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**Impact of the  
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specialists' health  
and well-being**

Anna Mason, MD, Kristin Atwood, PhD, Frieda Hodgins

# Impact of the family physician shortage on BC specialists' health and well-being

Specialist physicians have experienced negative effects on their health, career plans and trajectory, and professional and personal relationships due to the family physician shortage.

## ABSTRACT

**Background:** Little is known about the impact the shortage of primary care physicians has on specialists who are caring for patients who do not have a family physician.

**Methods:** This qualitative study involved semi-structured interviews with 37 specialists in Victoria, British Columbia; an additional 21 specialists provided written comments anonymously in an online forum. Participants were asked to describe the impact the shortage of primary care physicians has on their patient profile, clinical workflows, and work volumes.

**Results:** Participants reported an increase in the number of patients who do not have a primary care physician. This has affected specialists' ability to discharge patients, which has resulted in longer wait lists and a greater work burden. Additionally, patients who do not have a family physician seek care from specialists that is beyond the scope they can provide. Participants also reported a decline in the quality of their professional and personal relationships

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*This article has been peer reviewed.*

## IMPACT OF THE FAMILY PHYSICIAN SHORTAGE ON BC SPECIALISTS' HEALTH AND WELL-BEING: A QUALITATIVE STUDY

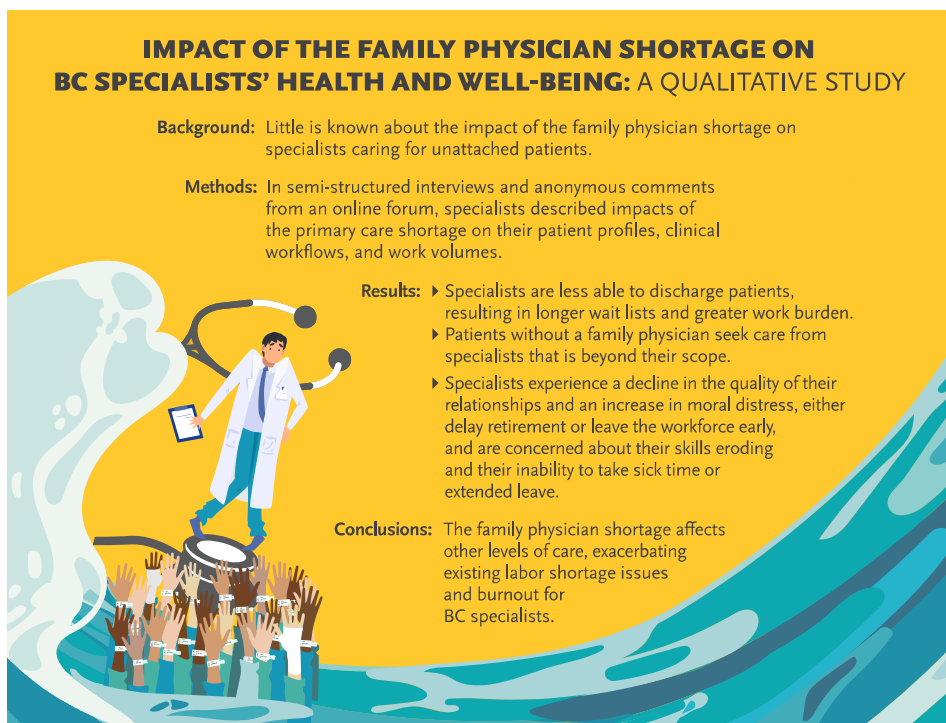
**Background:** Little is known about the impact of the family physician shortage on specialists caring for unattached patients.

**Methods:** In semi-structured interviews and anonymous comments from an online forum, specialists described impacts of the primary care shortage on their patient profiles, clinical workflows, and work volumes.

**Results:**

- ▶ Specialists are less able to discharge patients, resulting in longer wait lists and greater work burden.
- ▶ Patients without a family physician seek care from specialists that is beyond their scope.
- ▶ Specialists experience a decline in the quality of their relationships and an increase in moral distress, either delay retirement or leave the workforce early, and are concerned about their skills eroding and their inability to take sick time or extended leave.

**Conclusions:** The family physician shortage affects other levels of care, exacerbating existing labor shortage issues and burnout for BC specialists.



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and an increase in moral distress; some stated they were delaying retirement or leaving the workforce early and were concerned about the erosion of their skills and the ability to take sick time or extended leave.

**Conclusions:** The shortage of primary care physicians has ripple effects on other levels of care. This exacerbates existing issues related to labor shortages and burnout for specialists practising in BC.

## Background

The ongoing shortage of family physicians who provide primary care is well documented, and concerns about the implications for patients have become increasingly urgent.<sup>1-3</sup> However, little attention has been paid to how this shortage affects specialist physicians. Specialist and primary care services are complexly intertwined. Specialists rely on family physicians to appropriately

refer patients and to continue care after specialized services conclude. Specialists are already facing high levels of burnout and dissatisfaction with work–life balance, which has intensified due to the COVID-19 crisis.<sup>4–6</sup> The family physician shortage exacerbates existing capacity strains, especially when specialists find the care they can provide is less effective than it ideally would be.<sup>7</sup>

When specialists experience moral distress, they are more likely to leave medicine, which erodes the robustness of the physician workforce.<sup>8,9</sup> They are also more likely to disengage from patient-centred care, such as by avoiding or abbreviating tasks related to patient communication.<sup>10</sup> It is only through understanding the specific impacts of the family physician shortage on specialists that this negative spiral can be mitigated. We describe changes in the scope and volume of specialist work due to the increase in the number of patients who do not have a family physician and link these changes to outcomes for specialists' relationships, career experiences, and personal and familial health.

## Methods

This research was conducted in Victoria, British Columbia, between February and May 2022. Participants were recruited via postings in the local Medical Staff Association newsletter, which has an estimated readership of 500 physicians. The sample was self-selected. Ethical considerations were part of the funding approval process through the Medical Staff Association's review of the proposed project.

Two methods were used: qualitative semi-structured interviews (37 individuals) and an anonymous online forum (21 individuals, likely unique from those who participated in the interviews). A wide range of specialties (18) were represented, but there was clustering in pediatrics, psychiatry, and oncology, all of which have frequent interactions with primary care [Table 1].

In both methods, participants were asked how the family physician shortage has affected their patients, practice, and

**TABLE 1.** Number of study participants, by specialty.

Specialty	N*	Specialty	N*
Psychiatry	10	General surgery	< 5
Pediatrics	8	Hospitalist medicine	< 5
Oncology	6	Neurology	< 5
Addictions medicine	< 5	Obstetrics/gynecology	< 5
Anesthesiology	< 5	Orthopaedics	< 5
Cardiac surgery	< 5	Palliative care	< 5
Cardiology	< 5	Respirology	< 5
Emergency medicine	< 5	Urology	< 5
Endocrinology	< 5	Specialty not indicated	10
Gastroenterology	< 5	Total	58

\* Exact numbers are not provided for specialties with fewer than five participants. To support confidentiality, interview and online forum participants are combined.

## BOX. Interview and online forum questions

**1. Interviews:** The following questions were included in the interview guide. The interviewer had leeway to follow the course of the conversation with additional questions as seemed appropriate.

- What was it that caught your eye and made you respond to our project?
- Can you share some examples or stories about patients you have treated who do not have a family physician and how this has impacted their care?
- Have you found that the family physician shortage has impacted your practice? For instance:
  - How has your scope of practice changed?
  - How has the morbidity or mortality of your patients differed?
  - How have transitions of care been affected?

**2. Online forum:** Because the online forum was a more passive environment where no follow-up was possible, a more general prompt was provided in the hopes of eliciting a broad range of responses:

- How has the BC primary care crisis affected your practice?

well-being. They were also asked to estimate the proportion of their patients who did not have a family physician. The interview questions and forum prompts are provided in the **Box**.

Interviews were transcribed. All co-authors reviewed the first 10 interviews individually and identified initial themes, which were then discussed and finalized before one co-author analyzed the remainder of the responses. There were few discrepancies in coding, and they were resolved through consensus. Ensuring intercoder agreement enhanced the trustworthiness of the thematic coding. Thematic analysis was guided not by a priori theorization but

rather by a pragmatic, descriptive approach.

As with all qualitative research, researcher characteristics inform interpretation. In this case, researcher characteristics were diverse and brought unique perspectives to the project. The team consisted of a medical student, a family physician, and an applied sociologist, each of whom had their areas of expertise and “blind spots” that could be addressed by the others. This allowed for a full exploration of themes in the data as they emerged.

## Results

All participants indicated that the proportion of their patients who did not have a

family physician was increasing over time. Self-reported estimates ranged from 10% to 65%, with a median of 50%.

Specialists reported that patients who did not have a family physician were significantly further along in their disease state at initial referral than those who had a family doctor. In addition, specialists were unable to discharge patients who needed ongoing monitoring but not ongoing specialized services, and they had to provide a greater proportion of primary care within their specialty than they had previously done. The **Figure** represents the scope and workload pressures that participants identified.

As a consequence of these pressures, participants reported effects on their well-being in terms of relationship quality, career experiences, and personal health [Table 2]. These were not mutually exclusive; they exacerbated one another. First, the quality of their relationships with patients, colleagues, and loved ones had declined. In terms of career experiences, specialists were reducing the scope of services offered, delaying retirement, or exiting the workforce early. They also worried about the possible

erosion of their specialized skills. Finally, they experienced health impacts, including a lack of access to primary care for themselves, an inability to take time off work for illness or long-term absences such as parental leave, and an increasing sense of moral distress and injury.

**Discussion**

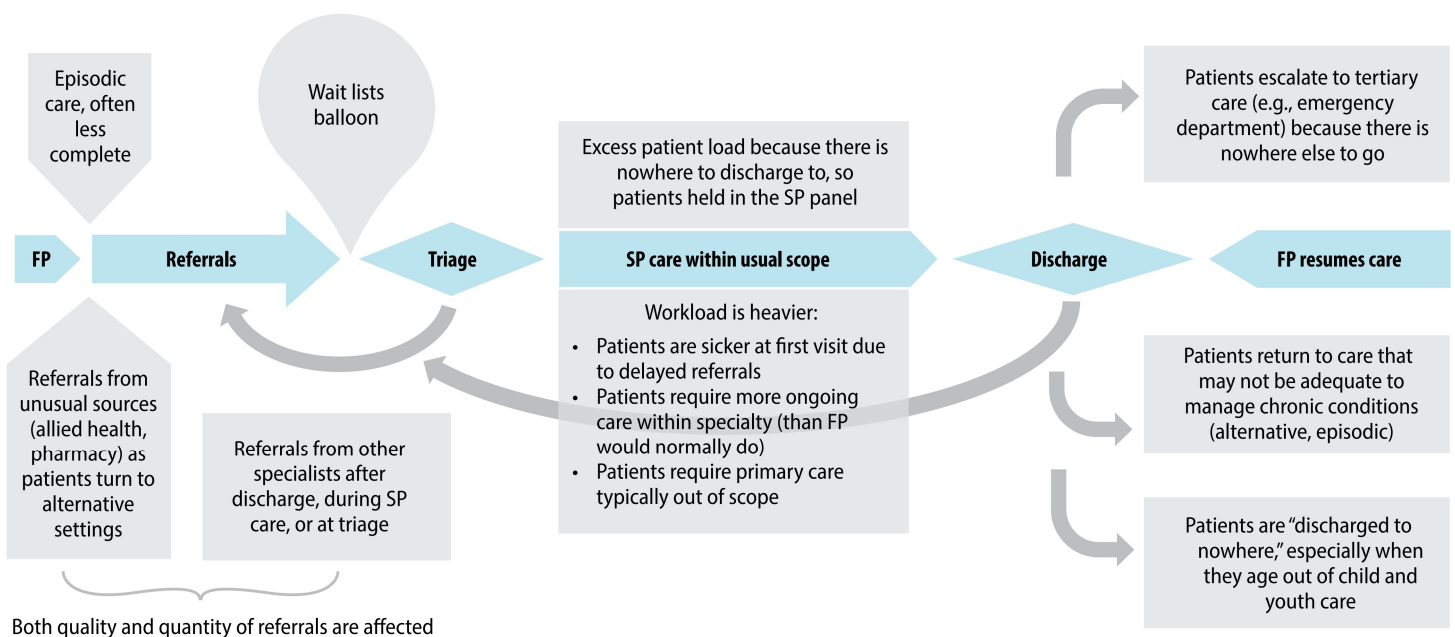
The family physician shortage has led to bottlenecks in discharging patients, ballooning wait lists, and a heavier and more complex workload. This results in negative outcomes for specialists individually, including declining quality of relationships with others, both personal and professional; effects on their career plans and trajectory; and negative health outcomes, particularly moral distress and injury. Because many specialties also face physician shortages, the lack of primary care physicians may exacerbate existing workforce pressures in specialist services.

Despite the interconnectedness of the health care system and the general awareness of the family physician shortage, few studies have examined the ripple effects

on specialists. However, heavier specialist workloads have been shown to be associated with more errors.<sup>11</sup> Lack of primary care capacity has been identified as a barrier to implementing care models that could improve the sustainability of the specialist workforce.<sup>12</sup> In addition, physicians tend to respond to resource limitations by “going above and beyond the call of duty,” which puts them at further risk of burnout.<sup>13</sup> The participants in this study work in an interdependent health system; therefore, the lack of family physicians has created ongoing and increasing challenges in their work and personal lives.

**Study limitations**

This study was limited by the self-selection of participants, who may have chosen to participate specifically because they were experiencing negative impacts related to the family physician shortage. Therefore, the findings cannot be generalized to the specialist population. Because this research is qualitative, a direct causal relationship between the family physician shortage and participants' experiences of negative



**FIGURE.** Impacts on specialist physician workflows due to increased numbers of patients who do not have a family physician. The blue boxes indicate expected patient flow when the system is well resourced; the gray boxes indicate workflow issues related to a lack of primary care physicians (FP: family physician; SP: specialist physician).

**TABLE 2.** Key themes and illustrative quotations regarding specialists' relationship quality, career experiences, and personal health outcomes related to the family physician shortage.

Area	Key theme	Illustrative quotation
Relationship quality	Patients	It's demoralizing to be disappointing people . . . it's me in the room, with the patient saying no . . . it just contributes to exhaustion and fatigue and burnout . . . with people super angry about . . . not being admitted [into our service]. That just contributes again to distress and burnout in the department. Because it's [not] like . . . we don't know. There's no individual in our department who's standing there cackling with an evil laugh being like "I'm going to deny you care." There's nothing to offer.
	Colleagues	It keeps funneling up and up, and you lose your collegiality and your working relationships with these other colleagues, and you start to feel very isolated and alone in your practice. Where before . . . there'd be much more of a feeling of working together, [now] it much more has a sense of "This is your problem; you deal with it . . . I've got a million other things to deal with." So, you lose that creativity that [comes from a team].
	Loved ones	Every day, I'm wrestling with this knowledge of I have to balance my relationship with my kids, who I love desperately, and I want to be with, with my commitment and responsibilities for work. So, I come home at 6:30, and it's like 45 minutes before my kids are in bed, or an hour . . . This morning, I was up at 6:00, doing paperwork and dictations. So, I'm busy while they're getting ready for school . . . how can I be the parent that I thought I was going to be? We never wanted to be on the hamster wheel. We wanted to have good work-life balance. I only wanted to work four days a week. Be home at 5:00. Be that attentive parent.
Career experiences	Reduction in services	I work in [a program] that's mandated for 3 years. I have patients that have been in the program for 5 years. And I can't discharge them from our service . . . I'm thinking, do I have to quit one of my jobs to be able to service the patients that shouldn't be there? So, do I need to quit my acute care job? . . . I've probably cut back on 50% of the [other] outpatient work I do because the areas just keep filling up . . . the next consequence, like I said, would be probably quitting one of my other jobs.
	Delayed retirement	Another colleague of mine . . . has abruptly gone half time and will probably do another year and then quit. Another colleague is reducing her time. And I have two more that are already down to 0.8, one of whom will be going down to half time . . . [My retirement] was a recent decision, because I needed to wait until we had somebody that could cover. I wasn't going to retire without a replacement, because that's a lot of additional work then that other people have to do.
	Early exit	I feel like I'm in a health care system with the wheels coming off. And I'm actually worried about what things are going to look like 5, 10 years down the road. It makes me feel uneasy, and it sort of makes me wonder. Sometimes I find myself thinking, looking for an exit strategy. And I really love my job.
	Erosion of skills	I have felt that transition of how much time I spend seeing . . . patients who are not acutely sick and requiring resuscitative care, and I think . . . there's only so long you maintain skills that you're not using . . . there could be unintended consequences in the long term of what happens to these physicians like me who are just not seeing that volume [of true emergencies].
Personal health outcomes	Lack of access to primary care	Honestly, even just for myself, if we have any health problem in our family, I have absolutely no idea how I would get care for anybody in my family without going to [Emergency], because you look on walk-in clinic wait lists, and they're done by eight o'clock in the morning. They're full for the day.
	Ability to take sick time	I still worked from home . . . 9 hours virtually, super sick. And so, the stress of taking time off is pretty big . . . unpredicted time away, it's just so stressful, like you just can't do that. Like I don't get to stay home if my kids are sick . . . I can't not be at work unless it's an absolute crisis.
	Ability to take leave	When you go on maternity leave, you can . . . take a reduced rate for your licensing fees because you're not working . . . However, if you pause your licence, then refills won't be refilled under your name for your patients . . . I'm planning on taking a maternity leave. But I'm concerned about pausing my licence because so many of my patients don't have a family doctor, and that means [they] won't be able to refill their medications. That could cause serious morbidity to patients . . . There's lots of little pieces to this puzzle, where the family doctor crisis has many effects, beyond even what we think about on the surface. And we're all really thinking about the system and our patients a lot. Even with our personal life decisions, like taking your maternity leave, and for how long, and for appropriate coverage, etc.
	Moral distress and injury	I feel that group level of distress increasing from a lack of primary care. None of us want to be closing our wait lists. I think we all would like to be serving the community and meeting the community's needs . . . It's sort of an increasing sense of hopelessness.

outcomes cannot be proven. The participants acknowledged that the family physician shortage was not the only stressor impacting their lives. Finally, a student researcher conducted the interviews. Some participants expressed concern that sharing their experiences could “scare her away” from medicine; as a result, they may have tempered their comments.

## Conclusions

This study illustrates the complex interdependencies between family physicians and specialists and provides insight into the unique experiences of physicians who are providing specialist care today. It is clear that the family physician shortage is having far-reaching consequences for patients. Equally clear is that the shortage is also impacting other health care professionals by compounding the capacity strains they were already experiencing. Without sustained attention to both the labor needs and current impacts of health care shortages, the system will continue to operate in a fragmented, suboptimal way, putting patients—and physicians—at continued risk. ■

## Competing interests

None declared.

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**Lack of primary care capacity has been identified as a barrier to implementing care models that could improve the sustainability of the specialist workforce.**