would be perfect to me if we had not necessarily full practice rights but extremely expanded practice rights to the point where we had at least full prescription rights within the realms of treating musculoskeletal cases*" (p. 14). There are two possible ways in which to view this debate. It could be argued that there is room for osteopathy to evolve and these individuals, through their frustration with the scope of practice, are attempting to drive this evolution. On the other hand, the argument is that osteopathy is complete as it is and those individuals who desire an altered scope of practice have wandered into the "wrong" profession. While this view may hold some merit, when considering the concept of a "wrong" profession in the context of leaving the profession, this is a simplistic viewpoint of a complex phenomenon. A more appropriate statement is that there may be a time when practising osteopathy is no longer the "right" profession for that individual. Once they realise that they are not in the "right" profession they may then decide to leave.

Change – The decision to leave practise

The concept of leaving as a process was not expressed in the reviewed literature. This hypothesis suggests that the final act of leaving is preceded by a period of time in which the individual experiences influences from both extrinsic and intrinsic factors and events and that this can lead to dissatisfaction as well as causing burnout. The actual decision making process is unclear and evidently personal to each individual but what is clear is that leaving the profession is a significant change, considering the effort that was taken by

that individual to become an osteopath and to continue to practise. Morrison (1998) states that change occurs when there is a felt need and reviewed formulae for change as relating to management and organisations. The discussion centres around the Formula for Change proposed by Beckhard and Harris (as cited in Morrison, 1998):

$$\text{Dissatisfaction (D) x Vision (V) x Knowledge of first steps (K) > Resistance to change (R)}$$

This formula proposes that change will occur when D (dissatisfaction with the current situation), V (desired vision for the future) and K (knowledge of the first steps needed towards change) exceed R (resistance to change or inertia and complacency) (Morrison, 1998, p. 18). The key to this formula is dissatisfaction, without which there would be no need to change. Dissatisfaction as a factor for leaving a profession is well documented in many healthcare professions (Flinkman et al., 2008; Landon et al., 2006; McCarthy et al., 2007; Wai Chi Tai et al., 1998; Williams et al., 2001) and is not specifically mentioned by the participants in this study as a factor as to why they left. However, when considering some of these factors and events, it is reasonable to conclude that some of them resulted in dissatisfaction. For example, when Leslie discussed being unhappy with the level of evidence base for osteopathy, this could be interpreted as a sign of dissatisfaction with that aspect of the profession. Another example is where Lindsay desired a higher level of financial income and was therefore dissatisfied with the level of income from practising osteopathy. It could be argued that the dissatisfaction created by these factors was needed in order for the participant to create a change; in these cases the change was leaving the profession. Beckhard and Harris' formula (also called Gleicher's Formula) by itself does not predict leaving the profession; instead it only predicts that a change will occur. What causes an individual to decide that the change will be leaving is something that cannot be concluded based solely from the results of this study. The insight provided by this study strongly suggests that the nature of the events and factors that are experienced as well the individual's personality, desires and satisfaction with the job will play a role in why they choose to leave the profession.

Limitations of this research

This study was a qualitative exploratory study into an under-researched field, based on experiences and opinions of a small sample of purposively selected individuals and therefore cannot be generalised across the osteopathic profession and to all those who leave the profession. A small sample size was appropriate because of the exploratory nature of this study and the use of interpretive description. Anecdotally and through discussions with supervisors, lecturers and clinical tutors, it had been established that osteopaths do leave the profession. This research project was then designed to discover what statistical data were available worldwide regarding osteopaths leaving the profession and to gain an understanding of why osteopaths leave the profession.

The lack of experience that the researcher had conducting semi-structured interviews was another limitation in this study. Due to my inexperience with the interview process there were some lost opportunities for information gathering. An example is that there were no questions asked regarding self-care practices. While this research was not investigating self-care practices, these have been shown to be effective in preventing burnout (Wells, 2005) and burnout was a factor in why some of these participants left the profession. However, self-care was not the topic of investigation and while it may have provided relevant data for consideration, the absence of this data does not detract from the findings of this study. Because of the lack of research into this field, all information that is relevant to the subject is useful and can be expanded upon or critiqued in future research.

Implications and recommendations for the profession

This research has implications for educational institutions, for professional bodies and for individual osteopaths.

Education

Entry into the osteopathic profession is through an educational programme. These educational programmes are well placed to ensure that those factors that can be addressed through education are covered in the selection of students and in the curriculum.

Selection criteria could be developed to ensure that those selected for a career in osteopathy are suited to it. While current requirements focus mainly on academic criteria, there is a need for criteria regarding suitability for osteopathic practice. This might include requiring that each potential student complete a defined period of time observing at an osteopathic clinic before commencing education, to ensure that they are aware of what they embarking upon.

Courses or modules could be incorporated into the curriculum that focuses on preparing the student for practice and increasing the chances for longevity in the profession. Preparation involves equipping individuals with the skills and knowledge that will be necessary to practise as an osteopath. This includes osteopathic knowledge but also includes business knowledge and the importance of self-care practices as a method to reduce stress and burnout. Another possibility is that students are made aware that support is important in practice. A form of ongoing support after graduation could be provided by a peer support network through the education facility.

Professional bodies

Professional bodies include the regulatory and societal organisations. These organisations are well situated to provide support for practising osteopaths. They could run mentorship programmes or insist on compulsory supervision. Such a programme would not only provide support for new graduates but also provide a valuable opportunity for ongoing education. Currently however, the profession is not sufficiently cohesive to make this a reality. Because of the many schools of thought within the osteopathic profession and large variations in the manner in which osteopathy is practised, it is difficult to determine what would constitute appropriate supervision. Other support could be given by peer groups, which some organisational bodies already offer. These organisations are well-situated to gather statistical data and form international connections with other osteopathic organisational bodies to share this data. Information regarding practising and non-practising osteopaths could be gathered and an exit-interview or survey could be conducted when an osteopath leaves the profession.

Individual osteopaths

This study provides an understanding of what can cause an individual to leave the profession. This is of benefit to the individual osteopath because understanding why osteopaths leave the profession is a first step towards addressing the applicable factors, bearing in mind that not all those who leave the profession need to be “saved”. This understanding may also mean that those who are considering leaving are supported in their decision by their osteopathic peers. Lastly, the findings described in this dissertation may be recognised by some individuals as affecting them in their practise. Hopefully this will show them that they are not alone in experiencing these issues.

Further research

As identified in Chapter Two, de Jager’s (1998) study is the only study in the osteopathic literature looking at reasons why osteopaths leave the profession. De Jager found that there were osteopaths who had left the profession in the UK and detailed the reasons for leaving. Two research studies do not fill the gap that exists regarding the phenomenon of osteopaths leaving the profession and there are many related areas that can be investigated. These areas include researching why osteopaths remain in the profession, job satisfaction, reality shock, support and burnout. Quantitative studies into whether there is a shortage of osteopathic practitioners and the scale of osteopaths leaving the profession are also warranted.

While this study has provided insight into why osteopaths leave the profession, the reasons for why osteopaths remain in the profession have not yet been elucidated. It is possible that other osteopaths have experienced similar events and factors as those described in this research but are still in the profession. A better understanding of why these osteopaths remain in the profession is needed. It is possible that the absence of reasons to remain in the profession causes individuals to leave. Therefore a study into why osteopaths remain in the profession would be valuable not only for its own merit but also to provide further insight into what contributes to leaving the profession.

A motivation for osteopaths to remain in the profession could be the satisfaction that they gain from practising osteopathy. As discussed above, according to the Formula for Change (Morrison, 1998) dissatisfaction is required before a change will occur. However, unlike in other professions cited, little is known about what creates job satisfaction for osteopaths. It is possible that there are aspects to osteopathic job satisfaction that differ from the other professions. Therefore there is room for further study into what contributes to osteopaths' job satisfaction.

The participants in this study, with one exception, left the profession within five years of graduation. This correlates with the finding that physicians who leave medicine usually do so in the first five years of practice (Goldacre et al., 2001). Wells (2005) hypothesised that burnout in new graduates may be commonplace. From the findings in this study the transition period into the profession seems to be a time in which many factors affect the individual to cause them to leave. Therefore research into those factors that occur in this time period would be valuable. This includes research into reality shock, support systems such as mentor or supervision programmes and burnout. All these factors appear to have the potential to influence a person's decision to remain in or leave the profession and therefore research into these factors in the profession of osteopathy is recommended.

Statistical data regarding the phenomenon of leaving the profession and a shortage of osteopathic practitioners were difficult to collate. It is currently unknown if the osteopathic profession is experiencing a shortage of practitioners. Further research into this area is highly recommended as well as the collation and analysis of the numbers of osteopaths who leave the profession internationally.

Summary

The current study's participants support some of the findings by de Jager (1998) as to why osteopaths choose to leave the profession. Differences in the findings are due to the exclusion criteria of this study, specifically focusing on excluding those osteopaths who had left for parental leave.

It cannot be concluded from this study that osteopathy is currently experiencing a shortage of professionals. There is at present no shortage being reported in the literature unlike in other health care professions. It is distinctly possible that there is an actual or numerical shortage of osteopaths, as exhibited by the low osteopath-to-population ratios and the proliferation of osteopathic colleges. However, a shortage cannot be concluded from this data alone.

Many factors and events that contribute to the decision to leave the profession occur during the transition period from student to practitioner. These include a lack of preparation for practice, lack of support for new graduates and a frustration with the scope of practice of osteopathy. This lack of preparation can cause reality shock. A lack of business training can create stress for a new graduate and may affect their financial decision adversely. Going from an environment of great support to one where there is little or none at all can enforce the experience that osteopathy is practised in isolation. This lack of support means the individual has nothing to rely upon when faced with difficult situations or situations that they feel are beyond their experience and skill to handle. Frustration with the scope of osteopathy represents a point of dissatisfaction with osteopathic practice.

Dissatisfaction is a large factor in why individuals or organisations change. Change can and will likely occur when dissatisfaction with the current situation, a vision of what would create satisfaction and the knowledge of how to attain that vision are greater than the resistance to change. Dissatisfaction may also mean that osteopathy is no longer the “right” career for that individual.

The limitations of this thesis relate to the method used in this study and the personal inexperience of the researcher in conducting research. The qualitative method which was appropriate for this exploratory study limits the findings to the participants in this study and cannot be generalised. The personal inexperience of the researcher meant that there were missed opportunities during the interviews for collecting information related to self-care practices.

This study has implications specifically for educational institutes, professional organisations and individual osteopaths. Educational institutes can implement selection criteria that focus on suitability for an osteopathic career, however as yet there is not clear

understanding of what these criteria are. They can incorporate into their curriculum courses that equip the student with skills and knowledge meant to increase longevity in the profession such as self-care practises and business training. Professional organisations are recommended to provide greater support for new graduates. This support would reduce the impact of reality shock as well as providing a valuable tool for ongoing education. They are also well situated to collect data and statistics on practising and non-practising osteopath numbers. For the individual osteopath, this research gives insight into what can cause a person to leave the profession and may alert the person that they themselves are experiencing some of these factors.

Further research is recommended into why osteopaths leave the profession as well as related factors. These are: why do osteopaths remain in the profession, job satisfaction, reality shock, support, burnout and quantitative investigations into the whether a shortage of osteopathic practitioners is occurring.

Concluding thoughts

The aims of this study were realised. Data relating to osteopaths leaving the profession were reviewed from the USA, UK, Australia and New Zealand. This retrospective review showed that there is a scarcity of statistical information about how many osteopaths leave the profession. The reasons why osteopaths choose to leave the profession were explored and shown to comprise of factors and events that an individual experienced during their time in the osteopathic profession.

That osteopaths do leave the profession is clear from the retrospective review findings. What is not clear is whether this is a “natural” attrition rate from the profession or whether this constitutes a problem. The profession is increasing in size and so there can be an expected increase in the relative numbers of osteopaths leaving.

Leaving the profession is the result of a process that involves factors that act upon (extrinsic) and from within (intrinsic) the individual and specific events. The decision to cease practising and leave is the result of this process and the accumulation of extrinsic and intrinsic factors, a specific event or a combination of both. While some of these factors are described in the literature for other health care profession, some factors appear unique to the osteopathic profession.

Some of the findings described in this research can be addressed through education programmes and ongoing support. Selection criteria could be implemented that focus on the individual’s suitability for an osteopathic career and courses could be introduced into the education curricula of osteopathic colleges that improve the chances of longevity in the profession, such as education on self-care and business.

Some participants left because they no longer felt that osteopathy was the “right” profession for them. These individuals look back on their time as an osteopath as a beneficial experience that provided them with skills that they use in their current careers. For these individuals it was simply time to move onto another career. Perhaps it is of some concern, but not something osteopathy can do much about. However, what is particularly concerning is that individuals do leave for reasons that can be addressed, such as lack preparation for practice and lack of support. The profession owes it to these

individuals and to itself to implement change in order that the valuable education and experience are not lost.

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APPENDIX A – EMAIL TO OSTEOPATHS ON GOSC
REGISTER

Dear Sir/Madam,

My name is Andre Kleinbaum and I am currently completing my Master of Osteopathy at Unitec New Zealand in Auckland, New Zealand. I am writing to you about the research project that I am currently undertaking as part of my degree.

The research involves interviewing osteopaths who have chosen to leave the profession. There is a lack of information regarding this topic and it would be beneficial to the profession in a number of ways to understand more about this phenomenon.

I would be grateful if you could think of any colleagues or persons you trained with who have left the profession. If so, would you please send me their contact details so that I may contact them personally.

Any information you could provide me with would be much appreciated.

Please note, the research project has been approved by the Unitec Research Ethics Committee.

If you have any queries please do not hesitate to email me at this email address or my supervisors (supervisors name and contact details omitted from the examination copy)

Thanking you in advance,

Yours sincerely,

Andre Kleinbaum

APPENDIX B – INFORMATION SHEET



Information for participants

Project Title

Why do osteopaths choose to leave the profession?

Introduction

My name is Andre Kleinbaum and I am currently enrolled in the Master of Osteopathy programme in the School of Health Science at Unitec New Zealand. I am seeking your help in meeting the requirements of research for a thesis course which forms a substantial part of this degree. If you agree to be a participant in this study then please contact me on (email address omitted for examination copy)

What is the purpose of the study?

The aim of this study is to explore the reasons behind the decision that qualified osteopaths have made to leave the profession before retirement, specifically to pursue another career. There is a lack of research into this phenomenon and it is hoped that this study will provide some insights into those issues that may lead to an osteopath leaving the profession. I hope that the results of the study will be of use to individual osteopaths, to professional bodies and to educational institutions.

What it will mean for you?

I would like to interview you about your experience of leaving the osteopathic profession. If you agree to participate, you will be asked to sign a consent form. This does not stop you from changing your mind if you wish to withdraw from the project. However, because of my schedule, any withdrawal of data must be done within 2 weeks of the

interview. You are welcome to contact me by email or phone should you want to withdraw your data from the study.

If you agree to participate, I will contact you via email or phone to arrange a suitable time. Phone interviews will be conducted using Skype™ if you are overseas. Skype™ is a free program that allows the user to call users of Skype™ for free or to a landline for a small fee. If you do not have access to a computer with Skype™ then please notify me and I may be able to arrange one for you or else arrange to call a landline. It is also important for you to know that these interviews will be recorded and stored as an mp3 file.

Your name and any information that may identify you will be kept completely confidential. All information collected from you will be stored on a password protected file and only you, I and my two supervisors will have access to this information. The recorded interviews will be transcribed. To ensure confidentiality of the information you give and your identity, the person transcribing the audio files will sign a confidentiality form.

When the interviews have been transcribed a copy will be sent to you for verification of accuracy. If you feel that what is transcribed does not accurately represent your experience and there is something you would like to add or if there is any personal information or details that you decide you do not wish to be included it will be changed to your satisfaction or removed.

All research data will be stored in a secure manner for five years following the project completion.

Please contact me if you need more information about this project. At any time if you have any concerns about the research project you can contact my supervisors.

UREC REGISTRATION NUMBER: (2008.806) This study has been approved by the UNITEC Research Ethics Committee from (January 2008) to (December 2008). If you have any complaints or reservations about the ethical conduct of this research, you may contact the Committee through the UREC Secretary (ph: 09 815-4321 ext 7248). Any issues you raise will be treated in confidence and investigated fully and you will be informed of the outcome.

APPENDIX C – INTERVIEW SCHEDULE/QUESTIONS

1). Prelude to osteopathy, prior careers, direct school leavers.

- What were you doing up until the point that you choose to study osteopathy?
- How did you become an osteopath?
- What were your reasons for studying osteopathy?
- Did your previous career/schooling help you in your study of osteopathy?

2). Schooling

- Where did you study?
- When did you graduate?
- Did you enjoy the process of studying?

3). After schooling career-leaving the profession

- Where did you start working?
- How long did you work there?
- Did you move on to another workplace? Etc.
- How long did you practice?
- When did you leave the profession?
- What were the influences that led to the decision to pursue another career? Were there multiple reasons for leaving?
 - Was it a specific incident?
 - Did you consider leaving over a period of time?

Did you enjoy working as an osteopath? What did you like the most about osteopathy?

4). Post leaving

- Where/are you happy/relieved to leave osteopathy?
- Was the experience of changing careers a positive or negative experience for you?
- Looking back do you feel you learnt skills or gained from being an osteopath?
- Do you feel that there was a gap in your education that could have better prepared you for professional practice?
- Do you feel that there was a lack of support during professional practice that influenced your decision?
- What was your experience of leaving the profession in regards to colleagues/ organisational bodies?

APPENDIX D – CONSENT FORM



Participant consent form

I have been given and have understood an explanation of this research project for the Master's of Osteopathy.

I have had an opportunity to ask questions and have had them answered. I understand that neither my name nor the name of my organisation will be used in any public reports.

I understand that until two weeks after the interview has taken place, I may withdraw myself or any information that I have provided for this project.

I also understand that all the information that I give will be stored securely for a period of 5 years.

I understand that my discussion with the researcher will be taped and transcribed.

I understand that I can see the finished research document.

I have had time to consider everything and I give my consent to be a part of this project.

Participant Signature: *Date:*

Project Researcher: *Date:*

UREC REGISTRATION NUMBER: (2008.806). This study has been approved by the UNITEC Research Ethics Committee from (date) to (date). If you have any complaints or reservations about the ethical conduct of this research, you may contact the Committee through the UREC Secretary (ph: 09 815-4321 ext 7248). Any issues you raise will be treated in confidence and investigated fully and you will be informed of the outcome.

APPENDIX E – EXAMPLE OF THEMATIC TABLE

Significant idea or statement from the transcript	Keywords/Phrase/ statement	Possible Concept/Theme
<p>I went to the British School of Osteopathy straight from school, so at 18. (p3)</p> <p>...and for me, that would have been very helpful. I mean I have to say I think, one if the big drivers for me leaving was probably the fact that I just started it too young anyway. (p8)</p> <p>I think one it would have given me some understanding of the real world, in terms of more rounded life experience. (p8).</p> <p>Because all of a sudden it seemed as though I'd gone, you know, O levels, A levels, BSO and bang there I was in a treatment room thinking I'm 22, is this it now for the next 60 years. (p8).</p> <p>...we did have quite a few mature students in my course and I am in contact with a couple of those now and they absolutely love it. But actually the perspective that they are able to--, to have on it and their experiences really help. Not only in just managing the business and--, the responsibilities that come with that but also in the way they approach treating patients really. (p8).</p> <p>But I think the downside of that was the responsibility of not being able to make people better. (p13).</p> <p>But I think I could be a lot more effective doing it now then I was doing it, you know, sort of 12-14 years ago.</p>	<p>Straight from school</p> <p>Big drivers for leaving started too young.</p> <p>Understanding of real the real world, more rounded life experience.</p> <p>I'm 22, is this it for the next 60 years.</p> <p>Mature students.</p> <p>Perspective and experience help in managing business and responsibilities and approach to treating patients.</p> <p>Responsibility to make people better</p>	<p>Lack of life experience / youth/ early start/ lack of perspective/ large responsibility for a younger practitioner/</p>