

2007 NPS: Specialty Resident Questionnaire

**Please complete this questionnaire if you are in your SECOND year of a Medical Residency Program at a Canadian University.**

**If you are in your second year of a medical residency program at a Canadian university, please indicate the category that best applies to you.**

- Family Medicine Training Program
- Other Specialty Medicine Training Program

**If you are not in your second year of a medical residency program, please indicate your status below.**

- I am a resident in a year OTHER THAN second year
- I am a physician in practice
- Other, specify

**A. About You**

**1. Your year of birth:** 19\_\_ \_\_

**2. Sex:**         male     female

**3. Marital status.**

- Married/living with partner         Single         Separated     Divorced     Widowed
- Please specify the profession of your spouse/partner: \_\_\_\_\_

**4.a) Do you have children?**     No                     Yes - Age of the youngest? \_\_\_\_\_ years

**4.b) Are you or your partner currently expecting a child?**     Yes                     No

**5. Select the ONE statement which best describes the environment in which you grew up prior to university.**

- Exclusively/ predominantly rural
- Exclusively/ predominantly small town
- Exclusively/ predominantly urban
- Mixture of environments

**6. In which province(s) or territories did you grow up prior to going to university?**

*Check ALL that apply.*

BC    AB    SK    MB    ON    QC    NB    NS    PE    NL    NT    YT    NU    Outside of  
Canada

2007 NPS: Specialty Resident Questionnaire

**7. Are you...? Check ALL that apply.**

- Caucasian
- Aboriginal (e.g., status, non-status, Métis, Inuit)
- Chinese
- South Asian (e.g., East Indian, Pakistani, Sri Lankan, etc.)
- Black
- Filipino
- Latin American
- Southeast Asian (e.g., Cambodian, Indonesian, Laotian, Vietnamese, etc.)
- Arab
- West Asian (e.g., Afghan, Iranian, etc.)
- Japanese
- Korean
- Other \_\_\_\_\_
- I prefer not to provide this information

**8. Were you born in Canada?**

- Yes
- No. Please indicate your status in Canada.
  - Canadian citizen
  - Permanent resident (landed immigrant)
  - Other \_\_\_\_\_

**9. How many years of POST-SECONDARY education did you complete before beginning medical school? (If you were a student in Quebec, please do not include CEGEP).**

0    1    2    3    4    5    6    7    8    9    10    >10

**10. Beyond secondary school, what degrees/ diplomas did you complete prior to entering medical school? Please check ALL that apply.**

- None
- Diplome d'étude collegial (CEGEP)
- Bachelor's
- Master's    Please specify field/discipline: \_\_\_\_\_
- Doctorate    Please specify field/discipline: \_\_\_\_\_
- Other \_\_\_\_\_

**11.a) What year were you awarded your M.D. degree? □ □ □ □**

**11.b) At which university were you awarded your M.D. degree?**

- University of British Columbia
- University of Calgary
- University of Alberta
- University of Saskatchewan
- University of Manitoba
- University of Western Ontario
- McMaster University

2007 NPS: Specialty Resident Questionnaire

- University of Toronto
- University of Ottawa
- Queen's University
- Université de Sherbrooke
- Université de Montréal
- McGill University
- Université Laval
- Dalhousie University
- Memorial University
- Other, please specify country \_\_\_\_\_

**12.a) At which university are you currently registered for your residency medical training?**

- University of British Columbia
- University of Calgary
- University of Alberta
- University of Saskatchewan
- University of Manitoba
- University of Western Ontario
- McMaster University
- University of Toronto
- University of Ottawa
- Queen's University
- Université de Sherbrooke
- Université de Montréal
- McGill University
- Université Laval
- Dalhousie University
- Memorial University
- Northern Ontario School of Medicine

**12.b) Please indicate the site of your residency training program (hospital or clinic, municipality, province).**

\_\_\_\_\_

**12.c) Please indicate the percentage of time spent during your residency in the following clinical settings:**

Rural hospital	_____ %	Small/community hospital	_____ %
Large teaching hospital	_____ %	Community office practice	_____ %
Office practice in hospital	_____ %	Other _____	_____ %

2007 NPS: Specialty Resident Questionnaire

**13. Considering all of the areas in medicine, what led you to select your area of specialty?**

*Please check ALL that apply.*

- |                                   |  |                                   |  |
|-----------------------------------|--|-----------------------------------|--|
| <b>A</b> <input type="checkbox"/> | Intellectual stimulation/challenge         | <b>G</b> <input type="checkbox"/> | Earning potential                            |
| <b>B</b> <input type="checkbox"/> | Doctor-patient relationship                | <b>H</b> <input type="checkbox"/> | Research opportunities                       |
| <b>C</b> <input type="checkbox"/> | Workload flexibility and/or predictability | <b>I</b> <input type="checkbox"/> | Teaching opportunities                       |
| <b>D</b> <input type="checkbox"/> | Influence of a mentor                      | <b>J</b> <input type="checkbox"/> | Ability to pursue non-work related interests |
| <b>E</b> <input type="checkbox"/> | Influence of my family                     | <b>K</b> <input type="checkbox"/> | Availability of training opportunities       |
| <b>F</b> <input type="checkbox"/> | Prestige                                   | <b>L</b> <input type="checkbox"/> | Other _____                                  |

**B. Training**

**14.a) Please indicate the training program you are in**

- Anatomical Pathology
- Anesthesiology
- Cardiac Surgery
- Cardiology
- Clinical Immunology and Allergy
- Clinical Pharmacology
- Clinician Investigator Program
- Colorectal Surgery
- Community Medicine
- Critical Care Medicine
- Dermatology
- Developmental Pediatrics
- Diagnostic Radiology
- Emergency Medicine
- Endocrinology and Metabolism
- Forensic Pathology
- Gastroenterology
- General Pathology
- General Surgery
- General Surgical Oncology
- Geriatric Medicine
- Gynecologic Oncology
- Gynecologic Reproductive Endocrinology and Infertility
- Hematological Pathology
- Hematology
- Infectious Diseases
- Internal Medicine
- Maternal-Fetal Medicine
- Medical Biochemistry
- Medical Genetics
- Medical Microbiology
- Medical Oncology
- Neonatal-Perinatal Medicine
- Nephrology
- Neurology
- Neuropathology
- Neuroradiology

## 2007 NPS: Specialty Resident Questionnaire

Neurosurgery  
 Nuclear Medicine  
 Obstetrics and Gynecology  
 Occupational Medicine  
 Ophthalmology  
 Orthopedic Surgery  
 Otolaryngology  
 Palliative Medicine  
 Pediatric Emergency Medicine  
 Pediatric General Surgery  
 Pediatric Hematology/Oncology  
 Pediatric Radiology  
 Pediatrics  
 Physical Medicine and Rehabilitation  
 Plastic Surgery  
 Psychiatry  
 Radiation Oncology  
 Respiriology  
 Rheumatology  
 Thoracic Surgery  
 Transfusion Medicine  
 Urology  
 Vascular Surgery

### 14.b) Please indicate your overall sense of satisfaction with your residency program.

Very dissatisfied	Dissatisfied	Neutral	Satisfied	Very satisfied
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### 15. For the following experiences within your residency training, please indicate:

- if the specific category of training is/was available to you (Please check all that apply);
- if you feel the training has adequately prepared you for future practice in this area;
- if, in your opinion, the specific category of training should be a mandatory component of your residency curriculum.

	Available?		Prepared for future practice?			Should it be Mandatory?	
	Yes	No	Yes	No	Don't know yet	Yes	No
Collaborative/interdisciplinary care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Communication skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Computer skills/ clinical information retrieval	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Critical appraisal skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
End of life issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ethics and professionalism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Evidence-based medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Office procedures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hands on research experience	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hands on teaching experience	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Working in a health care system	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**16.a) Do you feel that your residency training will prepare you for the kind of practice you are planning to undertake?**

- Yes       No       Don't know yet

**16.b) What areas of training are you lacking? (e.g. a specific procedural skill, etc.). Please specify:**

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**17. To what extent would you agree or disagree with this statement: the academic and the clinical service components of your residency program are balanced.**

- Strongly agree      Agree      Neutral      Disagree      Strongly disagree

**18. Do you intend to continue your residency by undertaking a fellowship position?**

- Yes    No    Don't know yet

### **C. Future Practice/ Work Setting Profile**

**19. Within 2-3 years after completing your residency, do you plan to:** *Check ALL that apply.*

**a) Practice in the field in which you are currently training?**

- Yes    No    Don't know yet

**b) Practice as a locum tenens?**       Yes    No    Don't know yet

***b)i) Indicate your reasons for wanting to practice as a locum tenens. Check ALL that apply.***

- Financial reasons       To assess potential future practice location    Clinical variety  
 Filling a service need       Flexibility/ability to set own schedule  
 Other, specify \_\_\_\_\_

***b)ii) For which patient population(s) do you intend to provide locum tenens care? Check ALL that apply.***

- Inner city  
 Urban/ Suburban  
 Small town  
 Rural  
 Geographically isolated/ Remote  
 Other \_\_\_\_\_

2007 NPS: Specialty Resident Questionnaire

Don't know yet

**c) Buy/ set up your own practice?**  Yes  No  Don't know yet

**d) Practice in a hospital setting?**  Yes  No  Don't know yet

**e) Practice within the same province in which you are currently training?**

Yes  No  Don't know yet

**f) Practice in another province or territory in Canada?**

Yes  No  Don't know yet *If yes, please specify province or territory: \_\_\_\_\_*

**g) Leave Canada to practice in another country?**  Yes  No  Don't know yet

**h) Take a maternity or paternity leave?**  Yes  No  Don't know yet

**i) Take a temporary leave of absence for reasons other than maternity or paternity?**

Yes  No  Don't know yet

**j) Sub-specialize within an area of your current specialty?**

Yes  No  Don't know yet *If yes, please specify: \_\_\_\_\_*

**k) Seek an administrative (non patient care) position?**  Yes  No  Don't know yet

**l) Apply for (a) hospital appointment(s)?**  Yes  No  Don't know yet

**m) Apply for (a) faculty appointment(s)?**  Yes  No  Don't know yet

**n) Provide patient care?**  Yes  No  Don't know yet

**o) Take on-call responsibilities?**  Yes  No  Don't know yet

**20.a) Are you being actively recruited for a practice location?**  Yes  No

**20.b) Where are the recruiters from?**

Other province or territory within Canada

Other community within the province

Your own community

Canadian Forces Health Services

USA

Other \_\_\_\_\_

**D. Future Practice/ Work Profile**

**21. Please describe the population PRIMARILY served by the practice you intend to undertake after completion of residency. Please check ONLY ONE.**

- |  |  |
|--|--|
| <input type="checkbox"/> Inner city                      | <input type="checkbox"/> Other _____                                   |
| <input type="checkbox"/> Urban/ Suburban                 | <input type="checkbox"/> Don't know yet                                |
| <input type="checkbox"/> Small town                      | <input type="checkbox"/> I don't intend to be involved in patient care |
| <input type="checkbox"/> Rural                           |  |
| <input type="checkbox"/> Geographically isolated/ Remote |  |

**22. Please indicate the languages that you could comfortably speak with your future patients.**

- |                                  |                                 |   |
|----------------------------------|---------------------------------|---|
| <input type="checkbox"/> English | <input type="checkbox"/> French | <input type="checkbox"/> Other(s) _____ |
|----------------------------------|---------------------------------|---|

**23. How do you intend to organize your practice?**

*Note that a solo or group practice could also include a nurse who does not have her/his own caseload.*

- Solo practice
- Group practice
- Interprofessional practice (physician(s) and other health professional(s) who have their own caseloads)
- Other \_\_\_\_\_
- Don't know yet
- N/A – Do not intend to set up or join a practice

**24. Which of the following types of health care providers have you collaborated with during your residency, and in your future practice do you plan to collaborate with these types of health care providers in providing patient care? Please check ALL that apply.**

	During my residency I have collaborated with the following in providing patient care	In my future practice I plan to collaborate with the following in providing patient care
Family physicians		
Other specialists		
Nurse practitioners		
Psychiatric nurses		
Other nurses (RN, LPN, RPN)		
Physician assistants		
Dietitians/nutritionists		
Occupational therapists		
Physiotherapists		
Chiropractors		
Psychologists		
Mental health counselors		
Addiction counselors		
Social workers		
Pharmacists		
Midwives		
Speech-language pathologists		
Chiropodists		
Complementary/alternative medicine providers (e.g. acupuncturists, homeopaths)		
Other	Specify _____	Specify _____

2007 NPS: Specialty Resident Questionnaire

**25. Please indicate if you feel adequately trained in the following areas, and which of these areas you intend to include as part of your practice. Please check ALL that apply.**

Area of Professional Activity	I feel adequately trained in these areas	I intend to provide these areas of care
Non-urgent health care		
Acute health care		
Emergency medicine		
Housecalls		
In-patient hospital care		
Intrapartum care		
Mental health care		
Palliative care		
Psychotherapy/counseling		

**26. Please indicate if you feel adequately trained to provide health care for the following patient populations, and if you intend to do so. Please check ALL that apply.**

	I feel adequately trained to care for the following	I intend to provide health care for the following
Neonates (<1 month)		
Infants (1-12 months)		
Children (1-11 years)		
Adolescents (12-19 years)		
Women		
Pregnant women		
Men		
Seniors (65+ years)		
Patients with respiratory problems		
Patients with hypertension		
Patients with diabetes		
Patients with heart disease/conditions		
Patients with chronic mental illness		
Patients with obesity		
Patients with cancer		
Patients with HIV/AIDS		
Patients with addictions		
Patients with permanent physical disabilities		

2007 NPS: Specialty Resident Questionnaire

**27.a) Please indicate ALL of the disciplines and areas of professional activity listed below in which you intend to practice/ work. Please note: you do not have to be certified in the discipline/ area of professional activity to include it in your profile.**

***Please check ALL that apply to you.***

	<b>Discipline/ Area of Practice</b>
	ACADEMIC/RESEARCH
<input type="checkbox"/>	Bioethics/Ethics
<input type="checkbox"/>	Clinical Epidemiology
<input type="checkbox"/>	Clinical Investigation
<input type="checkbox"/>	Epidemiology/Biostatistics
<input type="checkbox"/>	Medical Education (includes teaching and educational research)
<input type="checkbox"/>	Medical Science/Scientist
<input type="checkbox"/>	Social Sciences & Humanities in Medicine
	ACUTE/CRITICAL CARE
<input type="checkbox"/>	Critical Care Medicine/Intensive Care
<input type="checkbox"/>	Disaster Medicine
<input type="checkbox"/>	Emergency Medicine
<input type="checkbox"/>	Toxicology
<input type="checkbox"/>	Trauma
<input type="checkbox"/>	ADDICTIONS/SUBSTANCE ABUSE
	ANESTHESIOLOGY/ANESTHESIA
<input type="checkbox"/>	Anesthesiology/Anesthesia
<input type="checkbox"/>	Cardiac Anesthesia
<input type="checkbox"/>	ADMINISTRATION
<input type="checkbox"/>	AIDS/HIV
<input type="checkbox"/>	AVIATION/AEROSPACE MEDICINE
<input type="checkbox"/>	BIOMEDICAL ENGINEERING
	CARDIO-VASCULAR/THORACIC
<input type="checkbox"/>	Angiography
<input type="checkbox"/>	Cardiac, Cardio-Thoracic Surgery
<input type="checkbox"/>	Cardiac Electrophysiology
<input type="checkbox"/>	Cardiac Rehabilitation
<input type="checkbox"/>	Cardiology
<input type="checkbox"/>	Echocardiography/ECG/ Cardiac Stress Testing
<input type="checkbox"/>	Interventional Cardiology
<input type="checkbox"/>	Thoracic Surgery
<input type="checkbox"/>	CLINICAL IMMUNOLOGY & ALLERGY
<input type="checkbox"/>	CLINICAL PHARMACOLOGY
<input type="checkbox"/>	DERMATOLOGY
	ENDOCRINOLOGY
<input type="checkbox"/>	Endocrinology & Metabolism
<input type="checkbox"/>	Nutrition (including obesity)
<input type="checkbox"/>	ENVIRONMENTAL MEDICINE
<input type="checkbox"/>	GASTROENTEROLOGY
<input type="checkbox"/>	GERIATRIC MEDICINE

## 2007 NPS: Specialty Resident Questionnaire

<input type="checkbox"/>	GYNECOLOGIC REPRODUCTIVE ENDOCRINOLOGY & INFERTILITY
<input type="checkbox"/>	HEPATOLOGY
<input type="checkbox"/>	HEMATOLOGY
<input type="checkbox"/>	HOMECARE
<input type="checkbox"/>	HOSPITALIST
<input type="checkbox"/>	INFECTIOUS DISEASES
<input type="checkbox"/>	INFORMATION TECHNOLOGY
<input type="checkbox"/>	INTERNAL MEDICINE (GENERAL)
<input type="checkbox"/>	LABORATORY
<input type="checkbox"/>	Anatomical Pathology
<input type="checkbox"/>	Clinical Pathology
<input type="checkbox"/>	Cytopathology
<input type="checkbox"/>	Forensic Pathology
<input type="checkbox"/>	General Pathology
<input type="checkbox"/>	Hematological Pathology
<input type="checkbox"/>	Medical Biochemistry
<input type="checkbox"/>	Medical Microbiology
<input type="checkbox"/>	Neuropathology
<input type="checkbox"/>	Ocular Pathology
<input type="checkbox"/>	LEGAL/MEDICO-LEGAL CONSULTATIONS
<input type="checkbox"/>	MEDICAL GENETICS
<input type="checkbox"/>	MEDICAL ONCOLOGY
<input type="checkbox"/>	MILITARY MEDICINE
<input type="checkbox"/>	NEPHROLOGY
<input type="checkbox"/>	NEUROLOGY
<input type="checkbox"/>	Electromyography/EMG
<input type="checkbox"/>	Neurology
<input type="checkbox"/>	Neuro/Electrophysiology
<input type="checkbox"/>	NUCLEAR MEDICINE
<input type="checkbox"/>	OBSTETRICS/GYNECOLOGY
<input type="checkbox"/>	Gynecology
<input type="checkbox"/>	Gynecologic Oncology
<input type="checkbox"/>	Maternal/fetal medicine
<input type="checkbox"/>	Obstetrics
<input type="checkbox"/>	STD/Sexual Medicine
<input type="checkbox"/>	OCCUPATIONAL MEDICINE
<input type="checkbox"/>	OPHTHALMOLOGY
<input type="checkbox"/>	Neuroophthalmology
<input type="checkbox"/>	Ophthalmology
<input type="checkbox"/>	OTOLARYNGOLOGY
<input type="checkbox"/>	Head & Neck Oncology
<input type="checkbox"/>	Head & Neck Surgery
<input type="checkbox"/>	Neurotology
<input type="checkbox"/>	Otolaryngology
<input type="checkbox"/>	PALLIATIVE CARE/PALLIATIVE MEDICINE

## 2007 NPS: Specialty Resident Questionnaire

<input type="checkbox"/>	PAIN MANAGEMENT
	PEDIATRICS
<input type="checkbox"/>	Adolescent Medicine
<input type="checkbox"/>	Adolescent & Pediatric Gynecology
<input type="checkbox"/>	Neonatal/Perinatal Medicine
<input type="checkbox"/>	Pediatrics
<input type="checkbox"/>	Pediatric Anesthesiology/Anesthesia
<input type="checkbox"/>	Developmental Pediatrics (including disabilities)
<input type="checkbox"/>	Pediatric Cardiac Surgery
<input type="checkbox"/>	Pediatric Cardiology
<input type="checkbox"/>	Child Psychiatry
<input type="checkbox"/>	Pediatric Clinical Immunology & Allergy
<input type="checkbox"/>	Pediatric Critical/Intensive Care
<input type="checkbox"/>	Pediatric Diagnostic Radiology
<input type="checkbox"/>	Pediatric Endocrinology & Metabolism
<input type="checkbox"/>	Pediatric Emergency Medicine
<input type="checkbox"/>	Pediatric General Surgery
<input type="checkbox"/>	Pediatric Gastroenterology
<input type="checkbox"/>	Pediatric Hematology/Oncology
<input type="checkbox"/>	Pediatric Infectious Diseases
<input type="checkbox"/>	Pediatric Nephrology
<input type="checkbox"/>	Pediatric Neurology
<input type="checkbox"/>	Pediatric Neurosurgery
<input type="checkbox"/>	Pediatric Otolaryngology
<input type="checkbox"/>	Pediatric Orthopedic Surgery
<input type="checkbox"/>	Pediatric Pathology
<input type="checkbox"/>	Pediatric Plastic Surgery
<input type="checkbox"/>	Pediatric Respiratory Medicine/Respirology
<input type="checkbox"/>	Pediatric Rheumatology
<input type="checkbox"/>	Pediatric Urology
<input type="checkbox"/>	PHYSICAL MEDICINE & REHABILITATION
<input type="checkbox"/>	PRIMARY CARE/GENERAL PRACTICE/FAMILY PRACTICE
	PSYCHIATRY
<input type="checkbox"/>	Family/Marital Therapy
<input type="checkbox"/>	Geriatric Psychiatry
<input type="checkbox"/>	Psychiatry
	Forensic Psychiatry (Psychiatry and the Law)
<input type="checkbox"/>	Psychogeriatrics
<input type="checkbox"/>	Psychopharmacology
<input type="checkbox"/>	PUBLIC HEALTH
<input type="checkbox"/>	Community Medicine/Public Health
<input type="checkbox"/>	International Medicine
<input type="checkbox"/>	Travel/Tropical Medicine
<input type="checkbox"/>	RADIATION ONCOLOGY
	RADIOLOGY

2007 NPS: Specialty Resident Questionnaire

<input type="checkbox"/>	Diagnostic Radiology
<input type="checkbox"/>	Interventional Radiology
<input type="checkbox"/>	Neuroradiology
<input type="checkbox"/>	RESPIRATORY MEDICINE/RESPIROLOGY
<input type="checkbox"/>	RHEUMATOLOGY
<input type="checkbox"/>	SLEEP DISORDERS
<input type="checkbox"/>	SPINAL CORD INJURY
<input type="checkbox"/>	SPORTS MEDICINE
<input type="checkbox"/>	SURGERY
<input type="checkbox"/>	Colorectal Surgery
<input type="checkbox"/>	Cosmetic Surgery
<input type="checkbox"/>	General Surgery
<input type="checkbox"/>	General Surgical Oncology
<input type="checkbox"/>	Hand Surgery
<input type="checkbox"/>	Neurosurgery
<input type="checkbox"/>	Orthopedic Surgery
<input type="checkbox"/>	Plastic Surgery
<input type="checkbox"/>	Transplantation
<input type="checkbox"/>	Urology
<input type="checkbox"/>	Vascular Surgery
<input type="checkbox"/>	TRANSFUSION MEDICINE
<input type="checkbox"/>	ULTRASOUND
<input type="checkbox"/>	WOMEN'S HEALTH

**27.b) Please list any further skills that you feel you need to acquire.** \_\_\_\_\_

**28.a) For you, what factors do you think will be most important in having a satisfying and successful medical practice? Please check ALL that apply.**

- A  A specific type of practice environment (e.g., group or multidisciplinary practice, strong support staff). Please specify: \_\_\_\_\_
- B  Ability to achieve balance between work life and personal life
- C  Flexible work hours
- D  Sufficient medical competence to respond to health care needs of my patients
- E  Availability of continuing education resources
- F  Opportunities for research
- G  Opportunities for teaching
- H  Ability to achieve desired income
- I  Availability of medical support systems/resources
- J  Availability of relevant patient information at the point of care
- K  Ability to access appropriate care facilities for my patients (e.g. hospital beds, long-term care beds)
- L  Other, please specify: \_\_\_\_\_

**28.b) Please indicate which of the factors in 28.a is the one most important factor for you to have a satisfying and successful medical practice.**

- A  B  C  D  E  F  G  H  I  J  K  L

**29. The following statements address the role of alternative/complementary medicine in health services. Please check the category that best describes your opinion for each of the following:**

	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
Alternative/complementary medicine includes ideas and methods from which conventional medicine could benefit					
Treatments not tested in a scientifically recognized manner should be discouraged					
Alternative/complementary medicine is a threat to public health					

### E. Time Allocation

**30. Please indicate in which of the following areas you intend to spend time or participate upon completion of your residency training *Please check ALL that apply.***

i) <b>Direct patient care</b>	<input type="checkbox"/>
ii) <b>Indirect patient care</b> (charting, reports, phone calls, meeting patients' family, etc.)	<input type="checkbox"/>
iii) <b>Teaching/ Education</b>	<input type="checkbox"/>
iv) <b>Research</b> (including management of research and publications)	<input type="checkbox"/>
v) <b>Health facility committees</b>	<input type="checkbox"/>
vi) <b>Managing your practice</b> (staff, facility, equipment, etc.)	<input type="checkbox"/>
vii) <b>Administration</b> (i.e. management of university program, chief of staff, department head, Ministry of Health, etc.)	<input type="checkbox"/>
viii) <b>Continuing medical education/ professional development</b> (courses, reading, videos, tapes, seminars, etc.)	<input type="checkbox"/>
ix) <b>Other</b> (participation in professional or specialty organizations, medico-legal activities, etc.)	<input type="checkbox"/>

### F. Information Technology

**31. a) Have you used or been exposed to electronic medical records to enter/retrieve patient clinical notes during your clinical training?**

No  Yes.

**31.b) Please indicate the setting(s):**

hospital  physician office/clinic setting  other, specify: \_\_\_\_\_

**32. Would you expect to use electronic medical records to enter/retrieve patient clinical notes instead of paper when you enter into practice?**  Yes  No  N/A – do not intend to provide patient care

**33. What technology tools do you currently use in a clinical training setting?** *Check ALL that apply.*

- PDA (personal digital assistant/wireless device)
- Laptop computer
- Tablet
- Cell phone
- IPOD/MP3 player
- Other, specify \_\_\_\_\_

**34. What websites do you use for access to research clinical information?** *Check ALL that apply.*

Medical Organizations/Schools Websites:

- CFPC website
- RCPSC website
- CMA website
- Specialty Society website(s)
- Medical school/university website(s)
- Resident/student associations e.g. CAIR, CFMS website(s)
- Other, specify \_\_\_\_\_

Information retrieval websites:

- Medline
- PubMed
- Other, specify \_\_\_\_\_

Peer reviewed Medical journals:

- CFP
- CMAJ
- Other, specify \_\_\_\_\_

Non peer-reviewed medical journals. Please specify: \_\_\_\_\_

Clinical practice guidelines

## **G. Professional Income**

**35.a) If you had a choice, how would you prefer to be paid for your services as a physician?**

*Please check ONLY ONE.*

- Unsure
- Fee-for-service only
- Salary only
- Capitation only
- Sessional/ per diem/ hourly payments only
- Service contract only
- Blended payment



**35.b) What components would you want included in a blended payment method? Check ALL that apply.**

- Fee-for-service
- Salary
- Capitation
- Sessional/ per diem/ hourly payments
- Service contract
- Benefits/ pension
- On-call remuneration beyond fee-for-service
- Other \_\_\_\_\_
- Unsure

## **H. Finances**

**36. Please indicate the amount of debt you had and/or expect to have at various times in your medical education, as indicated below. Please refer to debt directly related to your medical education (e.g. tuition, books, accommodations, etc.)**

**36.a)i) Debt upon entering your medical residency training program**

**Debt directly related to medical education**

- no debt
- less than \$1,000
- \$1,001 to \$5,000
- \$5,001 to \$10,000
- \$10,001 to \$20,000
- \$20,001 to \$40,000
- \$40,001 to \$60,000
- \$60,001 to \$80,000
- \$80,001 to \$100,000
- \$100,001 to \$120,000
- \$120,001 to \$140,000
- \$140,001 to \$160,000
- Over \$160,000
- I prefer not to provide this information

**36.a)ii) You indicated that your debt directly related your medical education when you entered your residency program was.**

**Did your debt influence your choice of medical specialty in any of the ways listed below?**

*Check ALL that apply.*

- I purposely chose a short residency program
- I purposely chose a specialty that I believe to have a high earning potential
- No influence

**36.b) Current Debt**

**Debt directly related to medical education**

- no debt
- less than \$1,000
- \$1,001 to \$5,000
- \$5,001 to \$10,000
- \$10,001 to \$20,000
- \$20,001 to \$40,000
- \$40,001 to \$60,000
- \$60,001 to \$80,000
- \$80,001 to \$100,000
- \$100,001 to \$120,000
- \$120,001 to \$140,000
- \$140,001 to \$160,000
- Over \$160,000
- I prefer not to provide this information

**36.c)i) Anticipated debt upon completion of your medical residency training program**

**Debt directly related to medical education**

- no debt
- less than \$1,000
- \$1,001 to \$5,000
- \$5,001 to \$10,000
- \$10,001 to \$20,000
- \$20,001 to \$40,000
- \$40,001 to \$60,000
- \$60,001 to \$80,000
- \$80,001 to \$100,000
- \$100,001 to \$120,000
- \$120,001 to \$140,000
- \$140,001 to \$160,000
- Over \$160,000
- I prefer not to provide this information

**36.c)ii) You estimated that your debt directly related to your medical education when you complete your residency will be.**

**To pay off your debts, do you intend to do any of the following? Check ALL that apply.**

- Fulfill a return of service obligation
- Practice as a locum tenens
- Practice where I am offered a financial recruitment incentive
- Practice where I am offered a non-financial recruitment incentive
- Practice in the United States
- None of the above

**I. Family**

**37. Are any of your immediate family members working in medically related jobs? (If your parents or siblings are retired or deceased, please provide their main occupation while working.) Check ALL that apply.**

None of my immediate family members work in medicine

	Father	Mother	Sibling(s)
Medical doctor	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Nurse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pharmacist	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dentist	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Optician	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Chiropractor	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other healthcare professional	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**Comments:** \_\_\_\_\_

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**Please be assured that your response to this survey will be held in the strictest confidence. Analysis and publication of results will be at the aggregate level only. Thank you for your time and cooperation.**