National Physician Survey 2007

If you would like to complete the survey online, please go to this URL: cma.ca/NPS/FPGP/index.asp
To begin the survey online, you will be required to provide the identification number that appears in this box:

The identification number indicated on the cover page is for the administrative purposes of the National Physician Survey only. No correlation will be made to any ID numbers at the CMA, the CFPC, or the RCPSC. Data files generated from completed questionnaires will never be matched to individual names or addresses. Analysis and publication of survey results will be at the aggregate level only in order to protect individual respondent confidentiality.

If you have any difficulty accessing the online version of the survey, please contact Shelley Martin at 800 663-7336 x2258.

Si vous préférez répondre en français, veuillez communiquer avec nous en nous téléphonant sans frais au numéro suivant : 800 663-7336, poste 2163.
Il nous fera plaisir de vous faire parvenir un questionnaire en français.

You may earn 2 Mainpro C credits by completing a "Linking learning to practice" exercise related to the survey. Go to www.cfpc.ca.

A. ABOUT YOU

1. Please check ALL that apply to your current situation.

- ☐ I am in full-time or part-time medical practice.
- ☐ I am semi-retired.
- ☐ I am a locum tenens. *(If you do not have a permanent practice, complete in relation to last practice you served/are currently serving.)*
- ☐ I am employed in a medical or medically related field. *Please check ALL that apply.* ☐ Administration ☐ Teaching ☐ Research
- ☐ I am on a leave of absence or sabbatical from active patient care. *(Complete the questionnaire in relation to your most recent medical practice.)*
- ☐ I have a faculty appointment.
- ☐ I have a formal hospital appointment.

2. If you fall into any of the following categories, please check the appropriate category and return this UNCOMPLETED questionnaire in the enclosed stamped, self-addressed envelope. Thank you.

☐ I am a medical student ☐ I am a resident ☐ I am completely retired

3. Which of these best describes you? *Please check only ONE.*

- ☐ Family physician/general practitioner
- ☐ Family physician/general practitioner with a special focus to my practice, *please specify:* ______
- ☐ Medical/surgical/laboratory specialist, *please specify:* ______
- ☐ Physician working exclusively in a non-clinical setting, *please specify:* ______
- ☐ Other, *please specify:* ______

The College of Family Physicians of Canada

Le Collège des médecins de famille du Canada

Association Médicale Canadienne

Canadian Medical Association

The Royal College of Physicians and Surgeons of Canada

Le Collège royal des médecins et chirurgiens du Canada

NPS07-FP-E 001

4. Your year of birth: 19 ☐☐

5. Sex: ☐ male ☐ female

6. Marital status. *Please check only ONE.*

☐ Married/living with partner ☐ Single ☐ Separated ☐ Divorced ☐ Widowed

Please specify the profession of your spouse/partner: ______________________________

7. Do you have children? ☐ No ☐ Yes – *Age of the youngest?* _______ years

8. In which province(s)/territory(ies) did you grow up prior to university? *Check ALL that apply.*

☐ BC ☐ AB ☐ SK ☐ MB ☐ ON ☐ QC ☐ NB ☐ NS ☐ PE ☐ NL ☐ NT ☐ YT ☐ NU

☐ Outside of Canada

9.a) Year of your undergraduate medical graduation: ☐☐☐☐

Year of completion of your MOST RECENT postgraduate medical training (i.e., residency/internship): ☐☐☐☐

9.b) Please indicate where you completed your medical training. *UG = Undergraduate medical graduation, PG = MOST RECENT postgraduate medical training (i.e., residency/internship). Please check only ONE per category.*

Location	UG	PG	Location	UG	PG	Location	UG	PG
UBC	☐	☐	McMaster	☐	☐	McGill	☐	☐
U of Calgary	☐	☐	U of T	☐	☐	Université Laval	☐	☐
U of AB	☐	☐	U of Ottawa	☐	☐	Dalhousie	☐	☐
U of SK	☐	☐	Queen's	☐	☐	MUN	☐	☐
U of MB	☐	☐	U de Sherbrooke	☐	☐	U.S.A.	☐	☐
UWO	☐	☐	U de Montréal	☐	☐	Other. *Specify country*	________	________

10. Please check ALL that apply to you.

☐ Current member of the College of Family Physicians of Canada (CFPC) and hold the following designation(s):

☐ CCFP ☐ CCFP(EM) ☐ FCFP ☐ MCFP

☐ Specialty certification with the Royal College of Physicians and Surgeons of Canada (RCPSC)

Specify specialty(ies): ______________________________

☐ Specialty certification/attestation with the Collège des médecins du Québec (CMQ)

Specify specialty(ies)/attestation(s): ______________________________

☐ Other medical designation(s), *please specify:* ______________________________

☐ Other degree(s), *please specify:* ______________________________

☐ None of the above

11. In what year did you become licensed to practise medicine in Canada for the first time? ☐☐☐☐

12.a) Using the scale provided, please rate the AVAILABILITY AND EFFECTIVENESS of each of the continuing professional education methods listed below in maintaining/enhancing your knowledge, skills or competencies for your professional practice.

0=Not at all available/effective; 1=Poor; 2=Fair; 3=Good; 4=Very good; 5=Excellent, DU = Don't use.

	Availability							Effectiveness						
	0	1	2	3	4	5	DU	0	1	2	3	4	5	DU
Accredited conferences/courses	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Unaccredited educational dinners/lunches sponsored by pharmaceutical companies	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Peer-reviewed journals	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Non-peer-reviewed medical publications	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Evidence-based resources (e.g., clinical practice guidelines, data repositories)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Online education courses	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Rounds, journal clubs, small group activities	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Self-assessment programs (e.g., Multiple Choice Questions (MCQ), practice portfolios, CME logs, multi-source feedback)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Performance practice audits	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Self-directed learning methods (e.g., self learning, practice-based small group learning)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Simulators	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other, *specify:* ________________	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

12.b) Do you personally provide continuing professional development (CPD) courses/programs? ☐ No ☐ Yes

If yes, please specify to which type of audience. Please check ALL that apply.

☐ Physicians in your specialty/area of practice ☐ Physicians NOT in your specialty/area of practice

☐ Other health professionals

B. YOUR WORK SETTING(S)

13.a) The following is a list of work settings. Check the category(ies) which best describe(s) the setting(s) where you work. *Please check ALL that apply.*

A ☐ Private office/clinic (excluding free standing walk-in clinics)
B ☐ Community clinic/Community health centre
C ☐ Free-standing walk-in clinic
D ☐ Academic health sciences centre (ahsc)
E ☐ Community hospital
F ☐ Emergency department (in community hospital or ahsc)
G ☐ Nursing home/Home for the aged
H ☐ University/Faculty of medicine
I ☐ Administrative office
J ☐ Research unit
K ☐ Free-standing lab/diagnostic clinic
L ☐ Other________________

13.b) Please indicate which of the above settings is your MAIN patient care setting (i.e., the setting where you spend the most time providing patient care). *Following the categories provided above, please check ONLY ONE of the letters below. (If you do not provide patient care, please check N/A).*

☐ A ☐ B ☐ C ☐ D ☐ E ☐ F ☐ G ☐ H ☐ I ☐ J ☐ K ☐ L ☐ N/A

14. In which province(s)/territory(ies) do you currently work? *Check ALL that apply.*

☐ BC ☐ AB ☐ SK ☐ MB ☐ ON ☐ QC ☐ NB ☐ NS ☐ PE ☐ NL ☐ NT ☐ YT ☐ NU

☐ Outside of Canada

15. Please provide the 6-digit postal code of your MAIN patient care setting OR main work setting if you do not provide patient care: ☐☐☐☐☐☐

16. Indicate the main reason(s) you selected your current work location. *Check ALL that apply.*

- ☐ Availability of medical support system/resources
- ☐ Career opportunities for spouse/partner
- ☐ Family reasons
- ☐ Liked the location
- ☐ Opportunity for affiliation with a university
- ☐ Community needs were a good match to my career interests
- ☐ Practice opportunity was available
- ☐ Had to fulfill a return of service obligation
- ☐ Religious/social/cultural reasons
- ☐ Financial recruitment/retention incentives
- ☐ Non-financial recruitment/retention incentives
- ☐ Other_______________

C. YOUR PATIENT CARE SETTING(S)

17. Do you provide patient care? ☐ Yes ☐ No *(If no, skip to question 31)*

18. With respect to your MAIN patient care setting specified in 13.b, describe the population PRIMARILY served by you in your practice. *Please check ONLY ONE.*

- ☐ Inner city
- ☐ Urban/Suburban
- ☐ Small town
- ☐ Rural
- ☐ Geographically isolated/Remote
- ☐ Cannot identify a primary population
- ☐ Other _______________

19. Please indicate how your MAIN patient care setting is organized. *Please check ONLY ONE.*

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)

20. Please indicate with whom you regularly collaborate in providing patient care and whether your collaboration is part of a formal arrangement. *Check ALL that apply.*

	I regularly collaborate with the following in providing patient care	I have a formal arrangement for collaborating with the following	I do not collaborate with the following
Family physicians	☐	☐	☐
Psychiatric specialists	☐	☐	☐
Pediatric specialists	☐	☐	☐
Obstetrical/gynecological specialists	☐	☐	☐
Internal specialists	☐	☐	☐
Surgical specialists	☐	☐	☐
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)	☐	☐	☐

21. When collaborating with other professionals to provide patient care, do you: (*Check ALL that apply.*)

Consult by telephone?	☐ Yes	☐ No
Discuss patients/clinical issues electronically (email, list serve, internet)?	☐ Yes	☐ No
Meet together to review patients/clinical problems?	☐ Yes	☐ No
Provide a consultation/opinion without seeing the patient in person?	☐ Yes	☐ No
Share patient care decisions?	☐ Yes	☐ No
Discuss new evidence and its applicability to your patients?	☐ Yes	☐ No
Review adverse events/critical incidents together?	☐ Yes	☐ No
Participate in joint educational activities?	☐ Yes	☐ No
Feel this working relationship improves the care your patients receive?	☐ Yes	☐ No
Feel this working relationship enhances the care you can deliver?	☐ Yes	☐ No

22. What languages do you speak with your patients? ☐ English ☐ French ☐ Other(s) ____________________

D. PATIENT ACCESS TO CARE

23.a) Typically, if a patient contacts your office or is referred to you, how long would that patient wait until the first available appointment with YOU OR YOUR PRACTICE?

Urgent: ☐ Same day ☐ Days ____________(#) ☐ Unsure ☐ Not applicable

Non-urgent: ☐ Same week ☐ Weeks ___________(#) ☐ Unsure ☐ Not applicable

23.b) To what extent is your practice accepting new patients into your MAIN patient care setting? *Please check only ONE.*

☐ No restrictions; practice is open to all new patients

☐ Partially closed. Please estimate the number of new patients you accepted into your practice in the last 12 months: ___________.

☐ Completely closed

☐ Does not apply to my practice setting

24. What do you see as major impediments to your delivery of care to your patients? *Check ALL that apply.*

☐ System funding

☐ Payment mechanisms

☐ Paperwork

☐ Bureaucracy

☐ Availability of personnel

☐ External demands on your time

☐ Availability of test results

☐ Availability of relevant patient information at the point of care

☐ Computer and communications technology that are not compatible with your needs

☐ Lack of evidence-based clinical information

☐ Lack of appropriate facilities to care for complex/elderly/failing patients

Poor inter-personal communications with

☐ family physicians

☐ other specialists

☐ other allied health professionals

☐ Other___________________________

25.a) Please rate the accessibility to the following for your patients.

	Excellent	Very good	Good	Fair	Poor	Don't know
Other specialist physicians in general	☐	☐	☐	☐	☐	☐
Obstetricians/Gynecologists	☐	☐	☐	☐	☐	☐
Pediatricians/Pediatric specialists	☐	☐	☐	☐	☐	☐
Orthopedic surgeons	☐	☐	☐	☐	☐	☐
Ophthalmologists	☐	☐	☐	☐	☐	☐
Psychiatrists	☐	☐	☐	☐	☐	☐
Psychosocial support services (e.g., psychologists, social workers, etc.)	☐	☐	☐	☐	☐	☐
Mental health counselor services	☐	☐	☐	☐	☐	☐
Addiction counselor services	☐	☐	☐	☐	☐	☐
Cancer care services	☐	☐	☐	☐	☐	☐
Cardiac care services	☐	☐	☐	☐	☐	☐
Palliative care services	☐	☐	☐	☐	☐	☐
Operating room time	☐	☐	☐	☐	☐	☐
Anesthesia services	☐	☐	☐	☐	☐	☐
Emergency room/department services	☐	☐	☐	☐	☐	☐
In-home nursing services	☐	☐	☐	☐	☐	☐
Critical care beds	☐	☐	☐	☐	☐	☐
Long-term care beds (e.g., nursing home, chronic care, etc.)	☐	☐	☐	☐	☐	☐
Hospital in-patient care on an urgent basis	☐	☐	☐	☐	☐	☐
Hospital care for elective procedures	☐	☐	☐	☐	☐	☐
Routine diagnostic services (e.g., lab, x-rays, etc.)	☐	☐	☐	☐	☐	☐
Advanced diagnostic services (e.g., MRI, CT, etc.)	☐	☐	☐	☐	☐	☐
Drugs and appliances	☐	☐	☐	☐	☐	☐
Home care	☐	☐	☐	☐	☐	☐
Occupational therapy services	☐	☐	☐	☐	☐	☐
Physiotherapy services	☐	☐	☐	☐	☐	☐

25.b) Please indicate if there are other important access issues for your patients.

____

26. 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	Stongly 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.	☐	☐	☐	☐	☐

27. What arrangements do you have for care of your patients in your MAIN patient care setting outside of your usual office hours?

- ☐ No arrangements/direction provided
- ☐ Arrangements/direction provided. *Check ALL that apply.*
  - ☐ Extended office hours regularly (beyond Monday to Friday 9 am to 5 pm). *If so, number of extended hours per week: ______________hrs/week.*
  - ☐ After-hours clinic that is staffed by you or other providers in your practice.
  - ☐ Individualized 24/7 medical telephone advice where provider HAS access to patient medical records.
  - ☐ Individualized 24/7 medical telephone advice where provider DOES NOT HAVE access to patient medical records.
  - ☐ Directed to call regional/provincial/territorial 24/7 telehealth or telephone advice line.
  - ☐ Directed to call a housecall service.
  - ☐ Directed to go to a walk-in clinic/after-hours clinic that YOU DO NOT STAFF.
  - ☐ Directed to go to the emergency department.
  - ☐ Other ____

E. YOUR PRACTICE/WORK PROFILE

28.a) Please indicate if care for the following patient populations is provided by yourself and/or others in your practice. *Please check ALL that apply.*

	I provide health care for these patients	Other providers within our practice provide health care for these patients	This patient population represents more than 10% of our practice population
Neonates (<1 month)	☐	☐	☐
Infants (1-12 months)	☐	☐	☐
Children (1-11 years)	☐	☐	☐
Adolescents (12-19 years)	☐	☐	☐
Women	☐	☐	☐
Pregnant women	☐	☐	☐
Men	☐	☐	☐
Seniors (65+ years)	☐	☐	☐
Aboriginal peoples	☐	☐	☐
Ethnic minorities	☐	☐	☐
Recent immigrants	☐	☐	☐
People living in poverty	☐	☐	☐
Homeless/"street" people	☐	☐	☐
Transient/seasonal populations	☐	☐	☐
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	☐	☐	☐
Other, specify: ______________________	☐	☐	☐

28.b) Please indicate if the following are offered to your patients by yourself and/or others in your practice. *Check ALL that apply.*

	I offer this to my patients	Others within our practice offer this to our patients
Non-urgent health care	☐	☐
Acute health care	☐	☐
Emergency medicine	☐	☐
Alternative/complementary medicine	☐	☐
Anesthesia	☐	☐
Community medicine/public health services/health promotion	☐	☐
Cosmetic medicine	☐	☐
Dermatology	☐	☐
Gynecology	☐	☐
Liaison to home care	☐	☐
Hospitalist care (most responsible physician for patients in hospital to whom you do not provide care post hospital discharge)	☐	☐
Housecalls	☐	☐
Infectious disease care	☐	☐
In-patient hospital care	☐	☐

	I offer this to my patients	Others within our practice offer this to our patients
Intrapartum care *(If yes, number of births attended per year _________)*	☐	☐
Legal/medico–legal consultations	☐	☐
Mental health care	☐	☐
Nutritional counseling	☐	☐
Occupational/industrial medicine	☐	☐
Pain management	☐	☐
Palliative care	☐	☐
Psychotherapy/counseling	☐	☐
Rehabilitation medicine	☐	☐
Sports medicine	☐	☐
Substance abuse care	☐	☐
Surgery	☐	☐
Surgical assisting	☐	☐
Travel/tropical medicine	☐	☐
Well child care	☐	☐
Other, *specify:* ________________	☐	☐

28.c) Does your medical practice have (a) specific area(s) of focus (i.e., patient population, academic or administrative activity, subspecialty, etc.)?

☐ No ☐ Yes — *If yes, please specify and indicate the percentage of time you spend.*

Area(s) of focus	**Percent of time (%)**
________________________	__________
________________________	__________

28.d) Which of the following procedures do you perform as part of your practice? *Please check ALL that apply.*

- ☐ Incise & drain abscess
- ☐ Insert sutures/repair lacerations
- ☐ Cast fractures
- ☐ Cryotherapy of skin lesions
- ☐ Excise dermal lesions
- ☐ Scrape skin for fungus determination
- ☐ Use Wood's lamp
- ☐ Release subungual hematoma
- ☐ Drain acute paronychia
- ☐ Pare skin callus
- ☐ Infiltrate local anesthetic
- ☐ Remove corneal or conjunctival foreign body
- ☐ Remove cerumen/syringe ear canals
- ☐ Cauterize nose for anterior epistaxis
- ☐ Remove foreign body (e.g., fish-hook, splinter, glass)
- ☐ Insert nasogastric tube
- ☐ Test for fecal occult blood
- ☐ Place transurethral catheter
- ☐ Cryotherapy or chemical therapy for genital warts
- ☐ Pap smear
- ☐ Low forcep
- ☐ Mid-forcep and rotation
- ☐ Vacuum extraction
- ☐ Splint injured extremities
- ☐ Bag and mask ventilation
- ☐ Venipuncture
- ☐ Subcutaneous injection
- ☐ Intramuscular injection
- ☐ Insert peripheral intravenous line in both adult and child
- ☐ Insert central line in adult
- ☐ Prep for land or air transport
- ☐ Acupuncture
- ☐ Hypnosis
- ☐ NONE OF THE ABOVE

28.e) Please list any procedural skills that you feel you need to acquire. ________________________________

29. Please estimate the number of patient visits you have in a TYPICAL WEEK, EXCLUDING patient visits while on-call (on-call is defined as time outside of regularly scheduled activity during which you are available to patients): Number of patient visits per week_______________

F. ALLOCATION OF YOUR TIME

"ON-CALL" = time outside of regularly scheduled activity during which you are available to patients.

30.a) Do you do on-call?

☐ No *(Skip to 31)*

☐ Yes — *If yes, describe your on-call activity. Check ALL that apply.*

- ☐ Obstetrical on-call
- ☐ On-call for hospital in-patients
- ☐ On-call for non-hospitalized patients — telephone availability only
- ☐ On-call for non-hospitalized patients — telephone availability and see patients as required
- ☐ Emergency room on-call
- ☐ Nursing home/ LTC facility on-call
- ☐ Other ____

30.b) Please estimate your average total number of on-call work hours PER MONTH: _________hours/month

30.c) Please estimate how many of your on-call hours each month are actually spent in direct patient care (e.g., phone, email, face-to-face): _________ hours/month

Do you ever spend continuous 24-hour periods of on-call time in direct patient care? ☐ No ☐ Yes

If yes, are you ever required to provide direct patient care immediately after these 24-hour periods? ☐ No ☐ Yes

30.d) Please estimate the number of patients you SEE on-call per month: ________________patients/month

31. EXCLUDING ON-CALL ACTIVITIES, how many HOURS IN AN AVERAGE WEEK do you usually spend on the following activities? *Assume each activity is mutually exclusive for reporting purposes (i.e., if an activity spans two categories, please report hours in only one category).*

i) Direct patient care without a teaching component, regardless of setting............____________hours/week

ii) Direct patient care with a teaching component, regardless of setting ....____________hours/week

iii) Teaching/Education without direct patient care (contact with students/residents, preparation, marking, evaluations, etc.) ....____________hours/week

iv) Indirect patient care (charting, reports, phone calls, meeting patients' family, etc.) ....____________hours/week

v) Health facility committees ....____________hours/week

vi) Managing your practice (staff, facility, equipment, etc.) ....____________hours/week

vii) Research (including management of research and publications) ....____________hours/week

viii) Administration (i.e., management of university program, chief of staff, department head, Ministry of Health, etc.) ....____________hours/week

ix) Continuing medical education/professional development (courses, reading, videos, tapes, seminars, etc.) ....____________hours/week

x) Other (participation in professional or specialty organizations, medico–legal activities, etc.) ....____________hours/week

SUM of 31.i through 31.x **TOTAL HOURS WORKED PER WEEK**............____________hours/week

32. In the LAST YEAR, have you:

32.a) Been absent from work due to:

i) Maternity or paternity leave? ☐ No ☐ Yes — *If yes, approximate number of WEEKS absent:* _________

ii) Personal leave of absence? ☐ No ☐ Yes — *If yes, approximate number of WEEKS absent:* _________

iii) Illness or disability? ☐ No ☐ Yes — *If yes, approximate number of DAYS absent due to work related stress:* _________

Approximate number of DAYS absent due to any other illness/disability: _________

32.b) Volunteered your services as a physician (e.g., camp doctor, international aid, etc.)? ☐ Yes ☐ No

If yes, approximately how many weeks in the past year have been spent volunteering: _______________ (number of WEEKS).

Please specify area(s) of volunteerism: ______________________________

32.c) Used any locum tenens? ☐ Yes ☐ No, locum not available ☐ No, locum not needed

32.d) Personally provided locum tenens services for another physician? ☐ Yes ☐ No *(Skip to question 33.)*

If yes, i) Approximately how many weeks in the past year: _______________ (number of WEEKS)

... cont'd

ii) What patient population(s) did you serve? *Please check ALL that apply.*

- ☐ Inner city
- ☐ Urban/suburban
- ☐ Small town
- ☐ Rural
- ☐ Geographically isolated/remote
- ☐ Cannot identify a primary population
- ☐ Other ___________

iii) Do you have a permanent practice in addition to doing locum work? ☐ Yes ☐ No

iv) Why do you choose to locum? *Check ALL that apply.*

- A ☐ Financial reasons
- B ☐ To assess potential future practice location
- C ☐ Clinical variety
- D ☐ Filling a service need
- E ☐ Flexibility/ability to set own schedule
- F ☐ Other, *specify:* ___________

v) Following the reasons provided above, please check the ONE most important reason why you choose to locum.

☐ A ☐ B ☐ C ☐ D ☐ E ☐ F

G. YOUR PROFESSIONAL INCOME

33.a) In the last year, approximately what proportion of your professional income did you receive from each of the following payment methods? *Please note: TOTAL MUST EQUAL 100%.*

Payment method	%
Fee-for-service (insured and uninsured)	%
Salary	%
Capitation	%
Sessional/per diem/hourly	%
Service contract	%
Incentives and premiums	%
Other ___________	%
TOTAL	100%

33.b) If you had a choice, how would you PREFER to be paid for your services as a physician? *Please check ONLY ONE.*

- ☐ Fee-for-service only
- ☐ Salary only
- ☐ Capitation only
- ☐ Sessional/hourly payments only
- ☐ Service contract only
- ☐ Blended payment

IF YOU INDICATED BLENDED, what components would you want included? *Check ALL that apply.*

- ☐ Fee-for-service (FFS)
- ☐ Sessional/per diem/hourly payments
- ☐ On-call remuneration beyond FFS
- ☐ Salary
- ☐ Service contract
- ☐ Capitation
- ☐ Benefits/pension
- ☐ Other ___________

33.c) During the past 12 months, approximately what percentage of your professional income was from the following sources? *Total must equal 100%.*

Source	%
Provincial/territorial government medical/health care plans and programs	%
Regional health authorities/boards	%
Academic health science centres/universities	%
Community hospitals	%
Workers' Compensation Board/Workplace Safety and Insurance Board	%
Private insurance companies and third parties (e.g., legal fees for clinical consults/notes/testimony)	%
Direct federal health programs (e.g., CPP, DVA, RCMP, etc.)	%
Direct payment from patients	%
Professional and/or health care organizations (e.g., honoraria)	%
Industry funding (e.g., full salary, research fees, consulting, honoraria, etc.)	%
Research grants (non-industry)	%
Other, *specify:* ___________	%
TOTAL	100%

H. CHANGES TO YOUR PRACTICE

34. Are the following factors increasing the demand for your time?

Factor	Yes	No
Aging patient population	☐ Yes	☐ No
Increasing complexity of patient caseload	☐ Yes	☐ No
Management of patients with chronic diseases/conditions	☐ Yes	☐ No
Increasing patient expectations	☐ Yes	☐ No
Lack of availability of local/regional physician services in my specialty	☐ Yes	☐ No
Lack of availability of local/regional physician services in other specialties	☐ Yes	☐ No
Lack of availability of other local/regional health care professional services	☐ Yes	☐ No
Other, *specify:* ___________	☐ Yes	☐ No

35. With reference to the LAST 2 YEARS, please check all of the following changes you have already made. With reference to the NEXT 2 YEARS, please check all of the following changes that you are planning to make.

	LAST 2 years	NEXT 2 years
Reduce weekly work hours (excluding on-call)	☐	☐
Increase weekly work hours (excluding on-call)	☐	☐
Retire from clinical practice	☐	☐
Relocate my practice to another province/territory in Canada	☐	☐
Leave Canada to practise in another country	☐	☐
Focus practice in an area of special interest	☐	☐
Reduce scope of practice	☐	☐
Stop intrapartum practice	☐	☐
Reduce clinical hours (excluding on-call)	☐	☐
Increase clinical hours (excluding on-call)	☐	☐
Reduce teaching	☐	☐
Increase teaching	☐	☐
Reduce research	☐	☐
Increase research	☐	☐
Reduce administration responsibilities	☐	☐
Increase administration responsibilities	☐	☐
Reduce on-call hours	☐	☐
Increase on-call hours	☐	☐
Change practice due to personal health	☐	☐
Temporarily leave active practice for reason(s) other than above	☐	☐
Permanently leave active practice for reason(s) other than above	☐	☐
Change from solo to group practice	☐	☐
Become part of a practice network	☐	☐
Other change(s) MADE, *specify:* ______________________	☐	
Other change(s) PLANNED, *specify:* ______________________		☐
NO CHANGES	☐	☐

I. YOUR USE OF INFORMATION TECHNOLOGY

36. How would you rate your skill level with computers?

☐ Not proficient/don't use computers ☐ Beginner/basic ☐ Intermediate ☐ Advanced

37.a) What type of access do you have to the Internet in your MAIN patient care setting?

- ☐ None
- ☐ Dial-up
- ☐ High-speed (cable, DSL)
- ☐ Don't know what type
- ☐ Not applicable — I do not provide patient care

IF YOU DO NOT HAVE INTERNET access in your MAIN patient care setting, why not? *Please check all that apply.*

- ☐ No high-speed access
- ☐ Can't afford it
- ☐ Don't want it
- ☐ Don't need it
- ☐ Other, *specify:* ______________________

37.b) What type of access do you have to the Internet in other settings, for example at home?

☐ None ☐ Dial-up ☐ High-speed (cable, DSL) ☐ Don't know what type

38. Do you use email IN ANY SETTING to communicate with:

Your colleagues:
- ☐ for clinical purposes
- ☐ for other purposes

Your patients:
- ☐ for clinical purposes
- ☐ for other purposes

- ☐ Others
- ☐ Not applicable — I do not use email

39. Thinking about your MAIN patient care setting, which of these describes your record keeping system? *Please check ONLY ONE.*

- ☐ I use paper charts
- ☐ I use a COMBINATION OF PAPER AND ELECTRONIC CHARTS to enter and retrieve patient clinical notes
- ☐ I use electronic records (e.g., electronic medical record) INSTEAD OF PAPER CHARTS to enter/retrieve patient clinical notes
- ☐ Not applicable — I do not provide patient care

40.a) Please indicate which of the following you have, whether you use it in the care of your patients, and whether it is on a wireless device. *Check ALL that apply.*

	Have it	Use it	Use it on a wireless device
Electronic patient appointment/scheduling system	☐	☐	☐
Electronic billing	☐	☐	☐
Electronic records to enter and retrieve clinical patient notes	☐	☐	☐
Electronic reminder systems for recommended patient care	☐	☐	☐
Electronic warning systems for adverse prescribing and/or drug interactions	☐	☐	☐
Electronic decision aids (i.e., to evaluate treatment options)	☐	☐	☐
Electronic interface to external pharmacy/pharmacist	☐	☐	☐
Electronic interface to external laboratory/diagnostic imaging	☐	☐	☐
Electronic interface to other external systems (e.g., hospitals, other clinics) for accessing or sharing patient information	☐	☐	☐
Electronic interface to external chronic care patient registries	☐	☐	☐
Telemedicine/webcasting/videoconferencing	☐	☐	☐
Online access to journals, clinical practice guidelines, medical databases (e.g., MEDLINE)	☐	☐	☐
Email	☐	☐	☐
I DO NOT HAVE/USE ANY OF THE ABOVE ☐			

40.b) Do you have a practice Web site? ☐ Yes ☐ No

J. YOUR PROFESSIONAL SATISFACTION

41. Please rate your satisfaction with each of the following:

	Very satisfied	Somewhat satisfied	Neutral	Somewhat dissatisfied	Very dissatisfied	Not applicable
Your current professional life	☐	☐	☐	☐	☐	☐
The balance between your personal and professional commitments	☐	☐	☐	☐	☐	☐
Your relationship with your patients	☐	☐	☐	☐	☐	☐
Your relationship with family physicians	☐	☐	☐	☐	☐	☐
Your relationship with physicians in other specialties	☐	☐	☐	☐	☐	☐
Your relationship with hospitals	☐	☐	☐	☐	☐	☐
Your relationship with pharmacists	☐	☐	☐	☐	☐	☐
The usefulness and reliability of the consultations you receive from other specialists — i.e., not family physicians	☐	☐	☐	☐	☐	☐
Your opportunity to use your skills to their full extent	☐	☐	☐	☐	☐	☐
The availability of CME/CPD opportunities to meet your needs	☐	☐	☐	☐	☐	☐
Your ability to find locum tenens coverage for CME/CPD, holidays, personal time	☐	☐	☐	☐	☐	☐
Your comparative net revenue per hour compared to other family physicians	☐	☐	☐	☐	☐	☐
Your comparative net revenue per hour compared to other specialties — i.e., not family physicians	☐	☐	☐	☐	☐	☐

42. The ability to track a cohort of individuals over time would provide invaluable research information for health human resource planning. Would you be willing to allow these responses to be linked to your responses on future National Physician Surveys? (Accomplished by assigning you the same tracking ID# on each survey). Results from this cohort data would only be reported in aggregate form, never at the individual level. ☐ **Yes, I am willing to be part of the National Physician Survey cohort.**

43. Comments ______________________________

Thank you for your time and participation.

Please return the completed questionnaire in the business reply envelope provided to the National Physician Survey, c/o Canadian Medical Association, 1867 Alta Vista Drive, Ottawa ON K1G 3Y6.
If you have any questions about this survey, please contact Shelley Martin at 800 663-7336 x2258. ☐