



National Physician Survey 2007

If you would like to complete the survey online, please go to this URL: cma.ca/NPS/MD/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.

Family physicians — You may earn 2 Mainpro C credits by completing a “Linking learning to practice” exercise related to the survey. Go to www.cfpc.ca.
Other specialists — Earn 2 MOC credits, under Section 5, linked to completing this survey. Go to www.mainport.org for information about the process.

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:* _____

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

7.a) Year of your undergraduate medical graduation:

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

7.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	<input type="checkbox"/>	<input type="checkbox"/>	McMaster	<input type="checkbox"/>	<input type="checkbox"/>	McGill	<input type="checkbox"/>	<input type="checkbox"/>
U of Calgary	<input type="checkbox"/>	<input type="checkbox"/>	U of T	<input type="checkbox"/>	<input type="checkbox"/>	Université Laval	<input type="checkbox"/>	<input type="checkbox"/>
U of AB	<input type="checkbox"/>	<input type="checkbox"/>	U of Ottawa	<input type="checkbox"/>	<input type="checkbox"/>	Dalhousie	<input type="checkbox"/>	<input type="checkbox"/>
U of SK	<input type="checkbox"/>	<input type="checkbox"/>	Queen's	<input type="checkbox"/>	<input type="checkbox"/>	MUN	<input type="checkbox"/>	<input type="checkbox"/>
U of MB	<input type="checkbox"/>	<input type="checkbox"/>	U de Sherbrooke	<input type="checkbox"/>	<input type="checkbox"/>	U.S.A.	<input type="checkbox"/>	<input type="checkbox"/>
UWO	<input type="checkbox"/>	<input type="checkbox"/>	U de Montréal	<input type="checkbox"/>	<input type="checkbox"/>	Other. <i>Specify country</i>	_____	_____

8. 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

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

B. YOUR WORK SETTING(S)

10.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 <input type="checkbox"/> Private office/clinic (excluding free standing walk-in clinics) | G <input type="checkbox"/> Nursing home/Home for the aged |
| B <input type="checkbox"/> Community clinic/Community health centre | H <input type="checkbox"/> University/Faculty of medicine |
| C <input type="checkbox"/> Free-standing walk-in clinic | I <input type="checkbox"/> Administrative office |
| D <input type="checkbox"/> Academic health sciences centre (ahsc) | J <input type="checkbox"/> Research unit |
| E <input type="checkbox"/> Community hospital | K <input type="checkbox"/> Free-standing lab/diagnostic clinic |
| F <input type="checkbox"/> Emergency department (in community hospital or ahsc) | L <input type="checkbox"/> Other _____ |

10.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

11. 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

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

--	--	--	--	--	--

C. YOUR PATIENT CARE SETTING(S)

13. Do you provide patient care? Yes No *(If no, skip to question 21.)*

14. With respect to your MAIN patient care setting specified in 10.b, describe the population PRIMARILY served by you in your practice. *Please check ONLY ONE.*

- | | | |
|---|---|--------------------------------------|
| <input type="checkbox"/> Inner city | <input type="checkbox"/> Rural | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Urban/Suburban | <input type="checkbox"/> Geographically isolated/Remote | |
| <input type="checkbox"/> Small town | <input type="checkbox"/> Cannot identify a primary population | |

15. 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.

- | | |
|---|--|
| <input type="checkbox"/> Solo practice | <input type="checkbox"/> Interprofessional practice (physician(s) and other health professional(s) who have their own caseloads) |
| <input type="checkbox"/> Group practice | |

D. PATIENT ACCESS TO CARE

16.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

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

- | | |
|---|--|
| <input type="checkbox"/> No restrictions; practice is open to all new patients | <input type="checkbox"/> Completely closed |
| <input type="checkbox"/> Partially closed. Please estimate the number of new patients you accepted into your practice in the last 12 months: _____. | <input type="checkbox"/> Does not apply to my practice setting |

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

- | | | |
|--|---|--|
| <input type="checkbox"/> System funding | <input type="checkbox"/> Availability of relevant patient information at the point of care | Poor inter-personal communications with |
| <input type="checkbox"/> Payment mechanisms | <input type="checkbox"/> Computer and communications technology that are not compatible with your needs | <input type="checkbox"/> family physicians |
| <input type="checkbox"/> Paperwork | <input type="checkbox"/> Lack of evidence-based clinical information | <input type="checkbox"/> other specialists |
| <input type="checkbox"/> Bureaucracy | <input type="checkbox"/> Lack of appropriate facilities to care for complex/elderly/failing patients | <input type="checkbox"/> other allied health professionals |
| <input type="checkbox"/> Availability of personnel | | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> External demands on your time | | |
| <input type="checkbox"/> Availability of test results | | |

E. YOUR PRACTICE/WORK PROFILE

18.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)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Infants (1–12 months)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Children (1–11 years)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Adolescents (12–19 years)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Women	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pregnant women	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Men	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seniors (65+ years)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aboriginal peoples	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ethnic minorities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recent immigrants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
People living in poverty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Patients with respiratory problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Patients with hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Patients with diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Patients with heart disease/conditions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Patients with chronic mental illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Patients with obesity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Patients with cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Patients with HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

18.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	<input type="checkbox"/>	<input type="checkbox"/>
Acute health care	<input type="checkbox"/>	<input type="checkbox"/>
Emergency medicine	<input type="checkbox"/>	<input type="checkbox"/>
Housecalls	<input type="checkbox"/>	<input type="checkbox"/>
In-patient hospital care	<input type="checkbox"/>	<input type="checkbox"/>
Intrapartum care (If yes, number of births attended per year _____)	<input type="checkbox"/>	<input type="checkbox"/>
Mental health care	<input type="checkbox"/>	<input type="checkbox"/>
Palliative care	<input type="checkbox"/>	<input type="checkbox"/>
Psychotherapy/counseling	<input type="checkbox"/>	<input type="checkbox"/>

18.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 (%)

19. 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.

20.a) Do you do on-call? Yes No (Skip to 21.)

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

20.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

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

21. 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 21.i through 21.x **TOTAL HOURS WORKED PER WEEK** hours/week

22. In the LAST YEAR, have you:

22.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: _____

22.b) Used any locum tenens? Yes No, locum not available No, locum not needed

22.c) Personally provided locum tenens services for another physician? Yes No
If yes, approximately how many weeks in the past year: _____ (number of WEEKS)

G. YOUR PROFESSIONAL INCOME

23. 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%**.

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

H. CHANGES TO YOUR PRACTICE

24. 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)	<input type="checkbox"/>	<input type="checkbox"/>
Increase weekly work hours (excluding on-call)	<input type="checkbox"/>	<input type="checkbox"/>
Retire from clinical practice	<input type="checkbox"/>	<input type="checkbox"/>
Relocate my practice to another province/territory in Canada	<input type="checkbox"/>	<input type="checkbox"/>
NONE OF THE ABOVE	<input type="checkbox"/>	<input type="checkbox"/>

I. YOUR PROFESSIONAL SATISFACTION

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

	Very satisfied	Somewhat satisfied	Neutral	Somewhat dissatisfied	Very dissatisfied	Not applicable
Your current professional life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The balance between your personal and professional commitments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your relationship with your patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your relationship with family physicians	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your relationship with physicians in other specialties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

26. 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.**

27. 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.