You’re doing everything you possibly could do, and you know it’s not enough”: Family physician narratives of moral distress

Molinaro, Monica; Shen, Katrina; Agarwal, Gina; Inglis, Gabrielle; Vanstone, Meredith

DOI: https://doi.org/10.3399/BJGP.2023.0193

To access the most recent version of this article, please click the DOI URL in the line above.

Received 18 April 2023
Revised 26 July 2023
Accepted 10 August 2023

© 2023 The Author(s). This is an Open Access article distributed under the terms of the Creative Commons Attribution 4.0 License (http://creativecommons.org/licenses/by/4.0/). Published by British Journal of General Practice. For editorial process and policies, see: https://bjgp.org/authors/bjgp-editorial-process-and-policies

When citing this article please include the DOI provided above.
Author Names and Affiliations:
Monica L. Molinaro, PhD (Corresponding author)
Department of Family Medicine, McMaster University
David Braley Health Sciences Centre
100 Main Street West, 5th Floor
Hamilton, ON L8P 1H6
Email: molinaml@mcmaster.ca
ORCID ID: 0000-0002-5629-5974

Katrina Shen
Department of Family Medicine, McMaster University
David Braley Health Sciences Centre
100 Main Street West,
Hamilton, ON L8P 1H6

Gina Agarwal, MBBS (UK), PHD, MRCGP (UK), CCFP, FCFP, DIP, CAPM
Department of Family Medicine, McMaster University
David Braley Health Sciences Centre
100 Main Street West
Hamilton, ON L8P 1H6
ORCID ID: 0000-0002-5691-4675

Gabrielle Inglis, MD, MMSC, CCFP
Department of Family Medicine, McMaster University
David Braley Health Sciences Centre
100 Main Street West
Hamilton, ON L8P 1H6

Meredith Vanstone, PhD
Department of Family Medicine, McMaster University
David Braley Health Sciences Centre
100 Main Street West
Hamilton, ON L8P 1H6
ORCID ID: 0000-0002-7347-6259
Abstract

Background: Family physicians (general practitioners) working with patients experiencing social inequities have witnessed their patients’ health care needs proliferate. This increase in patient need, paired with increased workload demands fostered within current remuneration structures, has generated concerning reports of family physician attrition, and possible experiences of moral distress.

Aim: The purpose of this study was to explore stories of moral distress shared by family physicians caring for patients experiencing health needs related to social inequities.

Design and Setting: Conducted in Ontario, Canada, this study was a critical narrative inquiry informed by the analytic lens of moral distress.

Method: Twenty family physicians were recruited through purposive and snowball sampling via word of mouth and email mailing lists relevant to addictions and mental health care. Physicians participated in two narrative interviews, and had the opportunity to review the interview transcripts.

Results: Family physician accounts of moral distress were linked to policies governing physician remuneration, scope of practice, and the availability of social welfare programs. These structural elements left physicians unable to get patients much needed supports and resources.

Conclusion: This study provides evidence that physicians experience moral distress when unable to offer crucial resources to improve the health of patients with complex social needs due to structural features of the Canadian health and social welfare system. This finding provides impetus for critically interrogating how health and social welfare systems internationally must be reformed to both improve the health of patients, and increase family physician professional quality of life, potentially improving retention.

Keywords: Moral distress, family practice, primary health care, social determinants of health, health policy, social welfare

How this fits in
The moral distress of physicians who cannot provide adequate care due to systemic deficits is seldom heard in contemporary discussions about health care access and quality. Family physician stories of moral distress in relation to structural and systemic factors such as racism, colonialism, and drug, mental health, and housing policy, generate seemingly novel and vital understandings of the clinical work of primary care providers. The study findings are some of the first to illustrate family physicians’ experiences of moral distress, contributing to the limited body of literature on moral distress in primary care.
Introduction

Family medicine is the dominant primary care specialty in Canada and is a discipline that explicitly encompasses “a unique blend of biomedical, behavioural and social sciences, while employing a diverse range of cognitive and procedural skills” (1). Family physicians, elsewhere known as general practitioners, are integral to this specialty; their care encompasses both health promotion and illness prevention, they coordinate specialty care, and often advocate for their patients regarding “the care and services they need in all parts of the health care system” (1). What additionally separates family physicians from other health professions is their focus on complexity and uncertainty, which yields explicit acknowledgment of how social circumstances influence medical issues for many patients (2, 3).

The relationship between social circumstances and health outcomes are codified in theories of the social determinants of health (SDOH), which explain how social elements such as housing, income and social protection, social inclusion, and education determine health outcomes (4-6). This allows for an understanding of equity, which is:

- the absence of unfair, avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically or by other dimensions of inequality (e.g. sex, gender, ethnicity, disability, or sexual orientation) (7).

Health equity, thus, is “achieved when everyone can attain their full potential for health and well-being” (7). The SDOH provide us with an understanding of how social and health inequity are related, wherein lack of access to social goods can foster negative health outcomes. For example, access to population-based cancer screening is lower for those who experience racism, poverty, or precarious employment, resulting in later diagnoses of cancer and worse health outcomes (8-11).

Even though family medicine has a mandate to address SDOH and the health inequities stemming from lack of access to social goods (12, 13), it is situated within health and social care systems that are ill-equipped to respond to the structural causes of ill health. That is, while the sequelae of social and economic deprivation may not ideally be addressed within a family physician’s office, current social welfare systems are designed such that people who are struggling with addiction, mental ill-health, precarious housing, or insufficient income seek downstream solutions (e.g., safe supply, physician signature on social assistance supports) for the systemic conditions in which they are embedded. Primary health care represents one of the only consistent, accessible, and publicly-funded services available to people with multiple constellations of need, even when medical solutions may not be sufficient to address social and structural challenges (14). For instance, while family physicians could prescribe medication for insomnia, how can this treatment fully address the challenges of sleeping rough on the street or in crowded shelters, the anxiety of struggling to make ends meet financially, or the chronic stress of social exclusion from being unhoused? This entwinement of social and medical need is particularly acute for marginalized people, including individuals who face racism, poverty, ableism, and dangerous or precarious working conditions (15-18).

While family physicians working with marginalized patients cannot address the root causes of this insufficient resourcing, they are often left to pick up the pieces of these broader policy decisions when caring for their patients. In doing this work, these physicians are aware that their patients are experiencing multiple forms of harm and seeking care in a system that is ill-equipped
to respond to the root causes of ill health. While bearing witness to the limits of the system, these physicians are unable to offer the most greatly needed interventions that their patients need. Thus, examining the experiences of family physicians who work with disadvantaged patients is particularly important, as when family physicians are not able to help patients with unmet social needs that result in medical needs, there is potential that the physicians may experience moral distress (19-21).

Moral distress, defined as “when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action” (22), has become an increasingly topical concept in both scholarly literature and news media as a significant issue facing healthcare providers worldwide (23-33). However, moral distress has rarely been examined within the context of family medicine, and even less so in relation to the experiences of family physicians who specifically work with patients experiencing health needs related to social inequity.

Examining moral distress in this context is timely, as the discipline of family medicine has recently garnered worldwide attention for the increasing and disconcerting shortages of family physicians internationally (34-42). According to physicians who have left family medicine, the accumulation of conflicting, simultaneous increases in clinical care responsibilities and increasingly complex health needs of patients has been the impetus for leaving (34-42). What has not been explored is if these experiences are a result of, or possibly underpinned by moral distress. Thus, the purpose of this study was to explore family physicians’ stories of moral distress in caring for patients experiencing health needs related to social inequities.

Method
Study Design
This is a critical narrative inquiry informed by Jameton’s (22) conceptualization of moral distress. Critical narrative approaches are paradigmatically bound in critical theory, which aims to challenge and disrupt the status quo, with the ultimate goal of transformation (43, 44). When critically examining narratives, one can understand how a person’s morality is both embedded within how they narrate their connections to others, and “within issues of power and control” (45). When a person’s sense of identity is challenged or threatened, stories are useful for making sense of the ambiguities that characterize the person’s relationships with others and with the structures within which they are embedded (46-48). By critically interrogating these broader structures, narrative research can drive structural and institutional change. Stories also have persuasive value, particularly in policy decision-making contexts where decision-makers are tasked with making sense of multiple (and conflicting) forms of evidence (49). Please refer to [BLINDED] (50) for additional information regarding the methodology used for this study.

Reflective Statement
MM is a postdoctoral fellow with expertise in critical narrative methodologies and moral distress. MV is a primary care researcher specializing in social and ethical complexity. GA and GI are both family physicians who work extensively with marginalized populations and bring clinical expertise to this research. KS is an undergraduate research assistant with interests in conducting qualitative research with marginalized populations.
**Participant Recruitment**

Family physicians who were practicing in Ontario, Canada, and who self-identified as working with patients experiencing health needs related to social inequity (e.g., inadequate housing, issues with employment, income, or transportation) were eligible to participate. Ontario, Canada, in addition to being where the authors work, is an integral location for understanding experiences of working with patients who experience inequities; similar to many other provinces, states, and countries internationally, Ontario has a large population (51) where wealth is generally concentrated in urban pockets (52, 53), often leaving rural regions medically underserved (54).

After ethics approval was received from the Hamilton Integrated Research Ethics Board (#13610), all participants were recruited via purposive and snowball sampling. First, study collaborators emailed study materials to potential participants in their networks who worked with patients experiencing inequities. Study materials were also circulated via an email list of physicians working with patients who use substances. Any potential participants were encouraged to consider the social inequities their patient groups experience— the researchers did not suggest forms of inequity that participants’ patients may experience.

The intent of narrative inquiry is not to generalize findings to a particular population, but to generate rich data concerning a particular experience (55, 56). In particular, judgments of data sufficiency in narratological research focus on assessing the depth of participants’ stories and not on the quantity of possible participants. As such, our goal was not to recruit a large number of participants and reach saturation in our data, but rather to recruit a small number of participants who could speak at length about their work with marginalized patients. In this way, their interviews would generate rich stories that may be transferable to other family physicians and health professionals working with a similar population of patients.

**Data Collection**

Consistent with critical narrative approaches (57), participants were invited to two narrative interviews with MM that were conducted over the phone or Zoom. The first interview (Supplementary Box 1) acted as an opportunity for participants to freely narrate their experiences working with patients experiencing inequities, with MM probing in response to their stories. The second interview was an opportunity to probe for more “narrative detail” (57) that may have been missed in the original interview, such as the relevance of particular remuneration structures. The determination of relevance arose from the analysis of the first interview data. Stories of moral distress were told both in response to specific interview questions and spontaneously in conversations about what it meant to provide care for patients experiencing social inequity. These interviews were transcribed, analyzed, and sent to participants for review. To maintain trustworthiness and sincerity, we maintained an audit trail that included field notes, decisions regarding methods, feedback from collaborators to strengthen interpretations or future research decisions, and reflexive statements (58, 59).

**Data Analysis**

Data analysis methods were consistent with critical narrative approaches (56, 60). Narrative inquiry does not aim to uncover an objective truth amongst participant stories that is generalizable, correlational, and comparable across populations (61). Rather, rigorous narrative research can be recognized by an analysis which inspires reflection, by “prompt [ing] readers to
think beyond the surface of a text”(62) and consider the broader contexts that the narrative is situated within. Narrative analyses are iterative, and while grounded in the data, are based on the interpretations of those analyzing the data. In the case of this particular study, MM followed the approaches of Lieblich et al. (56) and Laliberte Rudman and Aldrich (60), whose analysis approaches consist of conducting multiple close reads of the data until a pattern is identified; noting any ambivalences, contradictions, or tensions to the pattern; deciding on and highlighting key content or themes; and reading the data for each identified theme; and noting the distinctive features (i.e., context, and transitions) of each theme. Many of the narrative themes were independently substantiated by KS via a separate analysis of all transcripts. These interpretations were presented to GA, GI, and MV, whose experience as clinicians and as family medicine researchers helped both confirm that interpretations were grounded in the data, and provided assistance in refining and contextualizing the interpretations.

Results

Twenty family physicians working throughout Ontario (Table 1) participated in 36 narrative interviews. While not all participants explicitly expressed the payment model they work within, many drew upon their experiences working in different payment models. These payment models included fee-for-service (billing the provincial health insurance plan for reimbursement for each medical service provided), salaried, and blended capitation (a payment per patient enrolled, regardless of service use paired with fee-for-service elements) models.

Moral distress was described as a ubiquitous feature of the professional lives by our participants; their narratives suggested they were often constrained in their ability to decide on and do what they felt was right for their patients. For example, PCP120 described feeling “powerless” to “help them [patients] reach any kind of well-being in life if they’re still struggling with just putting a roof over their heads. There’s no amount of medication that I’m going to prescribe that’s going to make that okay.” This description of powerlessness to help with available resources was echoed widely throughout the dataset through descriptions of feeling “helpless” (PCP103, PCP106, PCP109, PCP112), and “hopeless” (PCP106, PCP111, PCP112) about what could actually be done to help their patients. Others’ moral distress was elucidated through their descriptions of work being “soul-sucking” (PCP111), “demoralizing” (PCP102), and “frustrating” (PCP105, PCP107, PCP113).

Below, we present representative quotes from two narrative themes that were generated from, and illustrate the roots of physicians’ moral distress. These narrative themes address: 1) how policies governing physician remuneration and scope of practice left our participants both feeling overwhelmed with demands and forced to make compromises in what they chose to address; and 2) how our participants were limited by the behaviours of some patients, whose behaviours were influenced by and embedded within broader systemic constraints and availability of social welfare programs, leaving physicians unable to get them the resources needed to survive, let alone thrive.
**Table 1: Participant Demographics**

<table>
<thead>
<tr>
<th>Individual variables</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sex</strong></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>7</td>
</tr>
<tr>
<td>Female</td>
<td>13</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
</tr>
<tr>
<td>25-29</td>
<td>1</td>
</tr>
<tr>
<td>30-34</td>
<td>4</td>
</tr>
<tr>
<td>35-39</td>
<td>3</td>
</tr>
<tr>
<td>40-44</td>
<td>4</td>
</tr>
<tr>
<td>45-49</td>
<td>1</td>
</tr>
<tr>
<td>50-54</td>
<td>2</td>
</tr>
<tr>
<td>55-59</td>
<td>4</td>
</tr>
<tr>
<td>60-64</td>
<td>1</td>
</tr>
<tr>
<td><strong>Location</strong></td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>12</td>
</tr>
<tr>
<td>Rural</td>
<td>3</td>
</tr>
<tr>
<td>Both</td>
<td>5</td>
</tr>
<tr>
<td><strong>Practice Structure</strong></td>
<td></td>
</tr>
<tr>
<td>Family Health Team (FHT)</td>
<td>7</td>
</tr>
<tr>
<td>Family Health Organization (FHO)</td>
<td>1</td>
</tr>
<tr>
<td>Community Health Centre (CHC)</td>
<td>3</td>
</tr>
<tr>
<td>Indigenous Primary Health Care Orgs.</td>
<td>2</td>
</tr>
<tr>
<td>Independent solo</td>
<td>2</td>
</tr>
<tr>
<td>Independent group</td>
<td>3</td>
</tr>
<tr>
<td>Locum</td>
<td>3</td>
</tr>
<tr>
<td>Outpatient</td>
<td>2</td>
</tr>
<tr>
<td>Hospitalist</td>
<td>2</td>
</tr>
<tr>
<td><strong>Areas of focused practice</strong></td>
<td></td>
</tr>
<tr>
<td>Addiction medicine</td>
<td>4</td>
</tr>
<tr>
<td>Mental health</td>
<td>5</td>
</tr>
<tr>
<td>Unhoused patient care</td>
<td>4</td>
</tr>
<tr>
<td>Incarceration care</td>
<td>3</td>
</tr>
<tr>
<td><strong>Years of Experience</strong></td>
<td></td>
</tr>
<tr>
<td>&gt;1-4</td>
<td>6</td>
</tr>
<tr>
<td>5-9</td>
<td>3</td>
</tr>
<tr>
<td>10-14</td>
<td>3</td>
</tr>
<tr>
<td>15-19</td>
<td>1</td>
</tr>
<tr>
<td>20-24</td>
<td>0</td>
</tr>
<tr>
<td>25-29</td>
<td>5</td>
</tr>
<tr>
<td>30-34</td>
<td>0</td>
</tr>
<tr>
<td>35-39</td>
<td>2</td>
</tr>
</tbody>
</table>

Demographics of participants, including work location, practice structure, and areas of focused practice (if any).
“A death of 1000 cuts over time”: Increasing workload demands on already high workloads
A baseline contributor to experiences of moral distress, as narrated by the participants, was the increasing workload responsibilities taken on due to new family medicine remuneration and scope of practice structuring, leaving them with even less time to care for complex patients. This was exemplified by PCP120, who described how, while family physicians are “pretty adaptive people”, the “downloading [of] more work on to family doctors”, and the “increasing requirements and demands from multiple sources” signalled a continuous “eroding” of his (and his colleagues’) identity and values. His story suggested that he and other family physicians are now “negotiating” between completing remunerable tasks or providing unremunerated, dignified care for socially complex patients who need more than a typical 15-minute visit:

but when there’s just constantly more, being added to the expectations, that’s very, very demoralizing for sure. Because then remember, it’s- it’s not just a single negotiation of our identity and values and moral distress. It's a continuous one where it’s continually eroding and becomes a death of 1000 cuts over time. (PCP120)

This description of moral distress as a “death of 1000 cuts over time” exemplified the slow but continuous breakdown of the physicians’ moral resolve in their caregiving, and drew attention to an identity tension of being the physician they wanted to be and the physician they had the time and resources to be. Demonstrating this erosion of values in having to choose between workload and remuneration demands and dignified patient care, PCP113 narrated her own death of 1000 cuts by admitting that, while she “love[s] what I do on some days” if she were “back in medical school right now, knowing what [she] know[s]”, she would not have chosen to be a family doctor if she knew what the workload would be like:

I just think the risk of burnout, and the amount that’s being asked of family doctors in our province, versus the compensation, and the ability to actually balance work life, if you’re truly trying to live up to the aspirational goals of what a primary care provider should be, are just too great, right? Like, why would anybody want to do my job when they could work less hard, be happier, have more time with their families, have more time for their own wellbeing? (PCP113)

Her narrative further suggests that family physicians in Ontario are undervalued, and the realities of practice conflict with the values that she assigns to being a family physician and providing optimal care for her patients. This conflict, and constraint in being able to perform this care, caused her moral distress.

“They’re called ‘heart-sink’ patients because when I see their names my heart sinks”: Personal, structural and systemic barriers
Some physicians’ narratives suggested that their moral distress stemmed from their patients’ engagement in behaviours that ultimately limited their ability to receive care. This was exemplified by PCP110, who drew comparison between “systems issues” and “individual issues” in her story of “a young man that wants to start on an opiate replacement therapy”. She believes his initiative is “wonderful”, but knows “his behavior has been so bad that there's not a pharmacy that will accept him, because he'd been so abusive, or he's stolen so many times”:

I can't ask the pharmacist to give him one more chance when the first 13 chances didn't go well. [pause] I have nothing to offer him. [pause] He's probably going to die, he's probably going to overdose. [pause] I have nothing to offer. There's nothing anybody can offer him. [….] It was his own behaviors, and unfortunately, he's generally not a nice
person [...] That doesn't mean I won't see him, but it can sometimes really limit – it's not just [pause] there's nothing I can offer him. (PCP110)

Her narration also draws attention to her feelings of moral distress and continued empathy through her repeated use of the phrase “there’s nothing I can offer him”. This draws attention to the moral constraint she feels by her patient’s behaviours, knowing that broader structures had bearing on his issues with his mental health and addictions, and ultimately shaped his current behaviour.

Many of the physicians’ stories highlighted how their moral distress emanates from these “systems problems” (PCP110), conveying that “institutionalized obstacle[s] or hardships that the patient experiences in society, not even just in health care” (PCP102), particularly social welfare systems, have undeviating effects on their patients’ lives. However, addressing the issues generated by these poorly structured social welfare systems are not within their ability to help make meaningful change for their patients. PCP105, for instance, drew attention to her feelings of constraint by describing the “huge gap” between what her patients’ “needs are and what I can actually offer for them”:

here I am saying to somebody, ‘well you need to take this medication because it’s gonna help with your depression’ [...] and really all they’re thinking is, ‘Right now I just don’t wanna leave your office because it’s warm, and I don’t have a place to live. So can I hang out here a little bit longer and, you know, maybe have a cup of coffee?’ (PCP105)

Some participants expressed this sentiment more explicitly, such as PCP101, who, when asked if she experienced moral distress in her work, immediately responded with “Yes, totally. Oh my goodness”, and related her experience to structural factors of her patients’ lives that she does not have the power to alleviate: “Yeah, lots of the patients I care for die young because of our shitty toxic drug policy, and because of colonization, and because of racism. Uhh, yeah, that’s totally morally distressing.” From there, she compared her experiences to those of her patients who live in these conditions, by stating that she does not “think that I experience a ton more moral distress as a physician than [pauses] people experience living in their own communities that are under these terrible conditions of violence”. In this narration, she minimizes her own experiences of moral distress in relation to the trauma her patients have experienced, and continues on to state that “it’s probably better to experience moral distress and acknowledge it and work through it” than become unattached from her patients through “moral disintegration or moral detachment or–or you know other ways of dealing with those negative [pauses] emotions that come with moral distress.” (PCP101). Through this narration, she suggests remaining attached to and caring for her patients is more important than making changes to remediate her own moral distress.

Discussion

Summary

The stories of 20 family physicians who care for patients with medical needs related to social inequity highlights how moral distress can be grounded in broader systemic and structural factors. The study findings, to our knowledge, are some of the first to illustrate the moral distress experiences of family physicians, particularly those working with patients experiencing inequities, which builds upon the small body of moral distress scholarship in the primary care literature (63-69). Our participants’ moral distress was associated with remuneration structures and workload demands, and was exacerbated by a lack of social resources such as housing,
sufficient and comprehensive mental health and addictions services, which resulted in strict limitations on their ability to provide comprehensive care.

**Strengths and Limitations**

A strength of this study is consistency in its focus on narrative. Through the conceptualization of the research, narrative-eliciting interviewing approach, and highly immersive, multi-stage interpretive process, our study was epistemologically and methodologically tethered, which ensured rich data and substantial depth to the analysis. Further, the use of a critical narrative methodology allowed for both a nuanced understanding and situating of participant narratives in broader institutional and structural contexts.

A considerable strength of this research is its transferability to other provinces, countries and health care contexts where the social safety net is weak or non-existent. In these cases, the downstream effects of limited social support are often brought to family physicians, whom are insufficiently resourced to provide care for the upstream determinants of health.

Our research is bounded by the historical and geographical contexts in which it was conducted. While our findings are not intended to be generalizable to all family physicians, they may have less salience with family physicians working with patient populations who are not marginalized. Additionally, in contexts where social welfare policy and the social safety net is strong, such as countries in which safe and affordable housing and safe drug supply, these experiences may not be as relevant.

**Comparison with existing literature**

The stories told by our participants are congruent with the growing attention to the attrition of family physicians in many countries (70-72). Issues such as increasing workload demands related to escalating indirect care requirements in addition to the increased complexity of patients’ health needs because of delayed screenings during the COVID-19 pandemic have previously been cited as reasons for the mass exodus out of family medicine (34-42). Our findings are also congruent with research on American family medicine residents that demonstrates how workload and limited time to care for oneself contributes to moral injury, which is related to but distinct from moral distress. Moral injury is regarded as a deep violation of what one believes is right, and can be the identity-changing result of experiencing multiple morally distressing events (73). The findings from this study suggest that family physicians may be experiencing moral distress from their clinical work as early as their residency (74), drawing attention to the broader structuring of health and social care systems that physicians are embedded within. As long as upstream social welfare policy issues remain unresolved, family physicians will continue to compensate for them, maintaining likelihood that they will continue to experience moral distress.

There are also similarities between our findings and reports of American clinicians’ moral distress specifically during the COVID-19 pandemic (68). Similar to our participants, these clinicians experienced moral distress related to patients not receiving the best or necessary care, and bearing witness to the inequities experienced by patients, including homelessness and racism (68). It should be noted our participants did not experience moral distress by proxy of working with persons experiencing inequities. Rather, and in conjunction with the aforementioned study, moral distress was experienced by: 1) being rendered unable to help patients whose issues would
be alleviated by stronger social welfare policy, and 2) being embedded within both social welfare and health care systems that are ultimately harming their patients.

Implications for research and/or practice
Participant stories of moral distress in relation to structural and systemic factors provide a novel illustration of how a lack of social welfare supports results in compounding health needs brought to family physicians, who may not have access to corresponding resources (75, 76). This is also exemplified through the links drawn between individual behaviours and systems issues. While some physicians may see patient choices as non-compliance, our participants’ stories illustrated how the choices patients make are influenced, in part, by the systems they are bound within. As an example, a patient who takes their daily medication every second day and delays renewing said prescription for months may be perceived by some as non-compliant with treatment protocols. However, when contextualized with information about the patient’s low disability support payments and lack of pharmaceutical insurance coverage, these behaviours can be seen as directly related to structural causes of poverty.

Our findings have implications for primary care policy and practice, particularly through invocations to restructure family physician remuneration to encourage sensitive work with complex patients. Our findings illustrate that remuneration is an important factor in what care, if any, marginalized patients can receive. Capitation or salaried models, while not a perfect solution to blended fee-for-service (FFS) models (77-79), may offer physicians more time and ability to care holistically for patients with complex needs. Additionally, the use of interprofessional teams, in which patients have free access to social workers, legal advisors, and system navigators (as examples) may better address patient needs (41, 80, 81).

While both of these shifts would allow for better care for marginalized patients, these changes will ultimately not address the upstream deficiencies in social welfare systems that deprive people of safe and affordable housing, consistent and well-paying employment, and safe drug supply. The social and structural challenges experienced by persons experiencing inequity cannot be resolved until the prioritization of consistent, accessible, publicly-funded social services take precedence in social and political agendas worldwide.

Future research should examine experiences of moral distress within all forms of integrated care that constitute family medicine and general practice, in order to understand the links between moral distress and stringent primary care budgeting within differing institutional contexts. Further, while current remedies to moral distress include suggestions of practicing wellness and resilience (82-84) these interventions do not include focus on the structural and systemic roots of moral distress. Future research should therefore examine how institutional and structural change has bearing on experiences of moral distress.

Funding
MM is supported by a Banting Postdoctoral Fellowship. This research was supported in part by McMaster Department of Family Medicine Pilot Research Grant, and a McMaster Education Research, Innovation and Theory Scholar Pilot Grant. GA is supported by Canada Research Chair in Vulnerable Individuals in Primary Care. MV is supported by Canada Research Chair in Ethical Complexity in Primary Care.
Ethical Approval
Ethics approval was received from the Hamilton Integrated Research Ethics Board (#13610).

Competing Interests
The authors have no competing interests to report.

Acknowledgements
The authors would like to thank Shayan Mohammadzadeh Novin, Eunice Tunggal, and Auva Zarandi for their time transcribing interviews, as well as the participants for sharing their stories.
References
21. Parry JE. Primary care-based interventions to address patients' unmet economic needs 2022.
36. Larocque L, Perez J. Ottawa family doctors say burnout is real and some are leaving their practices. CTV News. 2022 June 7, 2022.