



National Physician Survey

2004

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

To begin the survey, you will be required to provide an identification number. Please enter the number that appears in this box:

If you have any difficulty accessing the online version of the survey, please contact Shelley Martin at 1 800 663-7336 x2258.

Si vous préférez répondre en français, veuillez communiquer avec nous en nous téléphonant sans frais au numéro suivant : 1 800 663-7336, poste 2163. Il nous fera plaisir de vous faire parvenir un questionnaire en français.

Thank you for taking the time to complete the questionnaire.



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

Please complete this questionnaire if one or more of the following apply to your current status. *Please check ALL that apply to you.*

- I am in full-time or part-time medical practice.
- I am a locum tenens. *Please complete the questionnaire in relation to the last practice that you served, or are currently serving.*
- I am employed in a medical or medically related field (e.g. administration, teaching, research).
- I am on a leave of absence or sabbatical from active patient care. *Please complete the questionnaire in relation to your most recent medical practice.*

If you **DO NOT** fall into any of the above-mentioned categories, please indicate your status below by checking the appropriate category. Return this UNCOMPLETED questionnaire in the enclosed stamped, self-addressed envelope. Thank you.

- Medical student
- Resident
- Retired
- Other (*please specify*)

A. Work Setting

1. 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.*

- | | |
|--|--|
| <ul style="list-style-type: none"> A <input type="checkbox"/> Private office/clinic (excluding free standing walk-in clinics) B <input type="checkbox"/> Community clinic/Community health centre C <input type="checkbox"/> Free-standing walk-in clinic D <input type="checkbox"/> Academic health sciences centre E <input type="checkbox"/> Community hospital F <input type="checkbox"/> Emergency department (community hospital or academic health sciences centre) | <ul style="list-style-type: none"> G <input type="checkbox"/> Nursing home/Home for the aged H <input type="checkbox"/> Administrative office I <input type="checkbox"/> Research unit J <input type="checkbox"/> Free-standing laboratory/Diagnostic clinic K <input type="checkbox"/> Other |
|--|--|

2.a) Please indicate which of the above settings is your MAIN work setting (i.e. the setting where you spend most of your work time). Following the categories provided above, *please circle ONLY ONE of the letters below.*

A B C D E F G H I J K

2.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 circle ONLY ONE of the letters below. (If you do not do patient care, please circle N/A, and SKIP TO QUESTION 10).*

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

B. Patient Care Setting

3.a) With respect to your MAIN patient care setting specified in 2.b), indicate how that setting is organized. *Please check ALL that apply.*

- Solo practice
- Group practice
- Practice network
- Other
- Not applicable

Indicate which of the following, if any, you share with other physicians. *Please check ALL that apply.*

- Office space
- Equipment
- Expenses
- Patient records
- Staff
- On-call duties
- Other

3.b) Indicate the types of health care providers with whom you share patient care within your MAIN patient care setting. *Please check ALL that apply.*

- | | | |
|--|--|--|
| <input type="checkbox"/> Family physicians | <input type="checkbox"/> Occupational therapists | <input type="checkbox"/> Other (<i>please specify</i>) |
| <input type="checkbox"/> Specialist physicians | <input type="checkbox"/> Physiotherapists | <input type="text"/> |
| <input type="checkbox"/> Nurse practitioners | <input type="checkbox"/> Social workers | <input type="checkbox"/> Other (<i>please specify</i>) |
| <input type="checkbox"/> Nurses (e.g., RN, LPN, RPN) | <input type="checkbox"/> Pharmacists | <input type="text"/> |
| <input type="checkbox"/> Dietitians/Nutritionists | <input type="checkbox"/> Technicians/Technologists | |
| <input type="checkbox"/> Psychologists | <input type="checkbox"/> Midwives | |

3.c) Is your MAIN patient care setting wheelchair accessible?

- Yes No N/A

C. Practice/Work Profile

4.a) Describe the population PRIMARILY served by you in your practice. *Please check ONLY ONE.*

- | | |
|---|---|
| A <input type="checkbox"/> Inner city | E <input type="checkbox"/> Geographically isolated/remote |
| B <input type="checkbox"/> Urban/suburban | F <input type="checkbox"/> Other _____ |
| C <input type="checkbox"/> Small town | G <input type="checkbox"/> Cannot identify a primary population |
| D <input type="checkbox"/> Rural | |

4.b) If there is a secondary population that you also serve, indicate which it is by circling the appropriate letter (using the categories provided in 4.a above). *Please circle ONLY ONE.*

- A B C D E F N/A

5. Do any of the following groups represent more than 10% of your practice population? *If yes, please check ALL that apply.*

- | | |
|--|---|
| <input type="checkbox"/> HIV/AIDS patients | <input type="checkbox"/> People living in poverty |
| <input type="checkbox"/> Patients with chronic mental illness | <input type="checkbox"/> Aboriginal peoples |
| <input type="checkbox"/> Patients with permanent physical disabilities | <input type="checkbox"/> Recent immigrants |
| <input type="checkbox"/> Patients with addictions | <input type="checkbox"/> Cultural minorities |
| <input type="checkbox"/> Homeless/"street" people | <input type="checkbox"/> Other |
| <input type="checkbox"/> Transient/seasonal populations | <input type="text"/> |

6. 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 clinical activity during which you are available to patients):

TOTAL patient visits per week

7. Please indicate ALL areas of professional activity that are part of your practice and/or are areas of special interest. For areas of special interest, also give the percent of time spent in each (percentages do not have to total 100% but must not exceed 100%). *Please note: you do not have to be certified in the area of professional activity to include it in your profile.*

Area of professional activity		Part of my practice	Area of special interest	If area of special interest, % of time
Addiction medicine	593	<input type="checkbox"/>	<input type="checkbox"/>	_____ %
Administration	523	<input type="checkbox"/>	<input type="checkbox"/>	_____ %
Alternative/complementary medicine	599	<input type="checkbox"/>	<input type="checkbox"/>	_____ %
Adolescent medicine	625	<input type="checkbox"/>	<input type="checkbox"/>	_____ %
Anaesthesia	101	<input type="checkbox"/>	<input type="checkbox"/>	_____ %
Cancer care/oncology	132	<input type="checkbox"/>	<input type="checkbox"/>	_____ %
Cardiology	103	<input type="checkbox"/>	<input type="checkbox"/>	_____ %
Chronic disease management	699	<input type="checkbox"/>	<input type="checkbox"/>	_____ %
Community medicine/public health	107	<input type="checkbox"/>	<input type="checkbox"/>	_____ %
Dermatology/cosmetic medicine	112	<input type="checkbox"/>	<input type="checkbox"/>	_____ %
Emergency medicine	115	<input type="checkbox"/>	<input type="checkbox"/>	_____ %
Family practice/general practice/ primary care	587	<input type="checkbox"/>	<input type="checkbox"/>	_____ %
Geriatric medicine/care of the elderly	121	<input type="checkbox"/>	<input type="checkbox"/>	_____ %
Gynecology	308	<input type="checkbox"/>	<input type="checkbox"/>	_____ %
Homecare	543	<input type="checkbox"/>	<input type="checkbox"/>	_____ %
Hospitalist care	545	<input type="checkbox"/>	<input type="checkbox"/>	_____ %
Infectious diseases	125	<input type="checkbox"/>	<input type="checkbox"/>	_____ %
International medicine	589	<input type="checkbox"/>	<input type="checkbox"/>	_____ %
Legal/medico-legal consultations	555	<input type="checkbox"/>	<input type="checkbox"/>	_____ %
Nutrition	541	<input type="checkbox"/>	<input type="checkbox"/>	_____ %
Obstetrics	307	<input type="checkbox"/>	<input type="checkbox"/>	_____ %
Occupational/industrial medicine	139	<input type="checkbox"/>	<input type="checkbox"/>	_____ %
Pain management	521	<input type="checkbox"/>	<input type="checkbox"/>	_____ %
Palliative care	427	<input type="checkbox"/>	<input type="checkbox"/>	_____ %
Pediatrics	141	<input type="checkbox"/>	<input type="checkbox"/>	_____ %
Preventive medicine	697	<input type="checkbox"/>	<input type="checkbox"/>	_____ %
Psychiatry	167	<input type="checkbox"/>	<input type="checkbox"/>	_____ %

Area of professional activity		Part of my practice	Area of special interest	If area of special interest, % of time
Psychotherapy/counseling	598	<input type="checkbox"/>	<input type="checkbox"/>	_____ %
Research	510	<input type="checkbox"/>	<input type="checkbox"/>	_____ %
Sports medicine	615	<input type="checkbox"/>	<input type="checkbox"/>	_____ %
Surgery	304	<input type="checkbox"/>	<input type="checkbox"/>	_____ %
Surgical assisting	306	<input type="checkbox"/>	<input type="checkbox"/>	_____ %
Teaching	695	<input type="checkbox"/>	<input type="checkbox"/>	_____ %
Travel/tropical medicine	591	<input type="checkbox"/>	<input type="checkbox"/>	_____ %
Women's health care	565	<input type="checkbox"/>	<input type="checkbox"/>	_____ %
Other _____	821	<input type="checkbox"/>	<input type="checkbox"/>	_____ %
Other _____	822	<input type="checkbox"/>	<input type="checkbox"/>	_____ %
Other _____	823	<input type="checkbox"/>	<input type="checkbox"/>	_____ %
Other _____	824	<input type="checkbox"/>	<input type="checkbox"/>	_____ %
Other _____	825	<input type="checkbox"/>	<input type="checkbox"/>	_____ %

D. Clinical Practice Profile

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

- | | |
|---|--|
| <input type="checkbox"/> Audiometry | <input type="checkbox"/> Removal of superficial skin lesions (e.g. nevi, keratoses, cysts) |
| <input type="checkbox"/> Refraction | <input type="checkbox"/> Cryotherapy of superficial skin lesions (e.g. warts, nevi, lentigo) |
| <input type="checkbox"/> ECG interpretation | <input type="checkbox"/> Skin biopsy |
| <input type="checkbox"/> Pulmonary function testing | <input type="checkbox"/> Other biopsy
_____ |
| <input type="checkbox"/> Pap smears | <input type="checkbox"/> Suturing |
| <input type="checkbox"/> IUD insertion | <input type="checkbox"/> Toenail surgery |
| <input type="checkbox"/> Endometrial aspiration | <input type="checkbox"/> Other minor surgery
_____ |
| <input type="checkbox"/> Lumbar puncture | <input type="checkbox"/> Other procedures
_____ |
| <input type="checkbox"/> Casting/splinting | |
| <input type="checkbox"/> Aspiration/injection of joints | |
| <input type="checkbox"/> Incising & draining abscesses | |
| <input type="checkbox"/> Anoscopy | |
| <input type="checkbox"/> Other endoscopy
_____ | |
| <input type="checkbox"/> Needle aspiration (for diagnosis/biopsy) | |

9. Please describe your involvement in maternity and newborn care.

- Maternity and newborn care are **not part** of my practice (*Please SKIP TO QUESTION 10*)
- Maternity and newborn care **are** part of my practice, and I provide: *Please check ALL that apply.*
 - Prenatal/Antenatal care
 - Intrapartum care. Please indicate the number of births you attend per year: _____
 - I do **not** provide intrapartum care, but usually refer low-risk women to:
 - Another FP/GP An Obstetrician/Gynecologist A midwife
 - Postpartum care (in hospital or office, with reference to the mother)
 - Newborn care (in hospital or office, with reference to the baby)

E. Time Allocation

10.a) 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 10.a)i through 10.a)x | TOTAL HOURS WORKED PER WEEK _____ hours/week |

10.b) Of your direct patient care hours (EXCLUDING ON-CALL ACTIVITIES) indicated above in 10.a) i and ii, please indicate how that time is broken down in the following activities.

- | | |
|--|--|
| i) Patient care in office/clinic | _____ hours/week |
| ii) Homecare | _____ hours/week |
| iii) Patient care in emergency room | _____ hours/week |
| iv) Hospital based activities | _____ hours/week |
| v) In-patient care in other types of institutions (e.g. nursing home, rehab facility, etc.) | _____ hours/week |
| vi) Other _____ | _____ hours/week |
| SUM of 10.b)i through 10.b)vi | TOTAL should not exceed the sum of i and ii in 10.a) _____ hours/week |

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

11.a) Describe your on-call activity. *Please check ALL that apply.*

- Do not do on-call (*Please SKIP TO QUESTION 12*)
- Do obstetrical on-call
- Do on-call for hospital in-patients
- Do on-call for non-hospitalized patients — telephone availability only
- Do on-call for non-hospitalized patients — telephone availability and see patients as required
- Do emergency room on-call
- Do nursing home/LTC facility on-call
- Other

11.b) Please estimate your average total number of on-call work hours PER MONTH

hours/month

11.c) Please estimate how many of your on-call hours each month are actually spent in direct patient care

hours/month

11.d) Please estimate the number of patients you see on-call per month

patients/month

12. In a TYPICAL year, how many weeks do you spend on each of the following activities?

_____ weeks engaged in clinical services/medical care, administration, teaching, research, on-going CME/CPD (continuing professional development)

_____ weeks away from practice for CME/CPD purposes

_____ weeks of vacation

_____ weeks in other activities

52 TOTAL MUST EQUAL 52 WEEKS

13.a) In the last year have you been absent from work due to illness or disability? Yes No

If YES, approximately how many days were you absent in the last year? _____ (number of days)

Was the cause of the illness/disability work related?

Yes No

13.b) In the last year have you taken time off work for personal reasons (e.g. maternity, paternity, care of family members)? Yes No

If YES, approximately how many days were you absent in the last year? _____ (number of days)

F. Professional Income

14.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%.*

Fee-for-service (insured and uninsured services)	_____ %
Salary	_____ %
Capitation	_____ %
Sessional/per diem/hourly	_____ %
Service contracts	_____ %
Incentives and premiums	_____ %
Other _____	_____ %

Total 100 %

14.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/per diem/hourly only
- Service contract only
- Blended payment

IF BLENDED, what components would you want included? *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 _____

14.c) Please indicate which of the following FUNDING MECHANISMS contribute to your income, either directly or through financial support of your practice setting/organization. Note: All of the funding mechanisms may not be available in your province/territory. *Check ALL that apply to you.*

- Alternative payment program
- Regional health authority/board
- Academic health sciences centre
- Blended funding program
- Block funding program
- Rural/northern/underserved incentives
- CMPA reimbursement
- Third party pension contributions or other benefits
- Other

G. Access to Care

15. What arrangements do you have for care of your patients outside of usual office hours? *Check ALL that apply.*

- Physician available
 - Individualized medical telephone advice
- If yes, who provides that advice? *Check ALL that apply.*
- a physician associated with your practice
 - a nurse or other health care team member associated with your practice
 - a service provided by an external agency (e.g. 1 800 toll-free telehealth line)

other

- Instructions to go to the emergency department
- Instructions to go to a walk-in clinic/after hours clinic
- Instructions to call a housecall service

Other

- No direction

16. Please rate the accessibility to the following for your patients.

	Excellent	Very Good	Good	Fair	Poor	N/A
Referral to specialist physicians in general	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Referral to Psychiatrists	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Referral to Obstetricians/Gynecologists	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Referral to Orthopedic Surgeons	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pediatricians/Pediatric specialists	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anaesthesia services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emergency room services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Palliative care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hospital in-patient care on an urgent basis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hospital care for elective procedures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Highly specialized services (e.g. trauma, stroke, renal dialysis, cancer, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Long-term care beds (e.g. nursing home, chronic care, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Routine diagnostic services (e.g. lab, x-rays, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Advanced diagnostic services (e.g. MRI, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs and appliances	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Community nursing services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Homemaking services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Occupational therapy services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physiotherapy services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychosocial support services (e.g. psychologists, social workers, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health care services in patient's language/culture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Female or male physicians as preferred by patient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

17. To what extent are you accepting new patients into your MAIN patient care setting? *Please check only ONE.*

No restrictions; practice is open to all new patients

Completely closed

Partially closed. *Please describe*

Not applicable

H. Changes to Your Practice

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

		Changes made in the LAST 2 years	Changes planned in the NEXT 2 years
Relocate my practice within the same province/territory	A	<input type="checkbox"/>	<input type="checkbox"/>
Relocate my practice to another province/territory in Canada	B	<input type="checkbox"/>	<input type="checkbox"/>
Relocate to Canada from another country	C	<input type="checkbox"/>	<input type="checkbox"/>
Leave Canada to practise in another country	D	<input type="checkbox"/>	<input type="checkbox"/>
Move from an urban/suburban to a rural/remote practice setting	E	<input type="checkbox"/>	<input type="checkbox"/>
Move from a rural/remote to an urban/suburban practice setting	F	<input type="checkbox"/>	<input type="checkbox"/>
Specialize in an area of medical practice _____	G	<input type="checkbox"/>	<input type="checkbox"/>
Reduce scope of practice _____	H	<input type="checkbox"/>	<input type="checkbox"/>
Expand scope of practice _____	I	<input type="checkbox"/>	<input type="checkbox"/>
Reduce teaching, research, and/or administration responsibilities	J	<input type="checkbox"/>	<input type="checkbox"/>
Increase teaching, research, and/or administration responsibilities	K	<input type="checkbox"/>	<input type="checkbox"/>
Take a temporary leave of absence	L	<input type="checkbox"/>	<input type="checkbox"/>
Reduce weekly work hours (excluding on call)	M	<input type="checkbox"/>	<input type="checkbox"/>
Increase weekly work hours (excluding on call)	N	<input type="checkbox"/>	<input type="checkbox"/>
Reduce on-call hours	O	<input type="checkbox"/>	<input type="checkbox"/>
Increase on-call hours	P	<input type="checkbox"/>	<input type="checkbox"/>
Change from solo to group practice	Q	<input type="checkbox"/>	<input type="checkbox"/>
Change to a multidisciplinary practice model	R	<input type="checkbox"/>	<input type="checkbox"/>
Become part of a practice network	S	<input type="checkbox"/>	<input type="checkbox"/>
Change in mode of remuneration	T	<input type="checkbox"/>	<input type="checkbox"/>
Retrain within the medical field	U	<input type="checkbox"/>	<input type="checkbox"/>
Retire	V	<input type="checkbox"/>	<input type="checkbox"/>
Leave active practice for reason(s) other than above _____	W	<input type="checkbox"/>	<input type="checkbox"/>
Other change(s) _____	X	<input type="checkbox"/>	<input type="checkbox"/>
NO CHANGES (if no changes made or planned, SKIP TO QUESTION 20)	Y	<input type="checkbox"/>	<input type="checkbox"/>

19.a) From question 18 above, please indicate the most significant change you **MADE** in the last two years. *Please circle ONLY ONE.*

A B C D E F G H I J K L M N O P Q R S T U V W X

19.b) From question 18 above, please indicate the most significant change **PLANNED** in the next two years. *Please circle ONLY ONE.*

A B D E F G H I J K L M N O P Q R S T U V W X

19.c) Please indicate your reasons for the most significant changes that you circled in questions 19 (a) & (b) above. *Please check ALL that apply.*

MOST SIGNIFICANT CHANGE Reason(s) for change(s)	Changes MADE (19.a)	Changes PLANNED (19.b)
Want(ed) a career change	<input type="checkbox"/>	<input type="checkbox"/>
Health reasons	<input type="checkbox"/>	<input type="checkbox"/>
Family obligations	<input type="checkbox"/>	<input type="checkbox"/>
Financial priorities/necessities	<input type="checkbox"/>	<input type="checkbox"/>
To meet population/community needs	<input type="checkbox"/>	<input type="checkbox"/>
Other(s) _____	<input type="checkbox"/>	<input type="checkbox"/>

I. Professional Satisfaction

20. Please rate your satisfaction with each of the following.

	Very satisfied	Somewhat satisfied	Neutral	Somewhat dissatisfied	Very dissatisfied	N/A
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 hospitals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your relationship with specialist physicians	<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 non-physician health care workers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The availability of CME/CPD opportunities to meet your needs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your ability to find locum tenens coverage for CME/CPD, holidays, personal time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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"/>

21. Which of your professional activities do you find particularly

a) STRESSFUL?

b) REWARDING?

J. Information Technology

22. 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

23. Please indicate which of the following is in your MAIN patient care setting, whether you use it, and whether it is on a PDA (personal digital assistant/wireless device).

	Have it	Use it	Have it on a PDA
Electronic patient health records	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Electronic patient appointment/scheduling system	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Electronic reminder systems for recommended patient care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Electronic interface to external pharmacy/pharmacist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Electronic interface to external laboratory/diagnostic imaging	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Electronic interface to other external systems (e.g. hospitals, other clinics) for accessing or sharing patient information	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Electronic warning systems for adverse prescribing and/or drug interactions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Electronic decision aids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Telemedicine/webcasting/videoconferencing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Online access to journals, clinical practice guidelines, medical databases (e.g. MEDLINE)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Online CME/CPD courses/programs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

K. Education and Demographics

24.a) When and where did you complete your MEDICAL training?

	Year of graduation	University name	Country
Undergraduate medical training	_____	_____	_____
	_____	_____	_____
Postgraduate medical training	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

24.b) Please specify any medical certification(s).

24.c) Please specify any other non-medical degrees.

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

single, separated, divorced or widowed

married, living with partner

Is your spouse/partner a: physician other health care provider neither

26. Do you have children or other dependents for whom you personally provide care/supervision?

No

Yes

If yes, do you have major responsibility for the care of these individuals?

Yes No

If these are children, what is the age of the youngest? _____ years

27.a) Of all of the areas in medicine, what led you to select your current career? *Please check ALL that apply.*

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

27.b) Indicate the ONE most important factor in 27.a) above.

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

28. When did you decide on your current field of medical practice? *Please check ONLY ONE.*

- Before medical school
- During medical school but prior to clerkship
- During clerkship
- During residency
- After a period of time in practice
- Other

29.a) In which province(s)/territory(ies) do you currently practise? *Circle ALL that apply.*

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

29.b) Indicate the main reason(s) you selected your current practice location. *Please check no more than 2 reasons.*

Availability of medical support system/resources

Family reasons/spousal influence

Liked the area

Opportunity for affiliation with a university

Community needs were a good match with my career interests

Practice opportunity was available

Religious/social/cultural reasons

Financial recruitment/retention incentives

Other (non-financial) recruitment/retention incentives

Other

29.c) Please provide the six-digit postal code of your MAIN patient care setting or MAIN work setting if you do not provide patient care.

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29.d) 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

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

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

30. What languages do you speak with your patients?

English

French

Other(s)

31. Your year of birth: 19

32. Sex: male female

33. Comments

**Please be assured that your response to this survey is anonymous,
and that all individual information will be held in the strictest confidence.
Analysis and publication of results will be at the aggregate level only.**

The identification number on the cover page is for mailing purposes only and has no correlation to any existing ID numbers at the CMA, the CFPC, or the RCPSC. The identification numbers are added to the questionnaires by an external third party as part of a double blind method. There is no mechanism for matching the data files generated from completed questionnaires to individual names or addresses. This ensures anonymity of responses. Should you wish additional information about the anonymization technique used in the National Physician Survey, please contact Shelley Martin at 1 800 663-7336 x2258.

Please return the completed questionnaire in the business reply envelope provided to the National Physician Survey, Canadian Medical Association, 1867 Alta Vista Drive, Ottawa ON K1G 3Y6

If you have any questions about this survey, please contact Shelley Martin at 1 800 663-7336 x2258

Thank you for your time and cooperation.