

Dealing with the doctor shortage: a qualitative study exploring French general practitioners' lived experiences, difficulties, and adaptive behaviours

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Context: The shortage of general practitioners (GPs) is a growing concern in Europe, especially in France. This problem is likely to continue until the end of the 2020s.

Objectives: To study the GPs' perceptions of access to care in medically underserved areas (i.e. with low physician density), its consequences on their working conditions, and how they cope with the resulting difficulties.

Methods: Semi-structured individual interviews were conducted between May and August 2021 of 29 GPs practising in areas of southeastern France with a low physician density or at risk of a doctor shortage. Purposive sampling was used to include profiles of diverse physicians and diverse rural and urban areas. The interviews, conducted with an interview guide, were transcribed and analysed thematically.

Results: The participants described a serious degradation of access to care in their areas. These issues also concerned urban areas, where they were, according to the participants, underrecognized. The participants' workloads were rising, at a rate often perceived as unsustainable: many participants, including the youngest group, reported they were exhausted. Their principal source of dissatisfaction was their impression that they could not do their work correctly. Participants reported that these difficulties required them to improvise and adapt without any official or formal method to keep their practice manageable.

Conclusion: These GPs were worried about the future of their profession and their patients. They expected strong measures by public policy-makers and officials, but paradoxically seemed to have little interest in the solutions these officials are promoting.

Key words: coping, doctor shortage, general practice, perceptions, qualitative research, working conditions

Introduction

General practitioners (GPs), also referred to as family practitioners and primary care physicians, are often patients' first contact with the health-care system. In France, full reimbursement for medical care by the National Health Insurance Fund requires patients to register with a GP (*médecin traitant*), who becomes responsible for referring them for more specialized care. These doctors provide individualized medical follow-up and monitor chronic illnesses, keep medical records up-to-date, are responsible for prevention, and coordinate their patients' health care.¹

Adequate access to medical care requires a sufficient number of GPs and other specialists and their optimal geographic distribution among the population. For many decades, unequal distribution of GPs has been common in developed countries. Access to services in rural regions has drawn policymakers' attention, although disadvantaged urban and suburban areas also present challenges.² More recently, medical density—ratio of the number of doctors (GPs and other specialists) per capita within a specified area—has been decreasing in Europe and elsewhere.³ This general

trend is attributable to the ageing of doctors and failure of health planning authorities to anticipate these changes. It is aggravated by increased demand for care partly due to population ageing. Reduction in the workforce, coupled with a foreseeable increase in demand for care, may worsen current physician shortages. Potential consequences include expansion of the areas where health-care access is very difficult and intensifying it to the point of creating “medical deserts,” that is, geographical areas where the paucity of doctors makes access to medical care very difficult and increases the workload and moral strain on the remaining physicians.

With an average density of 320 doctors per 100,000 inhabitants, France is below the EU-15 average (410 doctors per 100,000 inhabitants).⁴ Medical density has declined in France (–8% between 2012 and 2022),⁵ resulting in growing shortages of GPs in certain regions. Moreover, 32% of French GPs are aged 60 years or older and will retire during the next decade. Thus, the shrinkage of medical density in France from 2030 onwards is expected to be among the largest in Europe (estimated decline: –22.8%).⁶ Geographical health-access

Key messages

- Most participants reported substantial deterioration in patient access to care.
- GPs reported local authorities underestimate access problems in urban areas.
- Perceived reduced effectiveness was GPs' main source of work dissatisfaction.
- GPs had two main styles of emotional coping: commitment and detachment.
- GPs' adaptations to the doctor shortage were mainly improvised.
- Most GPs reported little interest in solutions proposed by public officials.

inequalities will likely be reinforced, and the quality of care is liable to deteriorate.

French health officials have taken steps nationwide to limit the shortage of doctors.⁷ These include financial incentives to set up practice in underserved areas and the promotion of multiprofessional primary care groups (MPCGs), specifically, teams of local health-care professionals who share a common health project and work in a coordinated, multiprofessional manner in the same geographical area. These measures have not yet been particularly effective.⁸ In 2021, policymakers also allowed the number of medical school and internship places to rise to increase the supply of recently graduated medical practitioners. This measure will not produce its first effects for a decade.

The doctor shortage affects GPs' working conditions and probably their health-care practices as well, but documentation of these topics is sparse. A multidisciplinary research project, named ROSAM (Raréfaction de l'offre de soins et adaptations des médecins: declining supply of doctors and adaptations), began in 2018 to study how French GPs are adapting to the decreased supply of doctors and the increased demand for health care. This project uses methods to analyse both quantitative data from a French national representative panel of self-employed GPs⁹ and of qualitative interview data reporting subjective attitudes and experiences of nearly 30 French GPs.

This article presents the project's qualitative study, which aimed at better understanding: (i) GPs' perceptions of health-care access in their practice area; (ii) the effect of the decreasing density of doctors on their working conditions; and (iii) the practical difficulties they face in their daily work, and how they cope with them.

Methods

Setting and participants

A qualitative survey, based on semi-structured interviews with GPs, took place between May and August 2021 in the Provence-Alpes-Côte d'Azur region of southeastern France. This area is characterized by a relatively aged population and a high medical density (407 doctors per 100,000 inhabitants)¹⁰ compared to the rest of France but close to the EU average. Geographical disparities are marked: coastal areas have the best medical coverage, while many municipalities, especially in rural and socioeconomically disadvantaged areas, face a shortage of doctors. This region was particularly appropriate for an exploratory qualitative study aimed at representing the widest possible variety of local contexts and practice conditions for GPs.

Participants were self-employed GPs practising in underserved areas or areas at risk of a doctor shortage because of

predictable retirements, population increases, and ageing (in various combinations). These areas were identified by an indicator (potential local accessibility) developed by the Ministry of Health; it considers travel time, GPs' working time, and the population seeking care.¹¹

Recruitment procedure

We used a purposive sampling strategy to include the profiles of a wide range of GPs, according to their individual characteristics (age, gender), type of practice (solo, group, or MPCG), and practice area (rural or urban zone, medical density).

In 2021, 364 GPs in southeastern France practised in areas either underserved or at risk of a doctor shortage. We randomly selected 142 and sent them a letter presenting the study with its objectives and procedures. A researcher subsequently called them to ask them to participate and make an appointment. Complementary snowball sampling also occurred. GP recruitment continued until we reached thematic saturation.¹²

Data collection

Three investigators—a senior social psychologist (HD) and 2 interns in general medicine trained in qualitative research (JBC and AD)—conducted semi-structured interviews between May and August 2021. All GPs gave their informed consent before participating. Interviews lasted between 25 and 77 min and were audio-recorded. Interviews were face-to-face (4/29) or by videoconference (25/29), depending on both the GP's practice location and the COVID-19 epidemiological situation. Videoconferencing surged during the pandemic, including in social sciences research. GPs could be interviewed in remote areas with visual contact that facilitated a climate of trust and allowed nonverbal information to be collected.¹³

An interview guide covering predefined topics (see [Supplementary Data](#)), based on the research questions and the literature, guided the questioning. The interviewers first asked participants to introduce themselves and talk about their perceptions and opinions about health-care access in their practice area. Subsequent questions explored how the decrease in medical density affects their working conditions (e.g. amount and pace of work, work-life balance) and professional practices (e.g. frequency and duration of appointments, time for listening to patients, preventive care), how they are coping with the doctor shortage and the increased demand for care and where they find the resources needed to provide it. Most questions were open-ended to reduce bias (e.g. social desirability bias). Researchers also used additional probes to encourage participants to expand their discourse.

Data analysis

Interviews were transcribed verbatim from the audio recordings and anonymized. We used interpretative phenomenological analysis to examine the corpus themes, applying an inductive-deductive approach and focusing on understanding GPs' lived experience of their work and its meaning for them. We reviewed all transcripts multiple times to become familiar with the data and then identified the emergent themes (open coding). In the next stage, we categorized these themes into main themes (axial coding). To confirm our analysis, we held team meetings to discuss the initial codes and then reorganized them to obtain the final codebook, including the themes' definitions and transcript excerpts exemplifying them.¹⁴

Results

Among the 142 GPs selected, 102 could be contacted, and 24 were interviewed (response rate: 24%). In addition, 5 GPs were recruited by snowballing, for a total of 29 interviews. Table 1 details participants' characteristics, while Table 2 provides an overview of the 8 themes identified for the 3 principal objectives.

Theme 1: Perceptions of health-care access in each general practitioner's practice area

Supply of doctors perceived as seriously insufficient.

Two thirds of the participants described access to GPs and to other specialists in their area as difficult: substantial delays for appointments, patients reporting difficulties in finding a GP, a greater number of patients without regular medical follow-up, or who have delayed or forgone care. Half the participants reported a "health catastrophe" and the multiplication of "disaster-stricken" zones. Some (6/29) expressed pessimism; they considered the situation irremediable and compared it to a patient "in a terminal phase." They also reported similar perceptions among their patients and local elected officials.

Problems less recognized in urban areas . Because GPs are so difficult to replace in rural areas, their retirements are events the GPs remaining in the area fear, comparing them to natural disasters: "it was a storm," "it was a tsunami." Each retirement created a new wave of "desperate" patients seeking a GP: "I was submerged." Participants noted that problems of access to care affected increasingly large areas.

In urban and suburban areas, participants reported that the existing medical care supply can be insufficient to meet the needs of populations that are increasing rapidly and have

Table 1. Participants' personal and professional characteristics

	Gender	Age	Type of area	Its medical density	Type of practice
1	Woman	43	Urban/suburban	Underserved area	Group
2	Woman	43	Urban/suburban	Risk of medical shortage	Single-site MPCG
3	Man	52	Rural	Underserved area	Single
4	Man	64	Rural	Risk of medical shortage	Single-site MPCG
5	Woman	52	Rural	Risk of medical shortage	Single
6	Man	55	Rural	Risk of medical shortage	Single
7	Man	61	Urban/suburban	Risk of medical shortage	Multisite MPCG
8	Woman	61	Rural	Risk of medical shortage	Single-site MPCG
9	Man	60	Urban/suburban	Risk of medical shortage	Single
10	Man	60	Rural	Risk of medical shortage	Single
11	Man	64	Rural	Risk of medical shortage	Group
12	Man	40	Urban/suburban	Risk of medical shortage	Group
13	Man	67	Urban/suburban	Risk of medical shortage	Group
14	Woman	46	Rural	Risk of medical shortage	Single-site MPCG
15	Man	60	Rural	Underserved area	Single
16	Man	61	Rural	Risk of medical shortage	Single
17	Man	60	Rural	Risk of medical shortage	Single
18	Woman	38	Urban/suburban	Risk of medical shortage	Group
19	Man	65	Urban/suburban	Risk of medical shortage	Single
20	Man	65	Urban/suburban	Underserved area	Single
21	Man	60	Urban/suburban	Underserved area	Single
22	Woman	47	Urban/suburban	Risk of medical shortage	Group
23	Woman	60	Urban/suburban	Risk of medical shortage	Group
24	Woman	35	Urban/suburban	Underserved area	Single-site MPCG
25	Man	30	Urban/suburban	Underserved area	Single
26	Man	54	Rural	Underserved area	MPCG project
27	Man	50	Rural	Risk of medical shortage	Single
28	Woman	55	Rural	Underserved area	Single-site MPCG
29	Man	72	Rural	Underserved area	Single

Table 2. Overview of main themes, subthemes, and topics raised

Main themes	Subthemes	Principal subjects mentioned
Theme 1: Perceptions of health-care access in each general practitioner's practice area	Subtheme 1.1: Supply of doctors perceived as seriously insufficient	<ul style="list-style-type: none"> • Substantial delays for appointments • Difficulty finding a general practitioner accepting new patients for registration • Pessimism about the changes in medical demography
	Subtheme 1.2: Problems less recognized in urban areas	<ul style="list-style-type: none"> • Both rural and urban areas affected by these issues • Different demographic processes • Less recognition of these difficulties in urban areas by authorities
Theme 2: Perceived effect of the decreasing medical density on working conditions	Subtheme 2.1: Physicians are dedicated to their work, but many are overworked	<ul style="list-style-type: none"> • High work volume and tempo, continuing to rise • Physicians overloaded and under pressure
	Subtheme 2.2: Feelings of lack of effectiveness, powerlessness, and dissatisfaction at work	<ul style="list-style-type: none"> • The feeling of not succeeding in doing one's work correctly is a source of dissatisfaction • Sometimes combined with feelings of powerlessness and guilt
	Subtheme 2.3: Doctors on the verge of a breakdown, even some young ones	<ul style="list-style-type: none"> • Exhausting job • Widespread physical and psychological exhaustion • Symptoms suggestive of burnout
Theme 3: How doctors cope with daily challenges	Subtheme 3.1: Two ways of coping: engagement and detachment	<ul style="list-style-type: none"> • Profile 1: combativeness and engagement • Profile 2: discouragement and disinvestment
	Subtheme 3.2: General practitioners who reported managing on their own	<ul style="list-style-type: none"> • Unconventional and improvised solutions • Reported objective: meet patients' needs
	Subtheme 3.3: A range of more long-term but often unofficial adaptations	<ul style="list-style-type: none"> • Development of more long-term solutions, also often improvised • Formal measures not often chosen by GPs

substantial health needs (patients who are elderly, in precarious situations, or have chronic diseases) or to cope with "overuse of care."

Some physicians stressed that these problems of access to care in urban and suburban areas are more difficult to document than in rural areas ("the numbers do not reflect — not at all!! — the reality, they give the impression that there isn't any problem") and are, from these doctors' points of view, under-recognized or even denied by the institutions: "I raised the topic with the Regional Health Agency, their response was: 'Ah but no, we observe that it's much worse elsewhere.' But how can it be worse?"

Theme 2: Perceived effect of the decreasing medical density on working conditions

Physicians are dedicated to their work, but many are overworked. Most participants reported a very high volume and an intense rhythm of work: "I often start my day before 8 a.m. and I finish late, rarely before 8 p.m." They described, simultaneously with their growing workload, a rise in patient expectations and requirements: "They want everything and right away." Half the physicians interviewed mentioned being constantly overwhelmed and a very strong "weight of responsibility," particularly those in solo practices in rural areas: "You're alone and you have to deal with it all by yourself."

They reported making personal sacrifices: 1 physician in 3 said that they work more hours than they want to, and half that this encroaches on their family and personal life; for example, they take few vacations and often forgo leisure activities. Moreover, among the 15 participants aged 60 years or older, 8 would like to retire or work less, but do not because they cannot find someone to take over their practice.

Feelings of lack of effectiveness, powerlessness, and dissatisfaction at work. One participant in 3 reported being "very dissatisfied" with their work and their practice conditions and unable to do their work correctly. They thus provide "poor medical care" that contradicts their professional values: they are unavailable for their patients, cannot listen to them, have long delays for appointments, make minimal home visits, and feel they rush over their work. This feeling is often mixed with powerlessness and frustration: "We do as much as we can, sometimes even more than that, but it's not enough." Some GPs experience this as personal failure; one admitted: "I can't do it, and I have to say that it eats away at me."

Doctors on the verge of a breakdown, even some young ones. The participants described their profession as tiring ("I think that a GP, at the end of 20 years, he's worn out"), and more than a third, including the youngest, expressed physical and mental exhaustion: "at the end of my rope" (*au bout du rouleau*), "[I'm] constantly on the edge." Some also recognized that they were irritable and impatient with their family or their patients, one commenting, "I can't stand anything anymore," and another "I've run out of empathy."

Several physicians reported burnout with prolonged sick leaves: "last year, I just broke down, completely. I stopped work for 4 months." A quarter of the participants, including the youngest, have thought about changing their profession or at least their type of practice (for example, to a salaried job, or locum) in the years to come.

Theme 3: How doctors cope with daily challenges

Two ways of coping: engagement and detachment. Two different profiles of emotional reactions characterized some

participants' modes of coping. The first, including about 1 in 4 participants, fit a profile of combative, engaged doctors, with a "sense of duty," "investment in a mission", and determined to "fight." This profile included both young GPs and those older than 65 years. These GPs expressed a willingness to alert the relevant officials ("I'm in the mayor's office every two months") and to actively seek solutions. They nonetheless had the impression they were neither heard nor supported and deplored the institutional inertia: "I've never had any response." This sometimes engendered frustration and anger: "I'm appalled."

The second profile, accounting for 1 in 5 participants, often succeeds the first. The second was marked by fatalism, discouragement, or both: "I've given up." These primary care physicians, fairly old, seemed emotionally detached and disengaged from their work: "now I'm waiting for only one thing — retirement."

General practitioners who reported managing on their own. Given the problems described above, physicians reported finding solutions by themselves. They described these as "do-it-yourself" (*bricolage*) or "resourceful" (*système D*) methods, improvising on the spur of the moment, or coming up with often unconventional "hand-crafted" (*artisanales*) answers. Their objective is to try to meet their patients' needs "with the means at hand": "we are always going to try to find a solution, we don't want to leave anyone out in the cold." For example, one GP explained, follow-up for a patient with a chronic disease and without medical follow-up could alternate teleconsultations with in-person appointments. The GPs recognized that these solutions are "stopgaps" (*dépannage*) and not always satisfactory.

A range of more long-term but often unofficial adaptations. The GPs tried to construct more organized and long-term solutions to regulate requests for care, optimize their time, and facilitate access to specialized care (Table 3).

Most participants reported selecting patients' requests (for regular GP care, urgent situations, and home visits) by different priority criteria, such as the patient's health status ("I give priority to the patients with chronic diseases"), the length of the doctor-patient relationship, family relationships ("I accept their family members"), and geographic proximity ("I only take patients living in the municipality"). A third of them referred patients to colleagues with greater availability or to emergency departments. One in 4 said that they "educate" their patients to limit futile or inappropriate use of care (for colds, coughing, and low fever, for example). Finally, some GPs encouraged their patients with a chronic disease to be more autonomous in managing their disease, especially by referring them to patient therapeutic education programs.

One quarter of the GPs reported prioritizing those tasks at the heart of their profession: the follow-up of patients with chronic diseases and the management of emergencies. Nearly half indicated that they delegate some tasks (mail, calling patients back, making appointments) to their secretary, but also the first sorting of telephone requests: "I've briefed my secretary, she knows my criteria for emergencies, and she sorts through the requests." Moreover, nearly a quarter of the doctors, mainly in rural areas, delegated some medical tasks (care, follow-up, home visits) to nurses in private

practice and developed informal procedures with them. Two physicians, in MPCGs, worked with *Asalée* (private practice team health care) nurses, trained in prevention and patient education.

Nearly 1 GP in 4 used tools for time optimization (software or apps for making appointments, outsourced telephone secretarial services, specially designed professional software). Others organized their work to channel the demand for care, such as consultations only by appointment, or the reservation of slots for unscheduled care. Others shortened the duration of appointments, or increased the time between follow-up appointments for patients with chronic diseases, or wrote certificates or renewed prescriptions without in-person consultations.

When waiting times for specialist consultations were considered too long, a third of the participants, mostly in private practices and urban areas, marshalled their network of specialist colleagues for appointments on an emergency basis, or sought opinions by telephone or text messages (sending, e.g. photographs of medical lesions and test results). Almost half referred patients to specialists or facilities with shorter delays for appointments, although this could involve a higher fee or longer travel time. Two participants also recommended that patients go to an ED to obtain some examinations, such as CT scans or MRI, rapidly. Nearly one third of the GPs chose to perform some follow-up or procedures generally done by other specialists (e.g. gynaecologists, paediatricians, and psychiatrists), including infiltrations or very minor surgery. Some had taken additional training courses to acquire these specialized technical skills. Young GPs and those in MPCGs seemed to adopt this strategy more frequently than others.

Most GPs did not take up formal proposals from health planning authorities. For example, the GPs—including in MPCGs—did not spontaneously mention MPCGs as a means of adapting to the onset of doctor shortage. Their feedback was mixed: MPCGs do not necessarily result in the arrival of new GPs nor does it lighten their workload. Some GPs nonetheless stressed the benefits of their colleagues' conversations and support ("if I need help, I just have to knock on the door next to mine") and a better balance between their work and personal lives: "its simpler to get organized and take vacations."

Finally, 3 GPs reported using remote consultations since the COVID-19 epidemic to provide access to care to patients without it, especially isolated individuals: "that allows everyone to be able to have a consultation"; "it provides a valuable medical response."

Discussion

Our qualitative survey is one of the first to examine the perceptions of GPs practising in areas with low medical density or at risk of a doctor shortage, the consequences on working conditions, and how these doctors adapt to them.

Shrinking access to care in rural and urban areas

Our participants' statements about access to care in their practice areas corroborate and add to the results of a 2022 national quantitative survey of 1,500 private-practice GPs in France⁹: 80%—a rate 11 points higher than in 2019—considered the supply of GPs in their type of practice area

Table 3. Objectives and examples of GPs' strategies

Objectives	Examples of strategies	Number of GPs (N = 29)
Limit and distribute the demand for care	Select patients	18
	Refer patients to colleagues or emergency departments	7
	Patient education to improve their autonomy	6
Optimize time	Prioritize tasks	7
	Delegate non-medical tasks	12
	Delegate medical tasks	6
	Use of tools (apps for making appointments, outsourced telephone secretarial services, professional software, etc.)	6
	Reduction of time per consultation	6
Facilitate access to specialists	Informal network of specialist colleagues	10
	Refer to specialists with shorter waiting times	14
	Performance of medical procedures most often performed by other specialties	9
Guarantee access to care for all	Teleconsultations	3

insufficient, and three quarters of them were pessimistic about the course of this situation. Today, 30% of the French general population lives in areas of low medical density, compared with 18% in 2018.¹⁵

Difficulty in access to care was reported by participants in rural but also urban and suburban areas, driven by different demographic mechanisms (mainly decreased supply for rural areas and increased demand for urban areas). Neither remote areas nor very socioeconomically disadvantaged urban neighbourhoods attract physicians,¹⁶ especially young ones. Our results also suggest that the health planning authorities appear less aware of the inadequate GP supply in urban and suburban areas where the population—and consequently the demand for care—has increased. Thus, they fail to prioritize measures to remedy it, perhaps because they make a trade-off in favour of the rural areas classified as underserved areas. Accordingly, in southeastern France, of the 435 municipalities classified as underserved by the Regional Health Agency, only 24 are urban, mainly neighbourhoods chosen because of their socioeconomic conditions.¹⁷

Increases in the amount and pace of work

Most participants reported the quantity and pace of their work are increasing, unsustainably for many. In 2019, the mean work week for French GPs was 54 h, a figure stable since 2014.¹⁸ By 2022, however, this working time nonetheless decreased in France, especially in underserved areas.⁹ This suggests that the GPs' pace of work has intensified, given the dwindling number of physicians and the growing demand for care. That is, for equivalent work hours, GPs practising in underserved areas have more patients and appointments and shorter consultations than do GPs in normally dense zones.¹⁹ Surveys in the United Kingdom also underline this issue of time management for GPs with high workloads.^{20,21}

High workload and work intensification have been shown to be associated with lower practice performance and quality of care, less time devoted to patient education and prevention, less time for CME, and more negative patient experiences.^{22–24} They are also associated with GPs' job stress and lack of professional satisfaction.²³

Work–life balance is also an important determinant of physician satisfaction.²⁵ In our study, many participants regretted that their work interferes with their personal and social lives. This result is consistent with a European

multicentre qualitative study in which GPs explained that they love their job but also need time for their families and leisure activities.²⁶

Several GPs expressed strong dissatisfaction, negative emotions (sadness, frustration, anger, feelings of powerlessness, and guilt), and psychological distress, fed by a sense of practising a degraded form of medicine and of not meeting their patients' needs. Some of them even admitted considering retiring early or changing careers.

General practitioners' burnout and brownout

We identified 2 main emotional coping strategies among GPs: engagement and detachment. At first glance, these two emotional reactions might appear to be contradictory. However, several interviews with older GPs suggest they may instead be successive responses. One hypothesis is that the motivation and engagement of initially combative GPs fade progressively, due to working conditions and the loss of effectiveness, sometimes to the point of burnout.²⁷

Our results suggest that several participants experienced burnout, that is, a state of physical and psychological exhaustion that occurs in emotionally demanding work.²⁸ According to a recent meta-analysis, nearly one third of GPs show a high level of emotional exhaustion (32%), signs of depersonalization (31%), and more than 25% a reduced feeling of personal accomplishment.²⁹

For some participants, they also suggest brownout—professional fatigue caused by a loss of meaning at work³⁰—manifested especially by discouragement and progressive disengagement from work and feelings of resignation, disillusionment, and lethargy. Factors promoting brownout range from the absurdity and uselessness of some tasks to a mismatch between work and personal values and to ethical conflicts generated by work. Being a GP is a vocational choice. Brownout could be related to the gap they perceive between the type of GP they want to be—a competent doctor who helps people, relieves their pain, and is available for their patients²⁶ and the medicine they feel they are practising, which does not correspond to their personality and personal values.

Burnout syndrome can promote the onset of different types of mental health disorders (depression, anxiety, sleep disorders, substance use, and suicidal behaviour) that are substantially underdiagnosed—and therefore untreated—in physicians.³¹ Moreover, numerous studies have shown that

these conditions also predict that they provide a poorer level of care and are at higher risk of medical errors.^{24,32–34}

Improvised and unofficial adaptations to difficulties

The GPs reported that the difficulties they encountered forced them to improvise to resolve problems. This discourse relates especially to two particularities of GPs. The first is the independence and professional autonomy³⁵ demanded by this professional corporation of mainly self-employed individuals. The second is pragmatic, intuitive mode of operation observed in some disorders, such as depression.³⁶ It is sometimes reflected by a distrust of clinical practice guidelines.³⁷ The GPs described modes of adaptation that were varied and had different objectives: to regulate the demand for care themselves, optimize their available time (including clinical time), and facilitate access to other medical specialties. The examples most often described were patient selection, informal task delegation, and the marshalling of their network of colleagues. In a qualitative survey of UK GPs, multiple strategies for managing work overloads were identified, but the most frequent were patient education and task delegation.²¹

This survey suggests that GPs mix potentially adaptive and maladaptive strategies: some adaptations could produce genuine increases in efficiency (i.e. improvements in processing patients with the quality of care maintained), while others, especially if they are systematized, could sacrifice quality for speed (e.g. shortening consultation times to the detriment of patients' needs).

The participants often described adaptations that were improvised and "handcrafted." They did not show much interest in the more formal and complex measures proposed by the health authorities, such as MPCGs, which were mentioned only occasionally and did not appear as convincing solutions to them. These practices, nonetheless, may offer a set of local outpatient health-care facilities, as well as public health and prevention actions.³⁸ Team work by GPs¹⁸ and the coordination of practices have increased substantially in France: the number of such practices (2200 in 2023) has doubled since 2017.¹⁵ Nonetheless, this model is used by only approximately 20% of GPs and 10% of nurses.¹⁵ MPCGs attract, in particular, young doctors,³⁹ while they may deter others, already overloaded with work, who consider this organizational form time-consuming and constraining (from an administrative perspective)¹⁵ or who fear a loss of autonomy and freedom,⁴⁰ and have little trust in the public authorities.⁴¹

Study limitations

Our results must be interpreted with caution, given its limitations. It is possible that our study participants were those most interested by its aim, those facing the most difficulties, or especially motivated by their desire to comment critically about the perceived difficulties and decline of their working conditions (recruitment bias). We interviewed only GPs practising in southeastern France. Nonetheless, this should not affect the generalizability of our results because we carefully included a wide variety of GP profiles with practices in different types of areas.

Conclusion

Most of the GPs interviewed had observed a reduction in access to care in their practice area and a degradation in both their working conditions and quality of care. In urban

areas, where the demand for care has increased due to population expansion and the presence of socioeconomically disadvantaged populations, participants reported that health officials were unresponsive to these concerns and contributed to perpetuating geographical inequalities. Many GPs reported increases in their workload and intensification of their work. Some participants' responses are strongly indicative of burnout, with concomitant psychological and behavioural disengagement and distancing from patients. In the face of these issues, these GPs maintain substantial expectations of policymakers and officials. Paradoxically, participants showed little interest in solutions proposed by health planners. Instead, GPs' adaptations were often improvised and unofficial.

The World Health Organization has put forward 10 proposals to strengthen the health-care workforce, including developing evidence-informed strategies to attract and retain health workers in underserved areas, creating working conditions that promote a healthy work-life balance, and adopting a stepped approach to protect these workers' mental health. Complementary interventions could be conducted to promote well-being at work and prevent burnout in newly qualified doctors, such as mentoring by experienced GPs or interventions of preparation for a self-employed medical practice.⁴²

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Supplementary material

Supplementary material is available at *Family Practice* online.

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Conflict of interest

None declared.

Ethical approval and consent to participate

Informed consent was obtained from all the study participants. The study was conducted in accordance with the Declaration of Helsinki, and the protocol was approved by the Ethics Committee of Aix-Marseille-Université (Reference 2021-01-07-03).

Data availability

The data underlying this article cannot be shared publicly for the privacy of individuals that participated in the study. The data will be shared on reasonable requests to the corresponding author.

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