



National Physician Survey 2010

If you would like to complete the survey online, please go to this URL: www.cma.ca/nps10-spec

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 Royal College. 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 x 2258

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 could earn MOC credits by developing a personal learning project, under section 4, stimulated by completing this survey. Go to www.mainport.org for information about the process.

The College of
Family Physicians
of Canada



Le Collège des
médecins de famille
du Canada

ASSOCIATION
MÉDICALE
CANADIENNE



CANADIAN
MEDICAL
ASSOCIATION



ROYAL COLLEGE
OF PHYSICIANS AND SURGEONS OF CANADA
COLLÈGE ROYAL
DES MÉDECINS ET CHIRURGIENS DU CANADA

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
- I am exclusively working in a non-medical field. *Please specify:* _____

Everyone else, please check ALL that apply to your current situation and proceed with the remainder of the questionnaire.

- I am in full-time medical practice.
- I am in part-time medical practice or semi-retired from the medical labour force.
- I am a locum tenens. *(If you do not have a permanent practice, complete the questionnaire in relation to last practice you served/are currently serving.)*
- I am employed in a medical or medically related field only or other non-clinical settings *(e.g., 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.
- Other, *please specify:* _____

A. ABOUT YOU

1. 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 as a physician in a non-clinical setting, *please specify:* _____
- Other, *please specify:* _____

2. Your year of birth: 19

3. You are: male female

B. YOUR WORK SETTING(S)

4a. 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) | H <input type="checkbox"/> Emergency department (in community hospital or AHSC) |
| B <input type="checkbox"/> Community clinic/Community health centre | I <input type="checkbox"/> Nursing home/Home for the aged |
| C <input type="checkbox"/> Free-standing walk-in clinic | J <input type="checkbox"/> University |
| D <input type="checkbox"/> Academic health sciences centre (AHSC) | K <input type="checkbox"/> Research Unit |
| E <input type="checkbox"/> Non-AHSC teaching hospital | L <input type="checkbox"/> Free-standing lab/diagnostic clinic |
| F <input type="checkbox"/> Community hospital | M <input type="checkbox"/> Administrative office / Corporate office |
| G <input type="checkbox"/> Other hospital | N <input type="checkbox"/> Other: _____ |

4b. 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 'NA').*

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

5. 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

6. Please provide the 6-digit postal code of your MAIN patient care setting OR main work setting:



C. YOUR PATIENT CARE SETTING(S)

7. Do you provide patient care? Yes No (If no, skip to question 18)

8. What languages do you speak with your patients? Check all that apply. English French Other(s): _____

9. What percentage of your gross professional income goes towards running your practice (e.g., part-time or full-time staff, leases/rent/mortgage, equipment leasing/rental, personal benefits, vehicle costs, professional fees, malpractice dues, other overhead expenses)?

% Not Applicable

10a. 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 - association (i.e., fee/cost-sharing relationship)
- Group practice - partnership (i.e., fee/cost-sharing; income sharing and financial/medical liability sharing)
- Interprofessional practice (physician(s) and other health professional(s) who have their own caseloads)
- Other, please specify: _____

10b. Are you incorporated: individually? Yes No as a group? Yes No

11. Please indicate with whom you REGULARLY REFER or HAVE COLLABORATIVE CARE ARRANGEMENTS (you work together to provide care to a common group of patients, with mutually agreed upon roles and responsibilities). Check ALL that apply.

	Refer	Collaborate		Refer	Collaborate
Other family physicians	<input type="checkbox"/>	<input type="checkbox"/>	Other health care providers. Please specify the three main health care providers to whom you regularly refer patients or have a collaborative arrangement with:		
Other specialists. Please specify the three main other specialist types to whom you regularly refer patients or have a collaborative arrangement with:					
_____	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>

12. Are there any barriers that currently exist to prevent you from engaging a Physician / Clinical Assistant or Nurse Practitioner in your practice? (Check all that apply)

	Physician / Clinical Assistants	Nurse Practitioners
Lack of information about them	<input type="checkbox"/>	<input type="checkbox"/>
They have not been introduced in my jurisdiction yet	<input type="checkbox"/>	<input type="checkbox"/>
Liability is not clearly defined	<input type="checkbox"/>	<input type="checkbox"/>
Regulatory framework does not permit me to delegate to them	<input type="checkbox"/>	<input type="checkbox"/>
Limited funding models	<input type="checkbox"/>	<input type="checkbox"/>
My practice would not benefit from them	<input type="checkbox"/>	<input type="checkbox"/>
Other, please specify: _____	<input type="checkbox"/>	<input type="checkbox"/>

D. PATIENT ACCESS TO CARE

13. Please rate your accessibility to the following on behalf of your patients.

	Excellent	Very Good	Good	Fair	Poor	Not Available	Don't Know
Other specialist physicians (in general)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Please indicate the top three specialties with whom you most commonly interact, and rate their accessibility:</i>							
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family physicians/ general practitioners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other health professionals (in general)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Please indicate the top three health professions with whom you most commonly interact, and rate their accessibility:</i>							
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer care services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac care services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Palliative medicine services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anesthesia services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Operating room time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emergency room/department services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Critical care beds	<input type="checkbox"/>	<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"/>	<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"/>	<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"/>	<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"/>	<input type="checkbox"/>
Advanced diagnostic services (e.g., MRI, CT, etc.)	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>
Other, please specify:							
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

14a. 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



14b. 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

E. YOUR PRACTICE/ WORK PROFILE

15a. Are you practicing within the main areas of the specialty as broadly taught during your residency?

- Yes (if yes, skip to question 15c) No

If No, please indicate why your practice differs from your training. *Please check all that apply*

Developments in my specialty:

- New medical information regarding my specialty
- New indications for treatment
- New diagnostics
- CPGs
- Technology
- Drugs
- Other, *please specify:* _____
- Changing disease patterns
- Increasing demands due to an aging population
- Shortages of other health care providers
- Implementation of interprofessional care
- New health care restructuring arrangements
- Patient needs
- Personal choice
- Other, *please specify:* _____

15b. If your practice extends beyond what you were taught during residency, what extra training did you pursue?

Check all that apply

- No additional formal training
- A fellowship after residency
- Continuing professional development offered by a national specialty society in Canada
- Continuing professional development offered by a medical society outside of Canada
- Continuing professional development offered by industry (e.g. medical devices)
- Other substantive training (e.g., simulator, other residency training), *please specify:* _____

15c. Considering the generally accepted domain of practice of your specialty, please describe the main focus of your practice.

	Yes	No	Not applicable
Full spectrum of my specialty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Limited to anatomy specific (e.g., hips only, chest only)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Limited to organ specific (e.g., luminal GI)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Limited to disease/ condition specific	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Limited to treatment specific	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Limited to specific populations (e.g., children, women, rural)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other, <i>please specify:</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

16. Please indicate if you care for the following. Please check ALL that apply.

<input type="checkbox"/> Neonates (<1 month)	<input type="checkbox"/> Street Involved
<input type="checkbox"/> Infants (1-12 months)	<input type="checkbox"/> Gay/Lesbian/Bisexual/Transgender
<input type="checkbox"/> Children (1-11 years)	<input type="checkbox"/> Transient/seasonal populations
<input type="checkbox"/> Adolescents (12-19 years)	<input type="checkbox"/> Patients with hypertension
<input type="checkbox"/> Women	<input type="checkbox"/> Patients with diabetes
<input type="checkbox"/> Pregnant women	<input type="checkbox"/> Patients with heart disease/ conditions
<input type="checkbox"/> Men	<input type="checkbox"/> Patients with mental illness
<input type="checkbox"/> Aged 65-74	<input type="checkbox"/> Patients with obesity
<input type="checkbox"/> Aged 75 - 89	<input type="checkbox"/> Patients with cancer
<input type="checkbox"/> Aged 90 and over	<input type="checkbox"/> Patients with neurological conditions
<input type="checkbox"/> Aboriginal peoples	<input type="checkbox"/> Patients with respiratory conditions
<input type="checkbox"/> Ethnic minorities	<input type="checkbox"/> Patients with HIV/AIDS
<input type="checkbox"/> Recent immigrants	<input type="checkbox"/> Patients with addictions
<input type="checkbox"/> People living in poverty	<input type="checkbox"/> Patients with permanent physical disabilities
<input type="checkbox"/> Homeless	<input type="checkbox"/> Other, <i>please specify</i> : _____

F. ALLOCATION OF YOUR TIME

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

17a. Do you do call?

- No (Skip to question 18)
- Yes - **If yes, describe your on-call activity. Check ALL that apply.**
- | | |
|--|--|
| <input type="checkbox"/> Obstetrical on-call | <input type="checkbox"/> On-call for regional referrals |
| <input type="checkbox"/> On-call for hospital in-patients | <input type="checkbox"/> Emergency room on-call |
| <input type="checkbox"/> On-call for non-hospitalized patients - telephone availability only | <input type="checkbox"/> Nursing home/ LTC facility on-call |
| <input type="checkbox"/> On-call for non-hospitalized patients - telephone availability and see patients as required | <input type="checkbox"/> Other, <i>please specify</i> :
_____ |

17b. Please estimate your average number of on-call work hours PER MONTH: hours/month

17c. 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



17d. Do you ever spend continuous 24-hour periods of on-call time in direct patient care? Yes No
 If yes, are you ever required to provide direct patient care immediately after these 24-hour periods? Yes No

17e. Please estimate the number of patients you SEE on-call per month: patients/month

18. 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.

a) Direct patient care without a teaching component, regardless of setting	<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> hours/week
b) Direct patient care with a teaching component, regardless of setting	<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> hours/week
c) Teaching/Education without direct patient care (contact with students/residents, preparation, marking, evaluations, etc.)	<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> hours/week
d) Indirect patient care (charting, reports, phone calls, meeting patients' family, etc.)	<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> hours/week
e) Health facility committees (academic planning committees)	<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> hours/week
f) Administration (i.e. management of university program, chief of staff, department head, Ministry of Health, etc.)	<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> hours/week
g) Research (including management of research and publications)	<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> hours/week
h) Managing your practice (staff, facility, equipment, etc.)	<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> hours/week
i) Continuing medical education/professional development (courses, reading, videos, tapes, seminars, etc.)	<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> hours/week
j) Other (participation in professional or specialty organizations, medico-legal activities, etc.), please specify:	<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> hours/week
SUM of 18.a) through 18.j)	TOTAL HOURS WORKED PER WEEK <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> hours/week

19. In the last year, have you:

a) Used any locum tenens? Yes No, locum not available No, locum not needed

b) Personally provided locum tenens services for another physician? Yes No

20a. Do you regularly work as a visiting physician? Visiting physicians are doctors who travel to other communities to provide care to individuals outside of their own practice, e.g., fly-in physicians for remote areas (but not as locums).

Yes No

20b. If yes, how many days per month do you practice as a visiting physician?

21a. Please indicate the frequency of use and impact on your practice of the following Continuing Professional Education methods:

Frequency: 1=Never 2=Once a year 3=Once every six months 4=Once a month 5=More than once a month

Impact: 1=Very insignificant 2=Somewhat insignificant 3=Neutral 4=Somewhat significant 5=Very significant DU=Don't Use

	Frequency					Impact					
	1	2	3	4	5	1	2	3	4	5	DU
Attending live accredited conferences, courses or events in person	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attending live unaccredited conferences, courses or events in person	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reading peer-reviewed journals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reading non peer-reviewed medical publications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Using evidence-based resources (e.g., clinical practice guidelines, data repositories)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Using computer-based, offline education (e.g., CD-ROM, DVD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Using internet-based education / eLearning (e.g., online courses, webinars)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Participating in hospital/clinical rounds, journal clubs and other small group activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Doing self-assessment activities (e.g., multiple choice questions, practice portfolios, CME logs, multi-source feedback)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Undergoing practice audits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Using simulation (e.g., full/partial task simulators, virtual reality, standardized patients, role play)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other, <i>please specify:</i> _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

21b. Please rate how significantly each of the following has served as a barrier to your participation in CME/CPD.

	not a barrier	somewhat significant barrier	very significant barrier	Not applicable
Time away from practice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lack of locum relief	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Time away from family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cost of travel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cost of actual CME/CPD activities (registration, materials, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lack of opportunity (few or no courses available, convenient or desired)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lack of relevance to my practice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other, <i>please specify:</i> _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

G. YOUR PROFESSIONAL INCOME

22. 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)	<input type="text"/>	<input type="text"/>	<input type="text"/>	.	<input type="text"/>	%
Salary	<input type="text"/>	<input type="text"/>	<input type="text"/>	.	<input type="text"/>	%
Capitation	<input type="text"/>	<input type="text"/>	<input type="text"/>	.	<input type="text"/>	%
Sessional/per diem/hourly	<input type="text"/>	<input type="text"/>	<input type="text"/>	.	<input type="text"/>	%
Service contract	<input type="text"/>	<input type="text"/>	<input type="text"/>	.	<input type="text"/>	%
Incentives and premiums	<input type="text"/>	<input type="text"/>	<input type="text"/>	.	<input type="text"/>	%
Other, <i>please specify:</i> _____	<input type="text"/>	<input type="text"/>	<input type="text"/>	.	<input type="text"/>	%
TOTAL	1	0	0	.	0	%



H. CHANGES TO YOUR PRACTICE

23. Please indicate which of the following factors are increasing the demand for your time at work. Check all that apply.

- | | |
|--|---|
| <input type="checkbox"/> Aging patient population | <input type="checkbox"/> Lack of availability of local/regional physician services in other specialties |
| <input type="checkbox"/> Increasing complexity of patient caseload | <input type="checkbox"/> Lack of availability of other local/regional health care professional services |
| <input type="checkbox"/> Management of patients with chronic diseases/conditions | <input type="checkbox"/> Medical liability concerns |
| <input type="checkbox"/> Increasing patient expectations | <input type="checkbox"/> Other, <i>please specify:</i> _____ |
| <input type="checkbox"/> Increasing administrative workload/paperwork | <input type="checkbox"/> None of the above |
| <input type="checkbox"/> Lack of availability of local/regional physician services in my specialty | |

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	
	Reduced	Increased	Reduce	Increase
Weekly work hours (excluding on call)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
On-call hours	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clinical hours (excluding on call)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Teaching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Research	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Administration responsibilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Scope of practice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	LAST 2 years		NEXT 2 years	
Retire from clinical practice	<input type="checkbox"/>		<input type="checkbox"/>	
Leave Canada to practice in another country	<input type="checkbox"/>		<input type="checkbox"/>	
Relocate my practice to another province/territory in Canada	<input type="checkbox"/>		<input type="checkbox"/>	
Focus practice in an area of special interest	<input type="checkbox"/>		<input type="checkbox"/>	
Stop intrapartum practice	<input type="checkbox"/>		<input type="checkbox"/>	
Become part of a practice network	<input type="checkbox"/>		<input type="checkbox"/>	
Other change(s) MADE, <i>specify:</i> _____	<input type="checkbox"/>			
Other change(s) PLANNED, <i>specify:</i> _____			<input type="checkbox"/>	
<input type="checkbox"/> No changes made or planned				

25. If you plan to retire in the near future, which of the following might entice you to practice longer? Please check all that apply:

- | | |
|--|--|
| <input type="checkbox"/> Ability to do locums only | <input type="checkbox"/> No hospital duties |
| <input type="checkbox"/> Increased flexibility in setting schedule (e.g., working part-time, sharing practice) | <input type="checkbox"/> Academic appointment |
| <input type="checkbox"/> Setting up a smaller practice in a new community | <input type="checkbox"/> None of the above |
| <input type="checkbox"/> Cash incentives (e.g., bonuses for every year worked past 65) | <input type="checkbox"/> Other, <i>please specify:</i> _____ |
| <input type="checkbox"/> Reduced on-call duties | <input type="checkbox"/> Not planning to retire in the near future |

I. YOUR USE OF INFORMATION TECHNOLOGY

26a. Do you have a practice Web site? Yes No

If yes, can patients contact your office to request an appointment through your website? Yes No

26b. Do you refer your patients to any websites? Yes No

If yes, please specify for what purpose (check all that apply)

- Disease information Treatment information Patient support Other, *please specify:* _____

26c. 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

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

- I use paper charts only (Skip to question 29)
 I use a COMBINATION OF PAPER AND ELECTRONIC charts to enter and retrieve patient clinical notes
 I use electronic records INSTEAD OF PAPER CHARTS to enter/retrieve patient clinical notes
 Not applicable - I do not provide patient care (Skip to question 30)

28a. Where do you access electronic records for your patients? Please check all that apply.

- A Office/community clinic/community health centre D Nursing home/home for aged
 B Hospital/AHSC/Emergency Department E Other, *please specify:* _____
 C University/faculty of medicine/research unit F Not applicable

28b. In which setting do you use electronic records most often? Please check only one.

- A B C D E Not applicable

28c. If you access electronic records in various locations, are the records in these locations electronically connected to each other to allow for access of the same electronic record from different settings?

- Yes, all of these settings are electronically connected to each other.
 Only some of these settings are electronically connected to each other.
 None of these settings are electronically connected to each other.

29. Please indicate which of the following you use, or plan to use, in the care of your patients. Check ALL that apply.

	Use it on a PC/laptop	Use it on a small handheld wireless device	Plan to start using on a PC/laptop or wireless device in next 2 years
Electronic patient appointment/scheduling system	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Electronic billing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Electronic records to enter and retrieve clinical patient notes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Electronic reminders for recommended patient care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Electronic warning for adverse prescribing and/or drug interactions	<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"/>
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"/>
Email	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Online CME	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Online discussion forums with other physicians for professional purposes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Online disease management tools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> I do not use or plan to use any of the above			



J. YOUR PROFESSIONAL SATISFACTION

30. 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"/>

For consulting physicians:

31a. Do the referral documents you receive contain sufficient information?

- Always Most of the time Sometimes Rarely Never Not Applicable

31b. If not satisfactory, which are the most important elements that could be enhanced in the referral documents you currently receive? Please check all that apply:

- Information about the problem to be addressed Relevant investigations and/or treatments already tried
 Clinical questions to be answered Medications
 Details the patient is unable or unlikely to provide Other, please specify: _____
 Concurrent medical problems

For referring physicians:

32a. Do the consultation reports you receive contain sufficient information?

- Always Most of the time Sometimes Rarely Never Not Applicable

32b. If not satisfactory, which are the most important elements that could be enhanced in the consultation reports you currently receive? Please check all that apply:

- Specific answers to specific questions
 Clearly stated diagnostic considerations
 A detailed treatment plan (e.g., medications, reasons behind the treatment plan)
 Possible effects of the disease or treatment on the patient's quality of life
 Contingency plans in the event of adverse events from (or failure of) treatment
 Prognostic statements
 Follow-up arrangements
 Other, please specify: _____

K. DEMOGRAPHICS

33. Where were you born? Canada USA Other Country _____

34a. Year of your undergraduate medical graduation:

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

34b. Please indicate where you completed your medical training. Please check only ONE location per category.

Undergraduate = Undergraduate medical graduation (medical school)

Post-graduate = MOST RECENT post-graduate medical training (i.e. residency/internship).

LOCATION	Undergraduate	Post-graduate
CANADA	<input type="checkbox"/>	<input type="checkbox"/>
US	<input type="checkbox"/>	<input type="checkbox"/>
Other, please specify country: _____	<input type="checkbox"/>	<input type="checkbox"/>

35. Current medical specialty certification/attestation. Please check all that apply.

- Royal College of Physicians and Surgeons of Canada
- College of Family Physicians of Canada
- Collège des médecins du Québec
- Other medical designation: _____

Other degree(s):

Masters: _____

PhD: _____

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

--	--	--	--

37a. Do you have children (including stepchildren)? No Yes - Age of the youngest?

--	--

 years

On average, how many hours per week do you have primary responsibility for the care/supervision of these children (excluding sleep hours)?

--	--	--

 hrs/wk

37b. Do you have any other dependents for whom you personally provide care (grandchildren/elderly/disabled)?

- No Yes

If you answered yes, how many other dependents do you have?

--	--

On average, how many hours per week do you spend caring for your other dependents (excluding sleep hours)?

--	--	--

 hrs/wk

38. 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? 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.

39. Comments:

Direct quotes that represent a concept expressed by many respondents may be used in publications and presentations, however, these quotes will not be attributed to any specific individuals.

- Check here to enter a draw for \$1000 tax-free for yourself or your favourite registered charity.

If you are the winner, your name and contact information will only be used to inform you that you have won and is not linked to survey responses.

For full contest rules, please go to: www.cma.ca/nps-p

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 1-800-663-7336 ext. 2258.

The College of
Family Physicians
of Canada



Le Collège des
médecins de famille
du Canada

ASSOCIATION
MÉDICALE
CANADIENNE



CANADIAN
MEDICAL
ASSOCIATION



ROYAL COLLEGE
OF PHYSICIANS AND SURGEONS OF CANADA
COLLÈGE ROYAL
DES MÉDECINS ET CHIRURGIENS DU CANADA

